NHS Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC AGENDA

Thursday 18th January 2024 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/2324/117	Welcome, introductions and apologies: Andy Smith, Ellie Houlston	Richard Wright	Verbal
	ICBP/2324/118	Confirmation of quoracy	Richard Wright	Verbal
	ICBP/2324/119	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/2324/120	Minutes from the meeting held on 16th November 2023	Richard Wright	Paper
	ICBP/2324/121	Action Log – November 2023	Richard Wright	Paper
09.10	**Strategy and Leadership**			
	ICBP/2324/122	Chair's Report – December 2023	Richard Wright	Verbal
	ICBP/2324/123	Chief Executive Officer's Report – December 2023	Dr Chris Clayton	Verbal
09:20	**Risk Management**			
	ICBP/2324/124	ICB Risk Register Report – December 2023	Helen Dillistone	Paper

Time	Reference	Item	Presenter	Delivery
09:30	**Integrated Assurance & Performance**			
	ICBP/2324/125	Integrated Assurance and Performance Report • Quality • Performance • Workforce • Finance	Dr Chris Clayton Dr Deji Okubadejo / Dean Howells Richard Wright / Michelle Arrowsmith Margaret Gildea / Linda Garnett Jill Dentith / Keith Griffiths	Paper
9:50	**For Discussion**			
	ICBP/2324/126	Financial Plan Update	Keith Griffiths	Verbal
	ICBP/2324/127	University Hospitals of Derby and Burton Foundation Trust Maternity Care Assurance Report	Stephen Posey/ Dean Howells	Paper
10:15	**Corporate Assurance**			
	ICBP/2324/128	Audit and Governance Committee Assurance Report – December 2023	Sue Sunderland	Paper
	ICBP/2324/129	Finance, Estates and Digital Committee Assurance Report – November/ December 2023	Jill Dentith	Paper
	ICBP/2324/130	Quality and Performance Committee Assurance Report – November 2023	Dr Deji Okubadejo	Paper
	ICBP/2324/131	People and Culture Committee Assurance Report – December 2023	Margaret Gildea	Paper
	ICBP/2324/132	Freedom to Speak Up Update – General Practice	Margaret Gildea	Paper
10:35	**Items for information**			
	The following items are for information and will not be individually presented			
	ICBP/2324/133	East Midlands ICB Collaborative Arrangements	Dr Chris Clayton	Paper
	ICBP/2324/134	ICB Constitution – approval letter from NHS England	Helen Dillistone	Paper
	ICBP/2324/135	Emergency Preparedness, Resilience and Response Annual Report 2022/23	Dr Chris Weiner	Paper
	ICBP/2324/136	Ratified minutes of ICB Committee Meetings: • Audit & Governance Committee – 12.10.2023 • People & Culture Committee – 6.9.2023 • Public Partnerships Committee – 31.10.2023	Richard Wright	Paper

Time	Reference	Item	Presenter	Delivery
10:40	**Closing Items**			
	ICBP/2324/137	Forward Planner	Richard Wright	Paper
	ICBP/2324/138	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/2324/139	Any Other Business	Richard Wright	Verbal
	ICBP/2324/140	Questions received from members of the public	Richard Wright	Verbal
Date and time of next meeting in public: **Date:** Thursday, 21st March 2024 **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	
				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	
Arrowsmith	Michelle	Chief Strategy and Delivery Officer/ Deputy Chief Executive Officer	Finance & Estates Committee Population Health & Strategic Commissioning Committee Quality & Performance Committee	Director of husband's company - Woodford Woodworking Tooling Ltd				✓	01/11/14	Ongoing	No action required as not relevant to any ICB business
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	ICS Executive Team Meeting	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	
				Providing part-time, short term corporate governance support to Shaping Health International Ltd (UK)	✓				09/03/23	30/09/23	
				Providing part-time, short term corporate governance support to Conexus	✓				01/06/23	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 ICS Executive Team Meeting	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	
Griffiths	Keith	Chief Finance Officer	Finance & Estates Committee Population Health & Strategic Commissioning Committee Integrated Place Executive ICS Executive Team Meeting	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

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	
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 Group Information Governance Assurance Forum ICS Executive Team Meeting	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
Lumsdon*	Paul	Executive Director of Operations	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
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
				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)	UEC Delivery Board (Chair) Provider Collaborative Leadership Board (Chair)	Chief Executive of UHDBFT	✓				01/08/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Board Trustee of the Intensive Care Society (ICS)		✓			01/08/23	Ongoing	
				Executive Well-Led Reviewer for the Care Quality Commission (CQC)		✓			01/08/23	Ongoing	
				Chief Executive Member of the National Organ Utilisation Group (OUG)		✓			01/08/23	Ongoing	
				Partner is Chief Executive Officer of the Royal College of Obstetricians and Gynaecologists				✓	01/08/23	Ongoing	
				Partner is a Non-Executive Director for the Kent, Surrey & Sussex (KSS) AHSN				✓	01/08/23	Ongoing	
				Partner is Trustee of Magpas Charity				✓	01/08/23	Ongoing	
				Partner is a Non-Executive Director for Manx Care				✓	17/05/23	Ongoing	
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	
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	

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	
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 Audit Chair of Joint Audit Risk & Assurance Committee for the Office of the Police & Crime Commissioner and Chief Constable of Derbyshire Husband is an independent person sitting on Derby City Audit Committee		✓ ✓		 ✓	01/07/22 01/07/22 01/07/22	Ongoing Ongoing 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 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 ICS Executive Team Meeting	Nil							No action required
Wright	Richard	ICB Chair	Population Health & Strategic Commissioning Committee Public Partnerships Committee Remuneration Committee	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

Abbreviations & Glossary of Terms

A&E	Accident and Emergency
AfC	Agenda for Change
AGM	Annual General Meeting
AHP	Allied Health Professional
AQP	Any Qualified Provider
Arden & GEM CSU	Arden & Greater East Midlands Commissioning Support Unit
ARP	Ambulance Response Programme
ASD	Autistic Spectrum Disorder
BAF	Board Assurance Framework
BAME	Black Asian and Minority Ethnic
BCCTH	Better Care Closer to Home
BCF	Better Care Fund
BMI	Body Mass Index
bn	Billion
BPPC	Better Payment Practice Code
BSL	British Sign Language
CAMHS	Child and Adolescent Mental Health Services
CATS	Clinical Assessment and Treatment Service
CBT	Cognitive Behaviour Therapy
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile
CEO (s)	Chief Executive Officer (s)

CfV	Commissioning for Value
CHC	Continuing Health Care
CHP	Community Health Partnership
CMHT	Community Mental Health Team
CMP	Capacity Management Plan
CNO	Chief Nursing Officer
COO	Chief Operating Officer (s)
COP	Court of Protection
COPD	Chronic Obstructive Pulmonary Disorder
CPD	Continuing Professional Development
CPN	Contract Performance Notice
CPRG	Clinical & Professional Reference Group
CQC	Care Quality Commission
CQN	Contract Query Notice
CQUIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CSE	Child Sexual Exploitation
CSF	Commissioner Sustainability Funding
CSU	Commissioning Support Unit
CTR	Care and Treatment Reviews

CVD	Chronic Vascular Disorder
CYP	Children and Young People
D2AM	Discharge to Assess and Manage
DAAT	Drug and Alcohol Action Teams
DCC	Derbyshire County Council or Derby City Council
DCHSFT	Derbyshire Community Health Services NHS Foundation Trust
DCO	Designated Clinical Officer
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHSC	Department of Health and Social Care
DHU	Derbyshire Health United
DNA	Did not attend
DoF(s)	Director(s) of Finance
DoH	Department of Health
DOI	Declaration of Interests
DoLS	Deprivation of Liberty Safeguards
DPH	Director of Public Health
DRRT	Dementia Rapid Response Team
DSN	Diabetic Specialist Nurse
DTOC	Delayed Transfers of Care
ED	Emergency Department
EDS2	Equality Delivery System 2
EDS3	Equality Delivery System 3

EIA	Equality Impact Assessment
EIHR	Equality, Inclusion and Human Rights
EIP	Early Intervention in Psychosis
EMASFT	East Midlands Ambulance Service NHS Foundation Trust
EMAS Red 1	The number of Red 1 Incidents (conditions that may be immediately life threatening and the most time critical) which resulted in an emergency response arriving at the scene of the incident within 8 minutes of the call being presented to the control room telephone switch.
EMAS Red 2	The number of Red 2 Incidents (conditions which may be life threatening but less time critical than Red 1) which resulted in an emergency response arriving at the scene of the incident within 8 minutes from the earliest of; the chief complaint information being obtained; a vehicle being assigned; or 60 seconds after the call is presented to the control room telephone switch.

EMAS A19	The number of Category A incidents (conditions which may be immediately life threatening) which resulted in a fully equipped ambulance vehicle able to transport the patient in a clinically safe manner, arriving at the scene within 19 minutes of the request being made.
EMLA	East Midlands Leadership Academy
EoL	End of Life
ENT	Ear Nose and Throat
EPRR	Emergency Preparedness Resilience and Response
FCP	First Contact Practitioner
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FIRST	Falls Immediate Response Support Team
FRP	Financial Recovery Plan
GDPR	General Data Protection Regulation
GP	General Practitioner
GPFV	General Practice Forward View
GPSI	GP with Specialist Interest
HCAI	Healthcare Associated Infection
HDU	High Dependency Unit
HEE	Health Education England
HI	Health Inequalities

HLE	Healthy Life Expectancy
HNA	Health Needs Assessment
HSJ	Health Service Journal
HWB	Health & Wellbeing Board
H1	First half of the financial year
H2	Second half of the financial year
IAF	Improvement and Assessment Framework
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICM	Institute of Credit Management
ICO	Information Commissioner's Office
ICP	Integrated Care Partnership
ICS	Integrated Care System
ICU	Intensive Care Unit
IG	Information Governance
IGAF	Information Governance Assurance Forum
IGT	Information Governance Toolkit
IP&C	Infection Prevention & Control
IT	Information Technology
IWL	Improving Working Lives
JAPC	Joint Area Prescribing Committee
JSAF	Joint Safeguarding Assurance Framework

JSNA	Joint Strategic Needs Assessment
JUCD	Joined Up Care Derbyshire
k	Thousand
KPI	Key Performance Indicator
LA	Local Authority
LAC	Looked after Children
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LGBT+	Lesbian, Gay, Bisexual and Transgender
LHRP	Local Health Resilience Partnership
LMC	Local Medical Council
LMS	Local Maternity Service
LPF	Lead Provider Framework
LTP	NHS Long Term Plan
LWAB	Local Workforce Action Board
m	Million
MAPPA	Multi Agency Public Protection arrangements
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MDT	Multi-disciplinary Team
MH	Mental Health
MHIS	Mental Health Investment Standard
MIG	Medical Interoperability Gateway
MIUs	Minor Injury Units

MMT	Medicines Management Team
MOL	Medicines Order Line
MoM	Map of Medicine
MoMO	Mind of My Own
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MTD	Month to Date
NECS	North of England Commissioning Services
NEPTS	Non-emergency Patient Transport Services
NHSE/ I	NHS England and Improvement
NHS e-RS	NHS e-Referral Service
NICE	National Institute for Health and Care Excellence
NUHFT	Nottingham University Hospitals NHS Trust
OOH	Out of Hours
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PCCC	Primary Care Co-Commissioning Committee
PCD	Patient Confidential Data
PCDG	Primary Care Development Group
PCN	Primary Care Network
PHB's	Personal Health Budgets
PHE	Public Health England

PHM	Population Health Management
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PIR	Post Infection Review
PLCV	Procedures of Limited Clinical Value
POA	Power of Attorney
POD	Project Outline Document
POD	Point of Delivery
PPG	Patient Participation Groups
PSED	Public Sector Equality Duty
PwC	Price, Waterhouse, Cooper
Q1	Quarter One reporting period: April – June
Q2	Quarter Two reporting period: July – September
Q3	Quarter Three reporting period: October – December
Q4	Quarter Four reporting period: January – March
QA	Quality Assurance
QAG	Quality Assurance Group
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QUEST	Quality Uninterrupted Education and Study Time
QOF	Quality Outcome Framework
QP	Quality Premium

Q&PC	Quality and Performance Committee
RAP	Recovery Action Plan
RCA	Root Cause Analysis
REMCOM	Remuneration Committee
RTT	Referral to Treatment
RTT	The percentage of patients waiting 18 weeks or less for treatment of the Admitted patients on admitted pathways
RTT Non admitted	The percentage if patients waiting 18 weeks or less for the treatment of patients on non-admitted pathways
RTT Incomplete	The percentage of patients waiting 18 weeks or less of the patients on incomplete pathways at the end of the period
ROI	Register of Interests
SAAF	Safeguarding Adults Assurance Framework
SAR	Service Auditor Reports
SAT	Safeguarding Assurance Tool
SBS	Shared Business Services
SDMP	Sustainable Development Management Plan
SEND	Special Educational Needs and Disabilities
SIRO	Senior Information Risk Owner
SOC	Strategic Outline Case
SPA	Single Point of Access
SQI	Supporting Quality Improvement
SRO	Senior Responsible Officer
SRT	Self-Assessment Review Toolkit
STEIS	Strategic Executive Information System
STHFT	Sheffield Teaching Hospital NHS Foundation Trust
STP	Sustainability and Transformation Partnership
T&O	Trauma and Orthopaedics
TCP	Transforming Care Partnership
UEC	Urgent and Emergency Care
UHDBFT	University Hospitals of Derby and Burton NHS Foundation Trust
UTC	Urgent Treatment Centre
YTD	Year to Date
111	The out of hours service is delivered by Derbyshire Health United: a call centre where patients, their relatives or carers can speak to trained staff, doctors and nurses who will assess their needs and either provide advice over the telephone, or make an appointment to attend one of our local clinics. For patients who are house-bound or so unwell that they are unable to travel, staff will arrange for a doctor or nurse to visit them at home.
52WW	52 week wait

MINUTES OF NHS DERBY AND DERBYSHIRE ICB BOARD MEETING IN PUBLIC

Thursday, 16th November 2023

via Microsoft Teams

Unconfirmed Minutes

Present:		
Richard Wright	RW	ICB Chair (Meeting Chair)
Michelle Arrowsmith	MA	ICB Chief Strategy and Delivery Officer / Deputy CEO
Jim Austin	JA	ICB Chief Digital and Information Officer
Dr Avi Bhatia	AB	Participant to the Board for the Clinical & Professional Leadership Group
Dr Chris Clayton	CC	ICB Chief Executive Officer
Jill Dentith	JED	ICB Interim Non-Executive Member
Helen Dillistone	HD	ICB Chief of Staff
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
Ellie Houlston	EH	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)
Prof Dean Howells	DH	ICB Chief Nurse
Paul Lumsdon	PL	ICB Executive Director of Operations
Dr Andrew Mott	AM	GP Amber Valley (Partner Member for Primary Care Services)
Dr Deji Okubadejo	DO	ICB Board Clinical Other Member
Stephen Posey	SPo	Chief Executive UHDBFT / Chair of the Provider Collaborative Leadership Board (NHS Trust and FT Partner 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:		
Dr Duncan Gooch	DG	GP, Derbyshire GP Provider Board (Item ICBP/2324/100)
Tiffany Hey	TH	360° Assurance
Dawn Litchfield	DL	ICB Board Secretary
Fran Palmer	FP	ICB Corporate Governance Manager
Ian Potter	IP	Managing Director, GP Provider Board (Item ICBP/2324/100)
Victoria Searby	VS	Finance Director, DHU Health Care CIC
Sean Thornton	ST	ICB Deputy Director Communications and Engagement
Apologies:		
Tracy Allen	TA	Chief Executive DCHSFT / Participant to the Board for Place
Stephen Bateman	SB	CEO, DHU Health Care CIC
Julian Corner	JC	ICB Non-Executive Member
Suzanne Pickering	SP	ICB Head of Governance
Andy Smith	AS	Strategic Director of People Services – Derby City Council (Local Authority Partner Member)

Item No.	Item	Action
ICBP/2324/ 091	**Welcome and apologies** Richard Wright (RW) welcomed everyone to the meeting. Today's meeting has been extended to allow more time for consideration of the Primary Care / General Practice items on the agenda, with a subsequent time reduction made to the confidential meeting.	

	The winter period is a busy time of the year for the NHS. It is also a time when it takes stock of the last 6 months, and starts to look at the next 12 months, as the start of the next 5 years, and the longer-term plans; it seems increasingly difficult to balance the shorter and longer term. RW urged everyone to get their covid, flu and MMR vaccinations. Prevention is so important to the smooth running of the system and helps reduce the load in the winter period. He appealed to NHS staff, and those of partner organisations, to support each other at this tough time, when they are already tired. Taking time to reflect on the good things being done is important; our staff are there for people when they are at their most vulnerable. Testament to this, today's news highlights how the NHS has developed treatments and will be tackling some of the blood disorders that have plagued us for years. RW thanked everyone, on behalf of the Board, for doing such good work - it is much appreciated. Julian Corner (JC) is leaving the ICB at the end of this month. He has been with the ICB since its inception and has brought with him a very different way of thinking about things; he will be missed. RW thanked JC for his input and wished him well for the future. Jill Dentith (JD) was congratulated on being appointed from an interim to permanent Non-Executive Member (NEM) role, as JC's replacement; the NEM roles may however be revised going forward. RW thanked JD for stepping in on an interim basis. This time last meeting we said goodbye to Zara Jones; today we are welcoming Michelle Arrowsmith (MA) who has joined us as the Chief Delivery and Strategy Officer and Deputy CEO; this stresses the delivery mode of the system. MA has a very interesting and diverse background which was welcomed. Apologies for absence were noted as above.	
ICBP/2324/ 092	**Confirmation of quoracy** It was confirmed that the meeting was quorate.	
ICBP/2324/ 093	**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, using the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/integrated-care-board-meetings/ Items ICBP/2324/100 and ICBP/324/101 – Dr Andy Mott (AM) and Dr Avi Bhatia (AB) declared a conflict of interest in these items as working GPs in Derbyshire. It was agreed that they would both remain in the meeting to inform the discussions on these items. No further declarations of interest were made.	

ICBP/2324/ 094	**Minutes of the meeting held on 21st September 2023** **The Board APPROVED the minutes of the above meeting as a true and accurate record of the discussions held**	
ICBP/2324/ 095	**Action Log – September 2023** <u>ICBP/2324/051 – Integrated Assurance and Performance Report</u> – This report now includes much more information to demonstrate system working and is an ongoing process. <u>ICBP/2324/075 – Integrated Assurance and Performance Report – Staffordshire residents</u> – A briefing note was circulated around the system after the last Finance, Estates and Digital Committee. This is an ongoing theme in conversations with regional and national colleagues. **The Board NOTED the Action Log**	
ICBP/2324/ 096	**Chair's Report** RW 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: • RW and Dr Chris Clayton (CC) are engaging with Local Authorities, District Councils and MPs on a routine basis. A constructive visit was undertaken yesterday to Northeast Derbyshire District Council, with mature discussions held on the wider determinants of health, the different roles around them, and what can be done to support each other; this was also the case at Derbyshire Dales District Council. Great discussions were held at the Integrated Care Partnership Board and the Health and Wellbeing Boards; there is a maturing position on rationalising and understanding the golden thread of what we all do and how we can support each other. CC concurred with this understanding. • The Board has started a development programme around inclusion (as opposed to equality of access), geared around what inclusion means in the future world, how to make it part of our psyche and strongly build it into the wider system. **The Board NOTED the Chair's report**	
ICBP/2324/ 097	**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: • We are heading into winter, with an important year ahead in 2024/25, whilst closing 2023/24 in the best way; we have a huge job collectively in the NHS family to focus on NHS delivery, ensuring safety and quality of Urgent and Emergency Care (UEC) services whilst maintaining a focus on planned and cancer care. At the same time, we are focusing on strategic direction over the next 5 years. The purpose of the important conversations with system partners is to maintain focus and influence across a broad stream of networks in terms of the wider determinants of health. A real purpose of strategic intent is being taken going forward.	

- The ICB commences a staff consultation tomorrow. Staff will be supported through this challenging time. There is no good time to do this necessary work, however this is the best time. Talking to colleagues, their views are to move forward and work through it; the Board is sensitive to this. Signalled in the intent are the 3 roles of the ICB; it has an important role in its statutory duties to ensure there are good quality, safe services to meet the population's need, with that comes an increasing oversight role, alongside NHSE, around growing expertise, and to support the NHS family to become more integrated and effective in the manner in which it delivers health and care. A mind's eye will be kept on how the ICB undertakes a facilitatory and supportive role whilst Provider Collaboratives and Places become more self-sustaining, recognising this is a journey that will need to be fine-tuned; during the consultation, CC will be having conversations with system leads to consider the role they play in this.
- Working with others on the wider determinants of health, the ICB will become a more influential partner in the broader regard; there is a commitment to the work being done with others.
- A new Secretary of State was appointed this week. CC will update the Board further once more is known about their views and the direction of health and care governance.
- CC thanked colleagues working inside and outside the health service who supported collective efforts to work through and recover from storm Babet. The ICB's administrative base at Cardinal Square was disrupted by flooding.
- Patient choice, and information and data elements, are described within the report, as are awards received by staff during these challenging times. Derby and Derbyshire continue to make progress.

Questions / comments

- Concern was expressed around the staff consultation, as many staff have been through this process many times before; it is a traumatic time for them. Thought needs to be given to the whole system approach, and perhaps whether there may be suitable alternative employment opportunities in the wider system. Colleagues will be working hard to ensure people are safe and supported. The staff work really hard, and nothing would be possible without them (JED).
- Congratulations were given to everyone who has won an award, particularly when they are working under such pressure; this is an excellent acknowledgement of the work going on in the system (JED)
- It was enquired whether the travel to treat arrangements are having an impact; people can opt to travel to different locations for treatment, presumably in and out of Derby and Derbyshire; it was asked how this might impact on efficiency arrangements in diverting staff away from the Derby and Derbyshire agenda towards the wider picture (JED). CC responded that it is too early to take a sense on this, however any impact on operational delivery will be assessed by the ICB's corporate committees and reported to the Board. Choice is not a new concept, it has been offered for some time, with different leanings towards it over the years, however, historically Derby and Derbyshire have worked with other partners to transfer care; it is not a new phenomenon. JED added that this has been a recent national advertising campaign.
- A high-level summary from the virtual wards summit was requested as this is something that the Quality and Performance Committee is particularly interested in (DO). Dr Chris Weiner (CW) advised that a virtual ward summit was held in September with broad engagement from across the system to look at the virtual wards process. There is

	enthusiasm to move forward and process development within the shared clinical environment. There is a broad base of clinical support for the development of virtual wards. It is a long-term development journey, which is being pushed hard this winter, recognising that it is a national priority to transform the way in which health care is delivered. This journey will take us through the next few years with commitment from the national team. The impact of the development session has resulted in an increase in the number of the virtual ward bed spaces available and utilisation of these bed spaces. There was 20% bed utilisation at the start of this year; it is now consistently running at over 50%, with a change being seen in clinical practice. There is still a long way to go. Greater usage of these beds is hoped for this winter to take pressure off Acute Trusts' front doors and manage people who could be better treated in the virtual ward space. RW was pleased to see the progress being made to embed this change. **The Board NOTED the Chief Executive's report**	
ICBP/2324/ 098	**Corporate Risk Register – October 2023** Helen Dillistone (HD) presented the Risk Register as at 31st October 2023, which provided assurance to the Board on the operational risks faced by the organisation. Each risk is allocated, actively monitored, and managed by one of the ICB's Corporate Committees. During October, two new risks were proposed: Risk 22: National policy not to fund the agenda for change pay award for bank staff or staff currently not on the payroll of NHS statutory bodies. The Finance, Estates and Digital Committee (FEDC) considered, at its meeting on 24.10.2023, that there is a risk in terms of being able to locally fund the pay awards, and also on staff morale. This could leave the Derbyshire system with a potential £13m recurrent liability. As this is a national decision the ICB has no mitigations. This risk is rated at a very high 25. Risk 23: There is a risk to Joined Up Care Derbyshire (JUCD) performance against the Cancer Standards, including 28 Day Faster Diagnosis Standard, 62 Day Waits and 104+ days due to an increase in referrals from Staffordshire into UHDBFT resulting in significant capacity challenges to meet increased demand for diagnostic investigations, diagnosis, and treatment. The System Quality Group approved this new risk at its meeting on 7.11.2023. This risk is rated at a very high 16. It is proposed that the following risk be closed: Risk 02: Changes to the interpretation of the Mental Capacity Act and Deprivation of Liberty Safeguards, results in a greater likelihood of challenge from third parties, which will have an effect on clinical, financial, and reputational risks of the ICB. It is recommended that this risk be closed due to the work being done with Midlands and Lancashire Commissioning Support Unit to process the applications. Questions / comments • Risk 22 – Following consideration at FEDC, the resource and staff morale elements were highlighted. A process is being done to reword this risk to cover both of these points; it was requested that this risk be	

	held in abeyance until this conversation has been held before being added to the Risk Register (JED). This rewording was welcomed, as it materially affects General Practice (GP); the quantum of this impact will be managed in a different way as it will fall on individual partnerships to fund. It was requested that GP also be built into this risk (AM). RW thanked Keith Griffiths for raising this issue at a national level. • Risk 02 – Mark Powell (MP) considered that if the Midlands and Lancashire Commissioning Support Unit are taking a hold on this, it will present less of a challenge. It does not specifically relate to DHcFt, although the Mental Capacity Act is on DHcFT's Risk Register. Paul Lumsdon (PL) supported the removal of this risk that was not mentioned in the King's Speech which could cause further delay; a watchful eye will be kept on this. • Risk 23 – This risk specifically refers to cancer, however it also affects the elective pathway; it was enquired whether this is covered elsewhere (DO). HD responded that, in terms of meeting the performance standards, there is a more general risk; this new risk relates to the increased referrals from Staffordshire and recognises the work underway on the pathway with Staffordshire colleagues. Stephen Posey (SPo) supported this risk being added to the register. **The Board RECEIVED and NOTED:** • **The Risk Register Report** • **Appendix 1, as a reflection of the risks facing the organisation as at 31st October 2023** • **Appendix 2, which summarises the movement of all risks in October 2023** • **APPROVED the CLOSURE of risk 02 relating to changes to the interpretation of the Mental Capacity Act and Deprivation of Liberty Safeguards**	
ICBP/2324/ 099	**Board Assurance Framework (BAF) Quarter 2 - 2023/24** HD presented the Quarter 2 BAF which covers the work undertaken by the ICB's Corporate Committees on the strategic risks identified. A significant review has been undertaken by Internal Audit on the controls and assurances being undertaken to ensure risk areas are being addressed and work is being done to close any gaps. The report demonstrated greater maturity, both in discussions and ownership. Decreases were recommended in the following risks: • <u>Risks 1 and 2</u> – The Quality and Performance Task and Finish Working Group recommended these risks be reduced from 20 to 16 as a result of maturity in the system and work being done to support these areas. • <u>Risks 7 and 9</u> – A thorough review of both risks was undertaken during Quarter 2, with several system gaps being removed. The description of Risk 9 has been reworded as follows: '*There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.*' • <u>Risk 8</u> – This risk was previously separated into two elements; however, it is now recommended that it be separated into two separate risks which would sit better in the Population Health and Strategic Commissioning Committee (PHSCC) and FEDC.	

	Questions / comments • Sue Sunderland (SS) echoed how much this has developed over the last six months; it now feels like there are targeted actions to address the gaps in place. It was requested that Committees, in the next quarter, focus on looking at how assured they are on the threats, particularly when actions have been completed; it was asked if those actions could be revisited to check why some are only partially assured and decide whether more work needs to be done. • RW considered that great progress has been made. It is worth reminding ourselves that changing the way we do things in order to improve our performance naturally increases risk during that change. Having no risk is almost impossible; however, the risk of not doing something is higher. These documents show how the risk of change is being managed; it is worth looking at them as a dynamic organisation rather than as a static system. **The Board:** • **APPROVED the Quarter 2 BAF strategic risks 1 to 10** • **NOTED the decrease in risk scores for Strategic Risk 1 and 2 from a very high score of 20 to a very high score of 16** • **NOTED the split of Strategic Risk 8 into two separate risks and the transfer of ownership of Strategic Risk 8 from the Finance, Estates and Digital Committee to the Population Health and Strategic Commissioning Committee**	
ICBP/2324/ 100	**Primary Care Model for Derby and Derbyshire** *AM and AB declared a conflict of interest in this item* Dr Andy Mott (AM) presented this item in his role as Medical Director for the GP Provider Board (GPPB). One of the prime outcomes from the May Board Development session was to develop the emerging model into something more tangible; this is one of the key functions of the Derby and Derbyshire GPPB. The model describes a potential way forward and distils the key benefits of GP within the constraints of the environment, including workforce. Engagement has been undertaken through many partner Boards and Committees. It is presented for discussion, endorsement, and consideration of next steps toward implementation. Dr Duncan Gooch (DG) highlighted the work done by the GPPB to make this a great document. CC has described the ICB as having a statutory duty to ensure there are good quality services which meet the needs of the population; this is also the driver behind this model. The NHS is not good enough at describing what the high-quality services are that meet the needs of the population from a primary care perspective. DG provided examples of how this proposed model will work for different patient cohorts and conditions. These examples demonstrated how the totality of provision remains within the scope of existing primary care services. By prescribing care in the way set out, there is a collective opportunity to build, create and deliver services to ensure services meet the needs of our population. Ian Potter (IP) stated that, subject to today's discussions and feedback, the next stage is to work up a detailed implementation plan and business case for this model, that will be fed into the annual planning process. IP advised this is a large, complex project which will be delivered over a	

period of time; there are clear alignments to work taking place in the community setting. There is a link to the community transformational work and the opportunity to learn from and align resources to the delivery of the model. In order to make it work, support is required from the system to implement it; data and digital are key to these processes and are not within the gift of the GPPB to deliver. System working will be required to unlock efficiencies to help deliver this model going forward.

RW acknowledged the amount of work that has gone into producing this.

Questions / comments

- This is a brilliant strategy document which answers a lot of questions on health and care for the population; if properly resourced and supported it will help to reduce the current problems. The idea of local interpretation and adaptation of the model to reflect local needs was supported; it was enquired how local success will be fed back up and shared across the system for consideration to improve care (DO). DG responded that this is about how transformation is delivered within PC; there are lots of organisations, both large and small, using distributed leadership to achieve change. This will not be a top-down approach as, as soon as an organisation is told what to do, it will give resistance. The description of the gap tells of the importance in using the right techniques to deliver transformation.
- Primary Care is a key component of our system and crucial to the delivery of workforce, finance, and efficiencies. Good examples were provided of how this is working in practice which is positive to see. From the perspective of the FEDC chair, JED wanted to ensure that these elements are being capitalised on; it is key to getting this up front and central to utilise what already exists or what needs to be changed. The governance arrangements appear to be complicated; it needs to be ensured that it supports and facilitates achievements rather than hindering them, providing a smooth process to ensure that everyone is safe in the governance forum (JED). DG considered that the reason this point was collectively reached and articulated was to provide a backup. If the public were asked what GP is, many different descriptions would be given that did not reflect reality. Being able to demonstrate what it means is important, as is the communication of it to the public. This model is an ongoing process through the life course which will help people understand what PC is and how they can best interact with it.
- This is an exciting proposal, from which benefits for patients will be seen. It was enquired how broadly this had been tested with GPs; there are multiple providers involved and it was asked how they will be managed. It was also asked whether there is learning from the practicalities of people receiving services from different teams (SS). DG confirmed that this has come from GP, and has been through many iterations, and discussed at the GP Conference and by the LMC, where it was widely supported.
- PC / GP are the bedrock of the NHS, with everything else building from them; this approach was welcomed. A way through the issues faced in terms of managing complex patients in a world with people are living longer with long term condition's, can be seen, and will be strengthened by this. It is all too easy to see this as a PC/GP led approach, delivered entirely by them. There are partners on our Board from acute, mental health and community trusts for whom there will be implications on future ways of working; it needs to be recognised upfront how we come together as a system to support the bedrock of GP (CW). DG

	considered that it is easy to think PC is GP. Every organisation is already delivering PC and first contact care. There is a need to discuss and organise the services together to provide a PC offering within the system. • This is excellent and will come as a relief to communities who are unsure how PC works. The system needs to come together and not just rely on the GPPB and colleagues. It will be a relief to communities to know this work is taking place. Effective communication is important, to prevent people with nostalgia for a family doctor who does everything, to see this as a powerful way forward (MG). • CC added that the Board has previously accepted the bedrock nature of GP in the health and care model and has actively supported to commit to it. There is a need to confirm our view; as planning is undertaken for 2024/25 and beyond, this will need to be put at the heart of what we do. • CC is grateful to GP leaders. The ICB has supported the development of a Derby and Derbyshire GP voice and now needs to get leverage out of it. On the Board's behalf, CC meets 2 to 3 times a year with all Primary Care Network (PCN) leads, both clinical and managerial. Some of the emerging themes from the conversations include the serious structural challenges faced by GP. It is clear that PC is broader than GP, however both are important. A significant shift in the workload and type of GP and General Practitioners has been seen, as well as a shift in the complexity in a surgery and consultation lists in the last 5 to 10 years; colleagues have very few simple cases. Strategically, the ICB has increased the complexity of the GP consultation list through supporting additional roles. A shift of funding is being seen; as more money is put into PCN's, a consequential challenge is seen to individual practices' financial sustainability; strategic thought needs to be given to this. There are challenges in terms of the individual supervisory requirements for ARRS. A new GP team is being created which needs to be supervised, developed, and trained. Linked to this is the financial security upon which we want GPs to build; there is uncertainty around the contractual framework. PC / GP estate is a real concern to colleagues; there is a mixed environment of estate, and thinking forward there is a need to increase our view on GP in the capital conversation. DG agreed that the role of General Practitioner has substantially changed; this model requires further change in the role of professional who have their own development needs. • CC supported the document which well described a functional model of care; however, there is still a need to see a structural response to the challenges being faced. This urgently needs strong engagement and membership conversations on the view of the structural model that supports the functional model. CC would like to know the views of the senior GP leaders in Derby and Derbyshire on the partnership and independent contractor models. DG has been deliberately evasive in talking about structural change in order to make progress, as this is a fundamental change in the delivery of PC. Historically the PC model was based on universal access; this model will articulate that a universal access system exacerbates health inequalities which is not the best way to deliver high quality services that meet the needs of the population. Services that are appropriate to the needs of the population need to be delivered. This model is a fundamental shift in thinking in terms of access to GP; if we distracted this by asking whether the partnership model exists and what structurally changes, we would not be able to move away from this. In terms of partnership model, there is commonality on GPs leading PC in local communities; the current infrastructure is the partnership model within the independent	

	contractor, although there are other models which are successful. The function of having local GPs who support and supervise across a whole group of people and can carry risk and make difficult decisions around people's health and care, is very important. The future still has this function whatever it might be and will be part of the next stage. AM added that engagement has been undertaken as wide as possible, however this is about sequencing; there would be no point in going to the harder to reach practices unless the ICB agreed it. Communication will be a significant part of the implementation plan; it was raised at the Healthwatch Derbyshire AGM. System support will be required with communication. The partnership structure requires consideration as it will have implications on what the GPPB's role is in future; it is currently established to deliver and drive this model as a collective representative voice. The GP provider ask at a scale is mentioned in the fuller stocktake and needs to be led by GPs. • CC fully understood the process undertaken to date, however there are structural challenges. The GPPB was requested to actively engage in conversations with practitioners on the structural questions. CC has asked PCNs to consider questions in preparation for his next visit, including clarity of the functional role at an individual GP, PCN and Place / Place Alliance level from a GP perspective; the GPPB was requested to actively support these conversations and return to the ICB Board in 3-6 months with thoughts that supports those functions. DG took CC's challenge on and challenged back that in order to do this the Board needs to commit to this model; structural change cannot be supported in a context of uncertainty, as it would become reductionist. There is a need to be ambitious about what we want to achieve for PC in Derby and Derbyshire. • PL echoed his support for the functional proposal and how the structure under that will come into play. The focus should be on the resilience of PC/GPs. The outcomes need to pick up the workforce indicators and build on existing expertise. • RW highlighted that the system is currently looking at the vision of where it wants to be in 5 years' time. He fully backed this model of care, and concurred with the point made that GP/PC has an effect on other parts of the system; there is a need to pull together localised care. GP is a big part of this system therefore needs to be considered when doing this. He agreed that one size does not fit all. **The Board:** • **ENDORSED the new Primary Care Model for Derby and Derbyshire** • **APPROVED the Primary Care Model for Derby and Derbyshire** • **SUPPORTED the proposed approach to implementation, and the need to ensure governance and architecture arrangements reflect the central role that Primary Care will play in the development and delivery of integrated care in Derby and Derbyshire** • **DISCUSSED the approach by which the GPPB will discuss and access support for implementation**	**AM/DG/ IP**
ICBP/2324/ 101	**System Level Primary Care Access Improvement Plan** *AM and AB declared a conflict of interest in this item*	

	Michelle Arrowsmith (MA) advised this is about the here and now of PC, as opposed to its future as discussed in the previous item. It is a national piece of work which the Board is required to approve. Clive Newman (CN) stated that this national plan has two main goals: 1. To tackle the 8am rush and reduce the number of people struggling to contact their practice. End to patients being requested to call back another day to book an appointment 2. For patients to know on the day they contact their practice how their request will be managed CN provided an overview of the measures being taken to reach these goals, details of which were included in the meeting papers. This work is necessary but insufficient and sits within a broader long-term vision. An access working group is overseeing the implementation of this plan, for which progress is being tracked. A year-end report will be presented to a future Board in March 2024. <u>Questions / comments</u> • It was enquired whether Urgent Treatment Centres (UTCs) play a role in this. A recent visit to Whitworth Hospital, highlighted a lack of PC presence. It was enquired whether there will be a return on these proposals in terms of a reduced load on acute hospitals or other parts of the system. In order to know where best to invest, given the limited resources available, there is a need to demonstrate the positives and negatives from a system perspective (RW). • More detail was requested around the primary/secondary interface that reduces bureaucracy in response to the Academy of Royal College's report in order to provide assurance on where outputs will be seen (CC). CW outlined the asks in terms of cutting bureaucracy. It was recognised that these requests were reasonable and longstanding, however they will present implications. Behavioural changes will be required of a large number of clinicians and services across Derby and Derbyshire. A process is required to get this change into the system. PC colleagues are involved and CPLG assistance will be required. Agreement is required on the standards we need to hold ourselves to, as a group of clinical services, in terms of enacting change. As a last resort, there may be a need to use the levers within the commissioning structures. Although these are simple requests, the amount of change, and number of people needing to change their practice in order to make it work effectively, is significant. It is hoped to see some progress in the next three months. • The interface is only one small part of this, there is a lot more to be discussed. It is not unreasonable to be asking for these measures to be implemented; it is nobody's fault that they have not been actioned already – it is an outturn of the complex ecosystem we work in. GPs spend a lot of time dealing with administration; not doing this would give them more time to do other things. It would be unfair to say this only comes from secondary care, as it comes from various organisations; other aspects also require consideration. Discussions will take place at CPLG to reach a clinical agreement and find a sensible way forward, looking at how it is implemented as a system to ensure ever changing staff and organisations are made aware of it. GP cannot be unilateral, it will work through it; however, in order to do so an agreement is needed that it is the right way for all. GP/PC has to be able to utilise resources as they see fit; ARRS is an example of	**MA/CN**

	where they are not allowed to do that. The system can help to take the population on this journey (AB). • As PCLB chair, time will be spent time on this as a collaborative. There is a need to understand whether reducing the demand on PC will help with the U&EC flow across the system; there is commitment by the system to do better on this. **The Board APPROVED the System-Level Access Improvement Plan**	
ICBP/2324/ 102	**Integrated Assurance and Performance Report** CC highlighted that this report is about the concept of balancing operations with finance and people, underpinned by quality and safety; going forward, this will be the approach built on. <u>Performance</u> – Michelle Arrowsmith (MA) outlined the key messages from a performance perspective, as described in the meeting papers. It was highlighted that the performance data has been validated. A lot of the metrics are considered on an hourly/daily/weekly basis and there is significant scrutiny on performance and what is underlying its delivery. Weekly system meetings are held on elective and cancer care, to scrutinise any issues and ascertain what needs be done to improve the situation. There are vulnerabilities around performance in some areas as we start to go into the winter pressures period; reassurance was provided that these are being scrutinised. <u>Workforce</u> – Linda Garnett (LG) outlined the key messages from a workforce perspective, as described in the meeting papers. The Board were asked to take confidence from the numbers, as the People's Services teams have undertaken a huge amount of work on them. The plan demonstrates a slight overspend, however there is a downward trend in terms of growth and workforce numbers against the pay bill and establishment. Attention was drawn to agency usage; NHSE requires the plan to reduce the agency staffing spend to be reported formally to the Board; it will be interesting to understand what is driving agency spend. All providers have strengthened the processes to sign off agency expenditure. Some of the services driving the use of agency have deep seated supply issues; the teams are working hard to make progress. <u>Quality</u> – Professor Dean Howells (DH) outlined the key messages from a quality perspective, as described in the meeting papers. Maternity services, local and nationally, were highlighted. The Section 29 improvements required by mid-December are being worked on. When the Board meets in January, the full published report into UHDBFT will be available. There will be an opportunity to look at it and the broader cultural elements being worked through. The PC interface with the CQC continues at pace; there will be a focus on this over the next 3 months. A discussion around sustainability of improvement is required; the work will flow through in the next few months as the activity continues. The time is now right for us to reconsider an extension of Strategic Risk 2 on short term operational needs, not just having an impact on health outcomes, but also on sustained quality compliance, taking note of the increasing pressure on compliance. DH has completed his front-line visits and it is evident that there is a strong culture on quality compliance and quality reporting however there is less focus on quality improvement as a system. DH has walked through the whole quality improvement journey at CRHFT and will be asking the Board to more systematically consider the Derby and Derbyshire improvement methodology. DH was impressed	

by the ICB's contribution to the safeguarding approach and the way Local Authorities respond to safeguarding referrals and high-profile cases.

Finance – Keith Griffiths (KG) outlined the key messages from a finance perspective, as described in the meeting papers. KG noted that, dependent upon industrial action, there is a potential £60-70m overspend at yearend, as things currently stand; this is driven by changes since the formal plan was submitted. This will be influenced by productivity delivered over the winter and the costs of U&EC. The national press has announced additional resources for the NHS; our share, against a £60-70 potential problem, will be £12.2m. There is a lot of work to do to square off the financials, against the workforce and operational challenges. Financial pressures are now being felt in all areas of the system, including PC, mental health, community services, Continuing Health Care and Out of Area Sector placements. Work is being done to triangulate performance expectations, workforce, and finances under the auspice of maintaining safe care over the winter period. This is the end of the first half year, with six more months to go. CC added that the letter was received this time last week. Assurance was provided to the Board that expert colleagues are working across the system on the individual components and will bring a view to the confidential Board planned for next week.

Questions / comments

- It was helpful to receive the extra information on agency use. It is pleasing that admin and estates has been investigated. It was enquired what measures were being taken to reduce/eliminate off framework agency usage (which is more expensive). One trust outside Derbyshire has stopped using off framework agency staff completely: it was asked how far this is being pushed (SS). LG responded that the plan is to eradicate off framework usage, this is linked to the controls providers are implementing to manage it. It is a difficult one; many providers will say it is in their process, as when faced with a difficult decision in the middle of the night, there is a need to do this. LG is unsure whether this can be totally eradicated. KG added that, in reality, it is about keeping patients safe therefore sometimes appropriate actions need to be taken.
- KG advised that it is important to recognise that the Derbyshire system is one of best performing financially in the Midlands. Some big issues are being dealt with which are manifesting themselves in the financials.
- RW felt that it would be good to have a better period of stability without any strikes in order to get control of this work; it has not been an easy year up to now.

RW thanked colleagues for this report, which contained a lot of information. Further work is required to streamline it, whilst highlighting the issues that really need to be looked at from a system level. Balancing the short / long term with inclusion, prevention, and healthy life expectancy, would be welcomed. It was confirmed that the whole system is now being covered.

The Board NOTED the Month 6 Operational Plan performance update against the planned commitments and targets

ICBP/2324/ 113	**NHS Operational Plan – October 2023 to March 2024** MA presented a refresh of the Operational Plan for the final 6 months of the year, with a particular focus on winter. The report was taken as read. The volatile performance on U&EC in October was highlighted. This is a good plan, however there are still some gaps, including acute respiratory hubs, a single point of access and virtual wards; all three of these areas will come into the forefront as to how they can help across the system during the winter period. The Plan is live and dynamic, and it is now about delivering, enacting, and monitoring against it to deal with any potential risks. MA will be leading this from a system perspective. **The Board NOTED the Derby and Derbyshire NHS' Operational Plan for October 2023 – March 2024**	
ICBP/2324/ 114	**Audit and Governance Assurance Report – September/October 2023 / 2022-23 Annual Report** Sue Sunderland (SS) presented these reports which were taken as read. It is hoped that people would find the Annual Report useful. Although the Board is well sighted on the financial position, the Committee benefited from a deep dive on the underlying issues and constraints that impact how well the ICB is able to mitigate the pressures it is facing; this was summarised in the assurance report. There is a need to keep this in mind, as some pressures are more difficult to address than others. There are ongoing issues regarding procurement. **The Board RECEIVED and NOTED the reports for assurance purposes**	
ICBP/2324/ 115	**Finance, Estates and Digital Committee Assurance Report – September/October 2023** Jill Dentith (JED) presented this report which was taken as read. A presentation was given on workforce that provided assurance on the more detailed aspects. Efficiencies link closely to transformation; there is a need to ensure that transformations are being embedded. Although savings are currently £2m over plan, this is due to non-recurrent aspects rather than recurrent; this has to be turned around to secure a better financial position. The National funding letter was received after the Committee meeting and will be picked up at the next meeting. The wider role of the Committee, how it fits in with other committees and the value it can add to the Board discussions, is being considered. CC/HD will discuss the roles of all committees to prevent overlap. RW noted that PC estates will be a big issue going forward, and so much relies on having a Shared Care Record (SCR) to be able to operate as a system. JA stated that the SCR is well established and rolled out in Derby and Derbyshire and work is now being done to enhance it; however, there are brakes being put on digital funding which we need to be mindful of. A deep dive will be taken to the committee in December. JED added that an estates strategy is being developed, of which PC is a key part. **The Board RECEIVED and NOTED the report for assurance purposes**	

ICBP/2324/ 106	**Derbyshire Public Partnership Assurance Report – September / October 2023 / 2022-23 Annual Report** SS presented these reports which were taken as read; no questions were raised. **The Board RECEIVED and NOTED the reports for assurance purposes**	
ICBP/2324/ 107	**Population Health and Strategic Commissioning Committee Assurance Report – October 2023 / 2022/23 Annual Report** DO presented these reports which were taken as read. No major concerns were reported and no questions were raised. **The Board RECEIVED and NOTED the reports for assurance purposes**	
ICBP/2324/ 108	**Quality and Performance Committee Assurance Report – September 2023 / 2022-23 Annual Report** DO presented these reports which was taken as read. There are ongoing concerns on quality and performance as outlined in the IAPR. The Committee has invited a PC representative to attend its meetings; AM is currently fulfilling this role. The Committee will be receiving a deep dive on maternity at its November meeting. No questions were raised. **The Board RECEIVED and NOTED the reports for assurance purposes**	
ICBP/2324/ 109	**People and Culture Committee Annual Report 2022/23** Margaret Gildea (MG) presented the Annual Report. It was noted that the Committee is working on key issues around workforce. A development session is scheduled for next week to look at how the Committee is performing and whether it is fulfilling its obligations. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/ 110	**Freedom to Speak Up Update** MG presented the report which was taken as read. Following the Lucy Letby letter, discussions were held as a system to ensure that Freedom to Speak Up systems and processes were working everywhere to provide people with freedom. MG has agreed to take on the role of ensuring that all systems and processes are in place and working effectively; this will be discussed at the P&CC on 6.12.2023. RW added that the Freedom to Speak up role has now been taken on for Primary Care. An update was requested at the next meeting. **The Board RECEIVED and NOTED the verbal update for assurance purposes**	**MG**

ICBP/2324/ 111	**Derbyshire County Council Director of Public Health Annual Report 2022/23** Ellie Houlston (EH) presented this report which was taken as read. It has been taken to various Boards across the system. It sets out statistics for mental health across the county, building on the 'Let's Chat Campaign' to promote good mental health. RW added that this report should be read under the context of the current financial pressures the Local Authority finds itself under. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/ 112	**Ratified minutes of the Derby and Derbyshire Health and Wellbeing Boards** • Derby City Health & Wellbeing Board – 7.9.2023 • Derbyshire County Health & Wellbeing Board – 5.10.2023 **The Board RECEIVED and NOTED the above minutes for information**	
ICBP/2324/ 112	**Ratified Minutes of ICB Corporate Committees** • Audit & Governance Committee – 10.8.2023 • Public Partnership Committee – 29.8.2023 / 26.9.2023 • Quality & Performance Committee – 31.8.2023/ 28.9.2023 **The Board RECEIVED and NOTED the above minutes for information**	
ICBP/2324/ 113	**Forward Planner** **The Board NOTED the forward planner for information**	
ICBP/2324/ 114.1	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. No	
ICBP/2324/ 114.2	Did any of the discussions prompt us to want to change any of the risk ratings up or down? No	
ICBP/2324/ 115	**Any Other Business** None raised.	
ICBP/2324/ 116	**Questions received from members of the public** No questions were received from members of the public.	

Date and Time of Next Meetings

Date: Thursday, 18th January 2024
Time: 9am to 10.45am
Venue: via MS Team

Derby and Derbyshire
Integrated Care Board

ICB BOARD MEETING IN PUBLIC

ACTION LOG – NOVEMBER 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	**March 2024**
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 effect to gain assurance, whilst ensuring that governance processes are adhered to.		**Ongoing**
ICBP/2324/075 21.9.2023	Integrated Assurance and Performance Report	Keith Griffiths	UHDBFT provides services for Staffordshire residents; it must be ensured that Staffordshire ICB receives funding based on its population, some of which will support the pressures UHDBFT incur. It is a material boundary issue that will have implications on income flows this year, and baselines for future years.	A briefing note was circulated around the system after the last Finance, Estates and Digital Committee. This is an ongoing theme in conversations with regional and national colleagues.	**Ongoing**

ICBP/2324/100 16.11.2023	Primary Care Model for Derby and Derbyshire	Dr Andy Mott / Dr Duncan Gooch / Ian Potter	PCNs have been requested to consider questions in preparation for CC's next visit, including clarity of the functional role at an individual GP, PCN and Place / Place Alliance level from a GP perspective; the GPPB was requested to actively support these conversations and return to the ICB Board in 3-6 months with thoughts that supports those functions.		**March 2024**
ICBP/2324/101 16.11.2023	System Level Primary Care Access Improvement Plan	Michelle Arrowsmith / Clive Newman	It was requested that a year-end report will be presented to a future Board in March 2024.		**March 2024**
ICBP/2324/110	Freedom to Speak Up Update	Margaret Gildea	The Freedom to Speak up role has now been taken on for Primary Care. An update was requested at the next meeting.	Agenda item	**January 2024**

NHS Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th January 2024

Item: 122

Report Title	Chair's Report – December 2023
Author	Sean Thornton, Deputy Director Communications and Engagement
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff
Presenter	Richard Wright, ICB Acting 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 Chair's Report.

Purpose

The report provides an update on key messages and developments relating to work across the ICB and ICS.

Report Summary

Thank you

It is important to record my formal thank you to everyone who played a part in managing our health and care services throughout Christmas, the New Year and through the periods of industrial action which flanked them. It's well-documented that the period of junior doctors' industrial action coincided with what is traditionally the busiest week of the year for the NHS, and we expected unprecedented challenges around patient flow and the knock-on effects of that for our emergency and community services. The system was significantly challenged through the period of action, but thanks to the efforts of everyone involved in frontline care our performance was strong, by a range of measures. Thank you to everyone who has played a part in our health and care response. It is of vital importance that we recognise the strain that these pressure events place on our teams, and ensure that we enable them to recharge their batteries given we are likely to continue to experience these high levels of pressure into 2024. We cannot deny however that there has been a detrimental effect on our elective waiting lists and we hope for a period of stability to allow us to address these.

Integrated Care Board Chair Appointment
Dr Kathy McLean OBE has been announced as the new Chair of NHS Derby and Derbyshire Integrated Care Board (ICB). Dr McLean will stand down from her chair role at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) to take up her new post from 1 May 2024. The role will be alongside her existing role as Chair of the NHS Nottingham and Nottinghamshire ICB and Integrated Care Partnership (ICP). The two roles complement each other and are aligned to the development of the Combined Council Authority across Derby and Derbyshire and Nottingham and Nottinghamshire. As mentioned by Chris in his email on the day, there is no inference that this appointment is a step towards an ICB merger; this is firmly not on the table and would require changes to primary legislation.

It has, and continues to be, a privilege to Chair the ICB Board over the last year and I look forward to supporting Kathy as she joins us in the coming months. Kathy's commitment to partnership working will bring huge benefits. I wish Kathy all the best and will continue to play a major role in Derby and Derbyshire as Vice Chair of the ICB and as an active Non-Executive Member. I am grateful for the support given to me through this period as interim Chair. It is evident what we can achieve individually, but in Derbyshire we are focussed on achieving so much more by working together.

Planning for Now and the Future
During my tenure as Acting Chair, the ICB has remained focussed on supporting the health and care system through challenging operational times whilst also maintaining a focus upon overall health improvement. In May, I will revert to my position as ICB Board Vice Chair and from January I have taken on the role of Chair of our Population Health and Strategic Commissioning Committee (PHSCC) and our Public Partnership Committee (PPC), two positions vacated by the departure of Julian Corner in November. Jill Dentith will remain as Chair of the System Finance Estates and Digital Committee.

In my Board reports as Acting Chair I have frequently referred to the need to balance our focus across the short term and the longer term with the necessity to keep progressing on both fronts. As I begin to understand the detailed remit of the two Board sub-committees I will be chairing, I am keen to make the connection between the two. It is clear that PHSCC has a critical role in shaping the future position and getting the balance between the improved health of the population and the treatment of illness. The ICP Integrated Care Strategy and Derby and Derbyshire NHS Five Year Plan all call for more focus and a flow of resources towards the former, with the real outcome being better and more equal healthy life expectancy. The new Provider Selection Regime gives us flexibility and efficiency in how we can seek to secure the provision of services, and PHSCC can put increased focus on the collective direction that we are expecting our contracts and commissions to deliver. The overall aim is that we will deliver a recurrently sustainable system in the medium/long-term, and that we can say with confidence that the £3bn available to the NHS in Derby and Derbyshire is really delivering what we need to support our citizens for the future. In setting the plan for 2024/25, it will be important to have clarity on the priorities, with a firm handle on how they begin to deliver the change we need over the next five years.

Integrated Care Systems Assessment Regime
The Care Quality Commission has been working closely with Integrated Care Boards, Local Authorities and Patient groups to develop their new Integrated Care Systems (ICS) assessment regime. ICS leaders are supportive in principle of the regulator's ICS assessment role, which spans health and social care and welcome the opportunity to benefit from external insight to inform system-wide improvement. ICS leaders involved in the CQC's ICS assessment pilots so far have found it a useful experience and the process has helped to pull system partners together.

The Department of Health and Social had asked the CQC to consult on an annual fee for assessments, which the NHS Confederation has noted this would ultimately result in a reduction in available funding for ICBs and ultimately impact on patient care. As part of the consultation, which closed in December, it proposed two alternatives; that ICSs could usefully take part in peer review approach to assurance, and that the Department of Health and Care might cover the additional costs of the assessment programme. The consultation continues.

Future commissioning of specialised services approved
NHS England has approved plans to fully delegate the commissioning of appropriate specialised services to integrated care boards (ICBs) in the East of England, Midlands and North West from April 2024. Joint commissioning arrangements in other regions will continue for a further year. This will enable more joined-up care for patients with a focus on population health management (PHM) and tackling health inequalities.

Right Care, Right Person
'Right Care Right Person' is a national agreement acknowledging Police are increasingly involved in responding to the public with a range of health or social circumstance needs including those having some form of mental health distress when they are not necessarily the most appropriate agency to respond. Nationally, this has led to the coroner attributing the cause of some deaths as avoidable where the police have been the only agency to get involved but are not formally trained to make "safe and well" decisions. Furthermore, when the Police do intervene, they are often not able to handover care to a more appropriate professional in a timely manner.

While there will always be cases where the Police need to be involved in responding to someone in a mental health crisis, the 'Right Care Right Person' approach will ensure the Police are only involved in mental health situations where necessary. This means that Police involvement will only occur where there is a real and immediate risk to life or serious harm, or where a crime or potential crime is involved. Given this, the impact on health providers and patients, whilst not yet fully quantified, will clearly be significant and requires a system wide response.

Further guidance has been emerging which we are reviewing across the system partners as we seek to understand implementation, which is anticipated by summer 2025. There is a working group in place with partners to oversee this programme and there will be a meeting with the Chief Constable later this month.

Dr Louise Jordan
It was with great sadness that the ICB heard of the death of Dr Louise Jordan, who was a prominent GP working from Baslow Health Centre. Dr Jordan was at the forefront of developments relating to the commissioning and provision of care for people who were reaching the end of their life, as well as campaigning to raise awareness and funding for Rob Burrow Motor Neurone Disease treatment centre appeal. Dr Jordan was herself diagnosed with MND in 2021 and retired from general practice in 2022. The ICB was very sad to hear of her passing and our thoughts and condolences are extended to her family, friends and colleagues at this time.

East Midlands Combined Council Authority
Derby City Council and Derbyshire County Council have approved plans to become a part of the new East Midlands Combined Council Authority (EMCCA), along with Nottingham City and Nottinghamshire County Council. It is anticipated that the new authority will receive £4bn of devolved funding for transport, skills and adult education, housing, the environment and economic development. A public consultation on East Midlands devolution, carried out between November 2022 and January 2023, showed strong support for the plans among local residents, businesses and community groups. Should legislation come into force, the EMCCA would seek to elect the first East Midlands Mayor in May 2024.

Derbyshire Health United Healthcare "Outstanding" - CQC

Derbyshire Health United (DHU) Healthcare's Chesterfield-based Urgent Care North out of hours service has been listed as 'Outstanding' by the Care Quality Commission following its most recent inspection. Based at Ashgate Manor, the service treats and cares for patients referred through DHU's own 111 service based on the symptoms they describe, receiving an appointment at one of seven Primary Care Centres in the region or a home visit, depending on the needs of the individual patient. Following a three-day visit from assessors in October 2023, the CQC rated DHU's service as 'Outstanding' in terms of providing an effective, caring, responsive and well-led service for patients, 'Good' in terms of a safe service and 'Outstanding' overall. Congratulations to the DHU Healthcare team.

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**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
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.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Not applicable to this report.

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?

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:**

<table>
<tr><td colspan="4">Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable</td></tr>
<tr><td>Yes ☐</td><td>No☐</td><td>N/A☒</td><td>Summary:</td></tr>
</table>

<table>
<tr><td colspan="4">Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:</td></tr>
<tr><td>Better health outcomes</td><td>☒</td><td>Improved patient access and experience</td><td>☐</td></tr>
<tr><td>A representative and supported workforce</td><td>☐</td><td>Inclusive leadership</td><td>☐</td></tr>
<tr><td colspan="4">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?</td></tr>
<tr><td colspan="4">Not applicable to this report</td></tr>
</table>

<table>
<tr><td colspan="6">When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?</td></tr>
<tr><td>Carbon reduction</td><td>☐</td><td>Air Pollution</td><td>☐</td><td>Waste</td><td>☐</td></tr>
<tr><td colspan="6">Not applicable to this report.</td></tr>
</table>

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th January 2024

Item: 123

Report Title	Chief Executive Officer's Report – December 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	None						
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

We often say it, but this will be a year of great significance to the NHS in terms of our service priorities, our organisational requirements and with the unknown impact of the political landscape of the General Election that constitutionally must take place this year. We speak often of the challenges of today and the challenges of tomorrow and we continue to seek to balance those, but it is during 2024 where we must accelerate the transition from dealing with daily operational pressures, to tackling some of the underlying foundation issues that continue to dominate our capacity.

Within this, I'm referring to a wide range of issues. Very locally, the ICB must conclude our organisational restructure to provide employment stability for our staff. We have now concluded the formal consultation with staff, which ran from Friday 17th November until 7th January 2024 and followed receipt of a letter from NHS England in March 2023 which set out a requirement for all ICBs to reduce running costs by a total of 30% by the end of the financial year 2025/26. ICB staff shown great resilience through the consultation and have provided very constructive feedback. We are now in the process of reviewing this and seeking to understand whether it will change the shape of the organisation that Executives set out within the consultation document.

This work will happen quickly, and we will take a further update to our Remunerations Committee on 26th January.

A further focus will be on our NHS 5-Year plan, as we seek to put some tangible milestones alongside our longer-term ambitions to enable us to unite behind priorities and make progress. Initially, this will feed our 2024/25 Operational Plan. Planning guidance emerged in part from NHSE prior to Christmas, although not yet on the detailed operational requirements and assumptions. In anticipation, all partners are working through their plans, under the leadership of the Executive Planning Group, and we will be seeking returns that align with the 5-Year Plan (Joint Forward Plan), the work of Place, the Provider Collaborative and the GP Provider Board, our enablers and other key areas. We hope to have a good picture emerging by the end of January, to help us have a running start to the 2024/25 financial year.

Operationally, our system has recently been navigating through the latest period of industrial action by junior doctors. Frontline teams and management are thanked for their continued efforts to deliver safe care across our system and their relentless efforts to manage this challenging period. Our forward planning for winter, and for the operational challenges raised by industrial action has been robust, and the system has seen the benefits of structural and strategic work undertaken during 2023 to ensure we are able to improve our position, especially on discharge planning and on ambulance handovers. There has been more community care available in Derby and Derbyshire this winter to support the flow of patients through their treatment and rehabilitation, and this is the result of focussed and strategic work during the year. Whilst demand is still greater than supply, the increased flow has enabled improved handovers from ambulance crews at the hospital front door, which in turn can support the ambulance service efforts to reach people who require support more quickly in the community. So while we remain in escalation during these challenging periods, we can see the results of our longer-term thinking bearing fruit.

There is more to do across these areas, and it remains 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. Capturing and quantifying the difference between our original winter plan and how that has played out additionally through industrial action will help us understand the activity and finance elements, but equally important in understanding the human impact on our teams. All of this will support our long-term solutions to these matters.

It's important to reflect on the strength of relationships within our system. Our close working on discharge between the NHS and local authorities, and the significant collaboration between our acute trusts, EMAS and community teams in managing flow and ambulance handovers is highly constructive, has been instrumental in enabling the system to manage risk and sees us pulling in one direction to maintain safe care patients. This continues to be a feature of our ability to manage the risks presented by industrial action and operational pressure.

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

Provider Selection Regime (PSR) regulations now in place
Parliament has approved the Provider Selection Regime regulations confirming that from 1 January 2024 relevant authorities must follow the PSR when arranging healthcare services. The PSR is a set of rules for procuring health care services in England by organisations termed relevant authorities. These are: NHS England, Integrated Care Boards (ICBs), NHS trusts and NHS foundation trusts, local authorities and combined authorities. The PSR does not apply to the procurement of goods or non-health care services (unless as part of a mixed procurement), irrespective of whether these are procured by relevant authorities.

New NHS software to improve care for millions of patients
From spring, the NHS will roll out new software to deliver better joined-up care for millions of patients, help tackle waiting lists and reduce hospital discharge delays. The software will bring together existing NHS data, making it easier for staff to access key information to provide improved and more timely patient care.

WorkWell prospectus published
WorkWell, a joint pilot between the Department of Health and Social Care (DHSC) and the Department for Work and Pensions, is an early intervention assessment service which provides holistic support to overcome health-related barriers to employment. Local system partnerships of ICBs, local authorities and local Jobcentre networks can use the prospectus to apply for funding to deliver WorkWell services.

NHS retention drive expanded across the country with thousands fewer staff leaving frontline roles
Thousands fewer staff left the NHS last year, thanks to a major new retention programme which is now being expanded across the country. The expansion comes as data shows the equivalent of 14,000 fewer staff left the NHS in the 12 months up to August 2023 (108,890) – compared to 122,970 the year before.

NHS expands mental health support for veterans
The NHS is rolling out an expanded mental health support service for Armed Forces veterans, as a survey found that more than half find it difficult to speak up about mental health issues. The health service launched a new campaign to highlight its Op COURAGE service, which now includes enhanced specialist support for addictions.

NHS vaccination strategy
The NHS vaccination strategy aims to improve access to vaccinations across the country. System leaders will have the flexibility to plan and deliver local services, with systems taking increased delegated responsibility by April 2025 for commissioning a vaccination delivery network tailored to the needs of their local population.

Millions more people receive GP appointments compared to before the pandemic
Four million more GP appointments a month are being delivered for patients compared to the same month before the pandemic, as part of the NHS primary care access recovery plan.

Another record-breaking year for NHS cancer checks
More people than ever before are getting tested for cancer with almost 3 million checks over the last 12 months. New analysis shows there has been a 133% increase in the number of people getting checked for cancer, over the last decade.

NHS App reaches record users on fifth anniversary
Three quarters of adults in England are now signed up to the NHS App. The total number of monthly logins has increased by 54% over 12 months, from 16.8 million in November 2022 to 25.8 million in November 2023 – the equivalent of 10 logins a second. Statistics also show that pensioners are the most active users of the NHS App.

NHS dementia diagnosis rates at three-year high
The NHS is diagnosing tens of thousands more people with dementia since the start of the pandemic. A dementia diagnosis is the first step in assessing whether someone would be suitable for treatments, or whether they and their family need further support.

Local developments

NHS Derby and Derbyshire appoints new Chair
Dr Kathy McLean OBE will take up her new post as Chair of NHS Derby and Derbyshire Integrated Care Board on 1 May 2024. The role will be alongside her existing role as chair of the NHS Nottingham and Nottinghamshire Integrated Care Board and Integrated Care Partnership. The two roles complement each other and are aligned to the development of the Combined Authority across Derby & Derbyshire and Nottingham & Nottinghamshire.

East Midlands Combined County Authority (EMCCA) is set to come into existence in spring
On Thursday 7 December, Derbyshire County Council, Nottinghamshire County Council, Derby City Council and Nottingham City Council each approved plans to create the East Midlands Combined County Authority (EMCCA), which is set to come into existence in the spring, if parliament passes the necessary legislation. If the legislation is passed, it will mean that residents across Derbyshire, Nottinghamshire, Derby and Nottingham will get the chance to vote for the first-ever East Midlands Mayor in May.

DHU Derbyshire Service Rated 'Outstanding' by the Care Quality Commission
DHU Healthcare’s Chesterfield based Urgent Care North out of hours service has been listed as ‘Outstanding’ by the Care Quality Commission following its most recent inspection. Based at Ashgate Manor, the service treats and cares for patients referred through DHU’s own 111 service based on the symptoms they describe, receiving an appointment at one of seven Primary Care Centres in the region or a home visit, depending on the needs of the individual patient.

Derbyshire County Council prepares to set 2024-2025 budget
Planning across all departments continues as Derbyshire County Council prepares to set out its budget in February. Responses from the Your Council Your Voice consultation, which concluded on Sunday 17 December, have fed into the main budget-setting process. The Council's Cabinet met on Thursday 11 January to consider a number of savings proposals put forward as part of the budget-setting process. The Improvement and Scrutiny Committee – Resources, will meet on Monday 22 January to consider the budget and provide feedback to Cabinet on the proposals. The budget will then be considered by Cabinet at its meeting on Thursday 1 February before going to Council on Wednesday 14 February.

More GP practice appointments than ever, thanks to 100s more health and care staff
The number of appointments at a GP practice in Derby and Derbyshire has grown 22% over the past four years, figures show. The increase has been achieved partly because hundreds of

health and care professionals have been recruited since 2019 to support GPs in busy surgeries. Additional staff such as physiotherapists, nurses, paramedics, pharmacists and social prescribers also mean patients can be seen more quickly than if they had to wait for an appointment with a GP.

Regeneration project is a trailblazer for tackling poor health
An innovative project is under way that will tackle some of the highest levels of health inequalities in Derbyshire. NHS colleagues are working together with partners to ensure that good health and wellbeing is integral to the redevelopment of Barrow Hill Memorial Hall, near Staveley, Chesterfield.

Expansion of mental health crisis services across Derby and Derbyshire
The range of local support services for people with immediate mental health needs has been expanded in Derby and Derbyshire. The expansion of mental health crisis services is part of a wider programme of partnership activity led by Joined Up Care Derbyshire which aims to improve outcomes for people with immediate mental health needs.

NHS England's National Medical Director Sir Stephen Powis meets innovative teams at UHDB
University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) recently welcomed Professor Sir Stephen Powis, National Medical Director for NHS England, to meet colleagues from across the Trust and visit departments at Royal Derby Hospital.

Colleagues on Sir Robert Peel's Philip Ward mark one year of helping patients on their discharge journey
The team in Sir Robert Peel Community Hospital's Philip Ward is celebrating a year since welcoming its first patients, after undergoing a dramatic transformation from an unused ward area to a "loving, friendly" ward.

Radiotherapy team highly commended in prestigious national award for work to improve service for breast cancer patients
University Hospitals of Derby and Burton's Radiotherapy team who are based at Royal Derby Hospital won Highly Commended in a prestigious national award for its innovative work implementing tattoo-free radiotherapy and improving the patient journey for patients receiving treatment for breast cancer.

Chesterfield Royal Hospital appoint new Chair
Chesterfield Royal Hospital NHS Foundation Trust has appointed Mahmud Nawaz as their new Chair. He will take up his role very soon and will replace Dr Helen Phillips, who has been Chair since 2015. Mahmud brings varied and rich experience across roles in the public and private sectors.

Further Diagnostic Services to Launch at Walton Hospital’s Community Diagnostic Centre
As part of a £29.9m investment in ‘one-stop-shop’ Community Diagnostic Centres (CDCs) in Derby and Derbyshire, Walton Hospital’s CDC opened two new services in December 2023 and further enhancements and developments are planned throughout 2024.

East Midlands Ambulance Service welcomes new Director of Quality Improvement and Patient Safety
Keeley Sheldon has been appointed as the new Director of Quality Improvement and Patient Safety at East Midlands Ambulance Service (EMAS). Keeley was formerly at Nottinghamshire Healthcare NHS Foundation Trust in the role of Deputy Director for Community Health Services

and started her career in the NHS 24-years ago, when she joined an acute hospital trust as an adult general nurse.
See also: Nichola Bramhall, Director of Quality Improvement and Patient Safety retires after 36 years in the NHS.

England's top nurse presents awards to four Trust colleagues for excellence in healthcare
Four healthcare workers at Derbyshire Healthcare NHS Foundation Trust have been awarded the prestigious Chief Nursing Officer (CNO) Healthcare Support Worker Award for showing excellence across the healthcare profession. The award, given by NHS England, recognises the vital contributions of healthcare support workers. Recipients must consistently demonstrate the NHS values and behaviours when fulfilling their everyday roles, to provide excellent patient care.

Publications that may be of interest:

Joined Up Care Derbyshire – December 2023 Newsletter
Team Up Bulletin – December 2023

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**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
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.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Not applicable to this report.

Financial impact on the ICB or wider Integrated Care System

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

<table>
<tr><td>Equality Impact Assessment</td><td>Yes ☐</td><td>No☐</td><td>N/A☒</td><td>Details/Findings</td></tr>
<tr><td colspan="5">Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable</td></tr>
<tr><td>Yes ☐</td><td>No☐</td><td>N/A☒</td><td>Risk Rating:</td><td>Summary:</td></tr>
<tr><td colspan="5">Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable</td></tr>
<tr><td>Yes ☐</td><td>No☐</td><td>N/A☒</td><td colspan="2">Summary:</td></tr>
<tr><td colspan="5">Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:</td></tr>
<tr><td colspan="2">Better health outcomes</td><td>☒</td><td>Improved patient access and experience</td><td>☐</td></tr>
<tr><td colspan="2">A representative and supported workforce</td><td>☐</td><td>Inclusive leadership</td><td>☐</td></tr>
<tr><td colspan="5">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?</td></tr>
<tr><td colspan="5">Not applicable to this report.</td></tr>
<tr><td colspan="5">When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?</td></tr>
<tr><td>Carbon reduction ☐</td><td colspan="2">Air Pollution ☐</td><td colspan="2">Waste ☐</td></tr>
<tr><td colspan="5">Details/Findings
Not applicable to this report.</td></tr>
</table>

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th January 2024

Item: 124

Report Title	Integrated Care Board Risk Register Report – December 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 – December 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 December 2023;
- Appendix 2, which summarises the movement of all risks in December 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**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

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, Chief Finance Officer

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 7 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.

Risk Matrix

Impact	1 – Rare	2 – Unlikely	3 – Possible	4 – Likely	5 – Almost certain
5 – Catastrophic					
4 – Major			1	4	3
3 – Moderate		4	3	2	
2 – Minor					
1 – Negligible					

Probability

Very High (Red) Operational Risks

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
Risk 01	*The Acute providers may not meet the new target in respect of 76% of patients being seen, treated, admitted or discharged from the Emergency Department within 4 hours by March 2024, resulting in the failure to meet the ICB constitutional standards and quality statutory duties, taking into account the clinical impact on patients and the clinical mitigations in place where long waits result.* **Update:** • The Derby and Derbyshire Clinical Navigation Hub (CNH) and Single Point of Access (SPoA) went live on 20th November 2023. • Wider communications are being disseminated across the system. • Co-ordinating, monitoring and reporting has commenced.	Overall score 20 **Very High** (5 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	November performance: • CRH reported 71.8% (YTD 77.6%) and UHDB reported 71.6% (YTD 73.1%). • CRH are no longer compliant with the local 75% target. The combined Type 1 attendances remain high and the Type 3 streamed attendances have increased, with an average of 238 Type 1 and 36 streamed attendances per day. • UHDB: The volume of attendances remains high, with Derby seeing an average of 214 Type 1 adult attendances per day, 127 children's Type 1s (a significant rise) and 139 at the co-located Urgent Treatment Centre (UTC). At Burton there was an average of 197 Type 1 attendances per day and 23 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 12 Resuscitation patients and 202 Major patients per day and Burton seeing 72 Major/Resus patients per day.		
Risk 03	*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:** • OPEL scoring and winter resilience meetings are in place, representation at these meetings includes the ICB, GP Provider Board, Derbyshire Local Medical Committee and links with the GP Task Force (Hub+). • A local communication plan is in place and a toolkit of national and local resources. These include graphics, key messages, guides for staff and patients and a media launch led by the ICB communications team. • Winter funding has been allocated to operationalise PCN-run Acute Respiratory Infection Hubs from December 2023 to March 2024.	Overall score 16 **Very High** (4 x 4)	Population Health and Strategic Commissioning 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:** • A return was submitted to NHSE on 22nd November demonstrating the impact of the 'national reset' of priorities for the remainder of this financial year.	Overall score 20 **Very High** (5 x 4)	Finance, Estates and Digital Committee

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	• The recurrent baseline is currently being understood to enable action planning for 24/25 onwards. This will be assisted by the opportunities, priorities and efficiencies being discussed at TCG/Delivery Boards/PCLB/Estates Group for 23/24 budgets. • The Financial Sustainability Group continue to oversee efficiency progress. • For 24/25 planning, the triangulation of finance, workforce and activity/productivity is a key focus. Productivity in elective activity is being reviewed to derive methodologies for understanding drivers of improvement, which can then be applied more widely across the System. This will further support the identification of opportunities for 24/25. • At the November meeting of the System Finance, Estates and Digital Committee, it was recommended that the probability was increased from 4 to 5. • The reason for this increase is the very high likelihood of the system reporting a deficit position for 2023/24 and that there will be a significant, recurrent deficit.		
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:** • There has been an extension of home care provision to support discharges out of Royal Derby Hospital and United Hospitals Derby and Burton (UHDB), with the contract negotiations due to commence in November. • Connex Voluntary Community and social Enterprise (VCSE) has been launched supporting 10 discharges per week into the High Peak.	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 Seekers and unaccompanied asylum seekers with undertaking health assessments.*	Overall score 16 **Very High** (4 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	Update: • There is no planned reduction in the use or the number of contingency hotels at this point in Derby or Derbyshire, therefore there is no change in the risk.		
22	*National funding for the 23/24 pay award and 22/23 one off payments excluded all staff who were not on NHS payrolls. Consequently staff employed by DHU, NHS subsidiary bodies, in PFI arrangements and Primary care were not eligible. Consequently there is an increasing risk of legal challenge as well as real, emerging loss of morale for over 4500 staff across the Derbyshire system which could affect recruitment and retention of critical frontline colleagues.* **Update:** • Individual organisations are now able to apply for payments. It is uncertain whether the applications, if successful, will cover all the nuances in the shortfall in the pay awards, however, it would cover a number of them. • The System Finance, Estates and Digital Committee agreed to decrease the score of this risk to 4 x 4 on the matrix. This was agreed at the meeting held in December.	Overall score 16 **Very High** (4 x 4)	Finance, Estates and Digital Committee
23	*There is a risk to Joined Up Care Derbyshire (JUCD) performance against the Cancer Standards, including 28 Day Faster Diagnosis Standard, 62 Day Waits and 104+ days due to an increase in referrals from Staffordshire into UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.* **Update:** • A Turnaround lead is in place at UHDB to deliver the recovery programme (managed through the ICB chaired Elective and Cancer Recovery Group).	Overall score 16 **Very High** (4 x 4)	System Quality Group

RISK MOVEMENT

Appendix 2 details the movement of risk scores during December 2023 and the graphs detail the movement since April 2023.

Two risks were decreased in score in December:

Risk 09: *There is a risk to patients on Provider waiting lists due to the continuing delays in treatment resulting in increased clinical harm.*

This risk was decreased from a very high score of 16 (probability 4 x impact 4) to a high score of 9 (probability 3 x impact 3).

This was approved by System Quality Group at the meeting held on 2nd January 2024.

Risk 22: *National funding for the 23/24 pay award and 22/23 one off payments excluded all staff who were not on NHS payrolls. Consequently staff employed by DHU, NHS subsidiary bodies, in PFI arrangements and Primary care were not eligible. Consequently there is an increasing risk of legal challenge as well as real, emerging loss of morale for over 4500 staff across the Derbyshire system which could affect recruitment and retention of critical frontline colleagues.*

This risk was decreased from a very high score of 25 (probability 5 x impact 5) to a very high score of 16 (probability 4 x impact 4).

This was agreed and approved by the Finance, Estates and Digital Committee at the meeting held on 19th December 2023.

One risk was increased in score in December:

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.*

This risk was increased from a very high score of 16 (probability 4 x impact 4) to a very high score of 20 (probability 5 x impact 4).

This was approved by the Finance, Estates and Digital Committee at the meeting held on 19th December 2023.

CONCLUSION

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 December 2023;
- Appendix 2, which summarises the movement of all risks in December 2023.

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

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)
01	23/24	The Acute providers may not meet the new target in respect of 76% of patients being seen, treated, admitted or discharged from the Emergency Department within 4 hours by March 2024, resulting in the failure to meet the ICB constitutional standards and quality statutory duties, taking into account the clinical impact on patients and the clinical mitigations in place where long waits result.	System Quality Group	Constitutional Standards/ Quality	3	4	12	- 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 reviewed at each board meeting focusing on key standards such as the ED performance, C2 Performance, Ambulance Handovers, VW Utilisation etc. The report is a being further developed to allow the group to focus on trends and areas of improvement. This will provide greater scrutiny of performance areas of concern to be highlighted and acted upon accordingly. - 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. The OCC have established daily system calls to check in with the system every morning at 9.30 this includes getting an operational update from each provider and raise any concerns and/or issues. When the system and/or a provider is in a state of escalation an update is shared with UEC leads, execs and on-call directors. - 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. - ECIST have visited both UHDB sites, the team are working through the recommendations - 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 - NHSE colleagues visited CRH in November to conduct a peer review on their processes and pathways. Awaiting the report from NHSE - Non Elective Improvement Group reinstated at RDH, this forum reviews the performance and trajectories internally and also focuses on alternative pathways to improve the ED position.	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. The Derby & Derbyshire Clinical Navigation Hub (CNH) / Single Point of Access (SPoA) will be live from 20th November following on from the one year pilot which started 1 December 2022. - Improving ambulance handover times through increased senior ownership within EDs and applying Releasing Time To Care principles in EMAS. - The HALO role is no longer in place due to the post holder moving on to a new opportunity. Alternative options are being explored to support ambulance handover times. - 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. Discussions have started through Team Up on SDEC flow to community services to avoid inappropriate admissions through. - 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. The new Opel framework reporting is now in place, both acutes are working on data accuracy of the metrics with the support of the UEC and OCC team (on track). - 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 have re-established the daily check in calls with system partners to support managing the day to day operations, improve system working and relationships. A highlight report is being developed alongside BI and performance colleagues as an output of this meeting. **- DDCNH+/SPoA went live on 20th November 2023. Wider communications being disseminated across the system. Co-ordinating, monitoring and reporting commenced.** - NHS UTC Standards have been published. The ICB is now working with UTC providers to develop a range of KPI's which will monitor UTC performance against these standards.
03	23/24	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.	Population Health & Strategic Commissioning Committee	Primary Care	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.
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.	Audit and Governance Committee	Corporate	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
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, Estates and Digital Committee	Finance	4	4	16	Dec Update: Actions are continually being taken against the detailed risk log to take smaller actions to mitigate the overriding risk. System strategies surrounding estates and digital plans, sharing risk across the System, and engagement into the ePMO to improve reporting, all play a part. Development of the Delivery Boards' objectives, including their role in financial efficiency delivery and ownership of such. Development of TCG and PCLB to ensure their work supports planning. The System moves towards understanding its underlying position and how this impacts a triangulated Medium Term Financial Plan. Stronger intelligence and clear process required for 24/25 planning. The System's liquidity position is considered; this period of financial challenge results in cash risks. A number of mitigating options have been provided including national solutions, enhanced management of working capital and PDC.	Dec Update: Finance, HR and Operational colleagues to work closer to understand the financial impacts of performance targets on a planning model, alongside a long-term strategy for estates and infrastructure. The group to set out the approach for 24/25 planning. Agreement on process to identify a pipeline of opportunities at organisational and system level, along with prioritisation process as part of 24/25 planning process
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.	Audit and Governance Committee	Corporate	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.
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.	System Quality Group	Clinical	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
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	Audit and Governance Committee	Corporate	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
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. September: Team has agreed portfolios and business partner arrangements to help horizon scan and plan for future work.	•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.

Risk Reference	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	November 2023 performance CRH reported 71.8% (YTD 77.6%) and UHDB reported 71.6% (YTD 73.1%). CRH are no longer compliant with the local 75% target. The combined Type 1 attendances remain high and the Type 3 streamed attendances have increased, with an average of 238 Type 1 and 36 streamed attendances per day. UHDB: The volume of attendances remains high, with Derby seeing an average of 214 Type 1 adult attendances per day, 127 children's Type 1a (a significant rise) and 139 co-located UTC. At Burton there was an average of 197 Type 1 attendances per day and 23 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 12 Resuscitation patients & 202 Major patients per day and Burton seeing 72 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	Dec-23	Jan-24	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Amy Ward Senior Operational Resilience Manager Dan Merrison Senior Performance & Assurance Manager Jasbir Dosanjh
03	August/September: 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 credibility, 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. October/November: Resilience meetings in place both looking at supporting individual and system resilience across general practice, Early warning score development progressing and will be discussed within upcoming resilience meeting. General Practice Improvement programme take up improving with a mixture of individual practice and PCN involvement of which completion of the Support Level framework is integral. Winter plan developed using scenario of funding/ no funding and options for both for consideration. December: OPEL Scoring and winter resilience meetings in place, representation including ICB, GP Provider Board, Derbyshire Local Medical Committee and links with the GP Task Force (Hub+). Local communication plan in place - Toolkit of national & local resources e.g., graphics, key messages, guides for staff and patients & Media launch led by ICB communications team. Winter funding allocated to operationalise PCN-run Acute Respiratory Infection hubs December 2023 – March 2024.	4	4	16	4	4	16	4	3	12	On-going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Dec-23	Jan-24	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Hannah Belcher, Assistant Director of GP Commissioning and Development Primary Care Judy Derricott Assistant Director of Nursing and Quality Primary Care
05	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. September Core Standards Submission has been made to NHS England with self assessed grading of substantially compliant. The EPRR team is currently challenging all standards for system providers, close of process anticipated e/o October 2023. Further testing and training planned for 2024. Full EPRR workplan for 2024 being drawn up against key identified EPRR risks. Industrial Action continues to pressurise providers and the ICB EPRR team in conjunction with the EPRR core standards process October Core Standards Submission has been made to NHS England with self assessed grading of substantially compliant, likely due to challenges that this will be changed to partially compliant as was predicted, inordinate amount of challenge from NHS England this year however the ICB will accept comments and work to improve standards position for 2023/24 submission. The EPRR team is currently challenging all standards for system providers, this has lead to an increase in non compliant providers in line with increased challenge from Regional team, close of process anticipated e/o October 2023. Further testing and training planned for 2024. Full EPRR workplan for 2024 being drawn up against key identified EPRR risks. Industrial Action continues to pressurise providers and the ICB EPRR team in conjunction with the EPRR core standards process November Core Standards Submission has been made to NHS England and approved as partially compliant, workplan has now been formed. Further testing and training planned for 2024. Full EPRR workplan for 2024 being drawn up against key identified EPRR risks. December Continued work is ongoing with EPRR, team is now in place for the completion of the core standards process, workplan continues to be delivered. Training programme confirmed for 2024. Industrial Action again pressuring the EPRR team and completion of tasks.	2	3	6	2	3	6	2	2	4	On-going	SR4 SR5 SR6 SR9	Dec-23	Jan-24	Helen Dillistone - Chief of Staff	Chris Leach Head of EPRR
06	Dec Update: A return was submitted to NHSE on 22nd November demonstrating the impact of the 'national reset' of priorities for the remainder of this financial year. The now £47.3m deficit was acknowledged by NHSE, but JUCD were tasked to go further. However, this deficit will now be impacted by upcoming strike action. Recurrent baseline being understood to enable action planning for 24/25 onwards. This will be assisted by the opportunities, priorities and efficiencies being discussed at TCG/Delivery Boards/PCLB/estates group etc for 23/24 budgets. Financial Sustainability Group continue to oversee efficiency progress. For 24/25 planning, triangulation of finance, workforce and activity/productivity is a key focus. Productivity in elective activity is being reviewed to derive methodologies for understanding drivers of improvement, which can then be applied more widely across the System. This will further support the identification of opportunities for 24/25. External support has been commissioned to support the Estates strategy; national timeline is now March 2024. Further cash support has been requested for Q4 23/24. At the November meeting of the System Finance, Estates and Digital Committee, it was recommended that the probability was increased from a 4 to a 5. The reason for this increase is the very high likelihood of the system reporting a deficit position for 2023/24 and that there will be a significant, recurrent deficit.	4	4	16	5	4	20	2	3	6	On-going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Dec-23	Jan-24	Keith Griffiths, Chief Financial Officer	Darran Green, Acting Operational Director of Finance Donna Johnson Acting Assistant Chief Finance Officer
07	August - No change - Limited progress due in part to workload and holiday absences within the HR team. September - No change - Limited progress due to workload and holiday absences within the HR team. October - No change - insufficient resource within the HR team to progress this work at the current time. Resources to be reviewed with a view to completing prior to the move from Cardinal Square to the Council House. November - No change - insufficient resource within the HR team to progress this work at the current time. December - The HR team are transferring a number of files to Scarsdale so that current admin resources in the team can commence scanning. However, additional resource will be required to be able to make significant progress on this work and therefore the HR team plan to recruit additional temporary resource in the New Year, following conclusion of the current consultation process. It is anticipated that the transfer from paper to electronic records could then be concluded by summer 2024.	2	3	6	2	3	6	1	2	2	Apr-24	SR6	Dec-23	Jan-24	Helen Dillistone - Chief of Staff	James Lunn, Head of People and Organisational Development
09	September: 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). However, ongoing work continues in the Equal access to all section. A piece of work is currently ongoing to review waiting times by ethnicity and deprivation. This work is progressing through the Systems Intelligence Group into Planned Care Delivery Board. For monitoring and assurance purposes, the Patient Safety Team, and Quality Team will liaise with Planned Care Board. It has been acknowledged that full assurance in relation to the framework is difficult due to the volume of patients waiting, and ongoing system and service pressures. There has however been substantial progress in relation to Communication and Waiting Well and Harm reviews whilst Equality of Access remains challenging. Equality of Access has been one area which is being looked at system wide. Concerns and Complaints remain in some areas, but Providers are resolving these at a local level and continue to work within their processes. In view of this, the risk rating proposed to be reduced to 12. Decrease in risk score not agreed at System Quality Group meeting on 3rd October 2023 due to the current risks and pressures in the system. October update: It should be noted there is significant 'lag' in the submission of information to the ICB in advance of the report submission; on occasion a delay of 2 Quarters. The Providers advise that these delays are due to their internal governance processes. Assurances have been received from all Providers that they have established processes to regularly reassess clinical pathways in alignment with local and national guidelines. DCHS currently holds an Amber rating for this KPI due to the ongoing refinements of their SOPs. Nevertheless, there is an overarching SOP in place for the Trust, and all planned care and specialist services have formulated their draft clinical harm SOP. The development of service specific SOPs is underway, starting with key services, and the plan is to gradually implement them across other services. No moderate or severe harms were reported in Q1 and Q2 across the Derbyshire System. November: The lag continues due to internal governance processes. This will be highlighted in a report to System Quality and Performance Committee in December for additional support. Dec 2023 - Q1 and Q2 report to be shared at Q&P Dec 2023 meeting. There has been significant strides made by our healthcare providers, their adherence to the quality standards and the measures taken to address identified harms and complaints. The report highlights that each provider has been assessed (some previously) and all key performance indicators are either on track or completed, with no indicators as not on track. This demonstrates a commitment to delivering high quality care even during the pressures they face with the increasing numbers of long waits. We are not seeing the amount of harm originally thought and we are assured that the harm processes in place are robust and are being monitored at Provider Board level. To be downgraded to 9 – Probability 3, likelihood 3.	4	4	16	3	3	9	3	2	6	Feb-24	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Dec-23	Jan-24	Prof Dean Howells Chief Nursing Officer	Letitia Harris Assistant Director of Clinical Quality Lisa Falconer Head of Clinical Quality (Acute)
11	Quarter 3 - Highlight Reports are being collated in readiness for reporting to NHSE SRO Review Meeting with NHSE take place quarterly, next meeting is scheduled for January 2024. Derby and Derbyshire ICB implemented the Net Zero mandatory training on ESR to all ICB staff on 1st October 2023. 20% of staff have now completed the training and there will be a communication to increase this number in December, uptake continues to be monitored by the central ESR team Travel and transport Survey – intention is to run the survey in the next 12 months Joint working with Local Authority – ICB are members of and work together on the Air Quality Group – links to ICB wellbeing strategy Green Maturity Matrix Self Assessment completed, deadline for completion 8 January 2024. 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	Dec-23	Jan-24	Helen Dillistone - Chief of Staff	Suzanne Pickering Head of Governance
13	•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. 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. November: ICB Staff Consultation on structures underway. November: Ongoing management of priorities via portfolios and mutual aid across the team. Set workload in place until end of calendar year, with limited capacity for additional work. December: ICB Staff Consultation on structures ongoing.	3	3	9	3	3	9	2	2	4	Jan-24	SR3 SR4 SR5 SR7 SR8 SR9	Dec-23	Jan-24	Helen Dillistone - Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement

Risk Reference	Year	Risk Description	Responsible Committee	'CFT' 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
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 July/August/September: No further update, position remains the same. October - It is not clear yet whether there will be any impacts on the ICB from the delegation of Specialised Services. Birmingham and Solihull ICB will be the host ICB for those services but the detail is not yet worked through to enable us to understand any impacts on Derby and Derbyshire ICB, therefore no change to the score currently. November/December: No change	3	2	6	2	3	6	2	2	4	Apr-24	SR4 SR6 SR7 SR9	Dec-23	Jan-24	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.	October: Updated provided by Chief Executive at Team Talk in October along with an overview of the HR Framework and proposed restructure timeline by HR. Continued promotion of wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider. HR have also communicated further support available for staff related to the upcoming organisational change, including the following:- •The NHS leadership Academy webinar on embracing change and uncertainty •Personal resilience •Looking after yourself •Supporting others in difficult times •How to work with emotions and care for your teams Sickness absence levels increased in September to 3.6% (last year for September = 2.91%). November: Formal launch of the consultation relating to the ICB running costs reduction and restructure proposals at Team Talk on 17 November 2023. Individual 'heads up' meeting conducted for staff potentially 'at risk' of redundancy and offer of one to one consultation meeting for all staff. Trade Unions and Professional Representative Associations engaged and included in the consultation process. Continued promotion of wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider. Sickness absence levels increased in October to 3.6% (last year for October = 4.4%). December: The consultation period runs until 7th January 2024 and the HR team are collating feedback received and responding to individual questions. Generic responses are being shared with colleagues via the ICB staff intranet. The Trade Unions and Professional Representative Associations are engaging in the consultation process and supporting members. Continued promotion of wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider. Sickness absence levels reduced in November to 3% (last year for November = 4.13%).	4	3	12	4	3	12	3	2	6	Dec-23	SR4 SR5 SR6	Dec-23	Jan-24	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 Partnership 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 in ICB OD programme •- Continued links with IC Strategy development programme •- Continued links with Place Alliances to understand and communicate priorities	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. November: BAF review of actions to provide assurance on progress. Option to review risk rating at this time. November: System workshops on priorities for delivery through Joint Forward Plan, next session 14/12/23. Aligned to development of 24/25 Operational Plan development and opportunity for public/stakeholder involvement in this during Q4, to be agreed. December: 14/12/23 session postponed until 2024. Continue to align with 24/25 Operational Plan development for potential public/stakeholder involvement in Q4.	4	3	12	4	3	12	3	2	6	Jul-24	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Dec-23	Jan-24	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 NHSE/I.	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, NHSE/I 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.	October/November: The ICB is supplying weekly updates to PCNs with regards to practices and access of patients to the NHS app including access to records. Practices have been kept up to date with webinars and communications regarding all aspects of the switch on, no safeguarding concerns have been raised to the ICB to present, additional feedback has been sought at Clinical Governance leads meetings. Review the risk following go live date in the event that concerns are raised re practice implementation or safeguarding. December: Go Live Date 01.11.2023 – no concerns or issues raised with the Primary Care Quality Team since the Go Live Date. The ICB continues to supply weekly updates to PCNs via Primary Contracting Team and any queries escalated to NHSE for response. Recommend that this is maintained at current Risk Rating and removed in two months	2	3	6	2	3	6	2	2	4	Dec-23	SR1 SR4 SR8 SR9	Dec-23	Jan-24	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	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	Discharge 1. ASCDF funded home care through CHS till end oct 23, plan to continue at current level till Feb 24 for discharge and flow support 2. DCHS led CRT providing reablement care for P1, increased investment through ASCDF to increase provision 2. P1 Strategy to be finalised Oct 23 3. Transport : Clinical Nav ensuring transport to community bedded care is booked to reduce incomplete discharges out and lost bed days in community beds, started CRH to be rolled out across all wards and to UHDB 4. Community Health Therapists working closely with County Adult Care and Community Response Teams to ensure P1 clients have clear goals and a planned date of discharge. This will help reduce the intensity and duration of care packages thus freeing up capacity 5. ASCDF funding VCSE 'home and settle from hospital' scheme to transport and support P0 discharges home plus county schemes coming on line in Oct / Nov : will reduce delays for P0/P1 patients awaiting discharge and reduce readmission rates as patients supported once discharged. 6. County ASC transformation to provide increased and improved P1 capacity. Launch date Jan 24 7. ASCDF funding staff to improve discharges out of CRH and UHDB, focus on weekend discharges 8. Care transfer hub process improvement work 9. OPTICA to provide IT solution for discharge planning identifying delays and supporting with prioritisation of tasks (aim to reduce duplication and better decision making) 10. integration in City of health and social care delivery to one reablement model of care 11. ASCD to mental health to improve flow through MH beds to enable increased capacity 12. CRH and UHDB focused work on ward processes to improve flow. Roll out of UHDB strength based approach to discharge (started ward 311) UEC interventions 1. SEC and SORG interventions. 2. Overview of HHO delays and robust scrutiny of progress to delivery improvement trajectories. 3. Performance management of workforce and abstraction rates to ensure necessary resources are in place to respond to demand 4. Implementation of EMAS Hospital Handover Harm Prevention Tool at Acute Trusts. 5. Ongoing work in commissioning Same Day Emergency Care and direct access to specialties 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. 6. Regular monitoring of Actions and risk by CQRG. 7. Local system governance structures to manage difficult decisions: Derbyshire System pressures quality review panel. Decisions and discussions held at SORG. 8. HALO - recruited to support both Acutes and crews with handover delays, directing appropriate patients to SDEC, supporting pinning off etc	Discharge 1. accept discharge to assess is a joint responsibility of health AND social care to deliver 2. Accept discharge out of P2 beds will have parity of impact with acutes as will create flow (25% P2b beds have patients in delay) 3. Reduce the number of handoffs within our pathways and improve faster access to pathways through joint improvement work 4. Accept OPTICA will lead to improved transparency of system delays and enable prioritisation of patient needs for discharge. All system partners to support embedding of tool 5. accept largest gain is in providing more pathway 1 access to support discharge flow, avoid use of temporary beds to place patients into who are in delay and acknowledge this leads to poor outcomes for patients and higher costs for the system 6. Accept there is limited care home capacity to accept needs of patients who have complex needs, where these are sought for discharge there will likely be delays to source 7. Reduce the delays caused by patients awaiting discharge letters / meds for discharge, 8. reduce the number of patients being discharged after midday and increase early morning discharges, this is achieved through improved discharge planning and decision making and access to transport 9. Accept decisions regarding discharge need to be made as a system with no one provider making unilateral changes to delivery without consulting with others through governance route of SDG 9. accept that process work around care transfer hubs requires transformation support of the system to enable true change to occur 10. transfer the learning from ward 311 strength based approach to UHDB so learnings can be used by the wider hospital 11. Provide assurance that ASCDF is delivering additional discharge capacity to the system through monitoring of impact and outcomes 12 accept there is a large decrease in weekend discharges due to reduced weekend staffing on wards and some providers. Unless there is significant investment in workforce across wards and community this will continue 13 accept there is a large opportunity to focus on P0 discharges which are 90+% of all flow which will likely not be supported by the care transfer hubs. UEC System actions to reduce hospital handover delays. System urgent care improvement action plans. 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 Sept 23 : Identification of P1 gap of approx. 49 discharges per week if CHS care ends in Nov, paper to execs to approve extension of CHS until ASC transformation is embedded (Feb 24), POG development support and agreement of system flow meeting, twice weekly, with all system partners to unblock flow from all providers. TOR agreed and to be shared with SDG. Require system support to facilitate this shift in meetings to outcomes, challenge and delegated decision making. Care transfer hub work to commence Oct 23 at CRH, request transformation support into these meetings Oct/Nov 23 : extension of home care provision to support discharge out of RDH and UHDB, contract negotiations due to start Nov. Connex VCSE launched supporting 10 discharges per week into high peak Dec: There is no update at this time due to managing system pressures.	5	4	20	5	4	20	2	5	10	December 23	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Dec-23	Jan-24	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. 20/09/23 - There are no planned reductions in the use of contingency hotels in the city or the county. Concerns also regarding the number of unaccompanied asylum seeking children arriving in the city and county. October/November: No plans to reduce the number of contingency hotels within the city or county - therefore no change in risk 17/12/23 there is no planned reduction in the use or the number of contingency hotels at this point in Derby or Derbyshire - therefore there is no change in the risk.	4	4	16	4	4	16	3	3	9	December 23	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Dec-23	Jan-24	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children
21	23/24	There is a risk that contractors may not be able to fulfil their obligations in the current financial climate. The ICB may then have to find alternative providers, in some cases at short notice, which may have significant financial impact.	Finance, Estates and Digital Committee	Finance	4	4	16	Understand financial pressures facing our providers. Maintain Contract Database Proactive Procurement November: Work with colleagues in the ICB and wider GP community to pick up early warning signs for practices at risk of handing in their contracts and, if it does happen, work rapidly with the same group to intervene and secure cover.	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	September/October: The ICB is close to agreeing all contracts perceived to be at risk of inflation/cost of living, the ICB would expect to have been notified or assessed the probability of this occurring. A more robust link between contract expiry and procurement planning has been established. November: A deep dive is scheduled to take place in November to clearly understand the current processes that are in place in respect to expiry of contracts where key decisions need to be made, the output of which is to be reported to the Audit and Governance Committee. December: Deep dive has commenced with further actions to complete which is being overseen via the Governance Team for example exploring software which may aid with maximising efficiencies re: contract lifecycle management. In addition to note that contracts with the 4 NHS JUCD providers still remain unsigned along with out of area NHS provider contracts where DDICB is an associate.	3	4	12	3	4	12	2	3	6	Ongoing	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Dec-23	Jan-24	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Craig Cook Director of Acute Commissioning, Performance and Contracting & Clive Newman Director of Primary Care
22	23/24	National funding for the 23/24 pay award and 22/23 one off payments excluded all staff who were not on NHS payrolls. Consequently staff employed by DHU, NHS subsidiary bodies, in PFI arrangements and Primary care were not eligible. Consequently there is a an increasing risk of legal challenge as well as real, emerging loss of morale for over 4500 staff across the Derbyshire system which could affect recruitment and retention of critical frontline colleagues.	Finance, Estates and Digital Committee	Finance	5	5	25	The only mitigation rests with Treasury as the funds required to equalise pay across the system have not been made available to the NHS nationally; it is not just a Derbyshire problem but rather a national one.	As the ICB cannot mitigate against this risk it must be accepted. The organisations which are affected are aware of this decision and the further risk to the health and care system is that staff may be demotivated, feel undervalued, feel that they are being treated unfairly and may leave the organisations, therefore increasing the risk of inadequate workforce in Derbyshire to support our patients.	December: Individual organisations were now able to apply for payments. It is uncertain whether the applications, if successful, would cover all the nuances in the shortfall in the pay awards, but it would cover some of them. System Finance, Estates and Digital Committee agreed to decrease the score of this risk to 4 x 4 on the matrix. This was agreed at the meeting held in December.	5	5	25	4	4	16	TBC	TBC	TBC	Ongoing	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Dec-23	Jan-24	Keith Griffiths, Chief Financial Officer	Keith Griffiths / Darran Green
23	23/24	There is a risk to Joined Up Care Derbyshire (JUCD) performance against the Cancer Standards, including 28 Day Faster Diagnosis Standard, 62 Day Waits and 104+ days due to an increase in referrals from Staffordshire into UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.	System Quality Group	Clinical	4	4	16	There is a growth in 2 week wait referrals seen by UHDB comparing Jul-22 – Jun 23to 2019/20. Overall the activity for UHDB has increased by 29% compared to an overall growth nationally of 18%. This position is being driven by particularly large increases for patients from Staffordshire and to a lesser extend from LLR whilst the increase for Derbyshire is much closer to the national average. •The East Midlands Cancer Alliance has agreed to fund posts for 18 months at UHDB, as a Tier 1 Trust to support recovery, particularly for triage to build front end capacity to meet additional demand. •Work with Staffordshire ICB to understand drivers for referral increase •UHDB have a turnaround lead in place who is supporting with work to address LGI pathway implementation and system plans to implement tele dermatology	•Recruitment to range of posts funded through EMCA to support recovery. •Prioritisation of Best Practice timed pathways across key tumour sites – LGI, Urology, Skin and Gynae •Development of UHDB tumour site recovery action plans (with support from NHSEI IST team) due – Oct-23 •Development of referral triage functions: Gynae, LGI and Urology •Work underway to understand drivers for variance in Histology TAT at tumour site level. •Work going to enhance access to PET scanning (Longer term ambition to develop PET service within Derbyshire) •Oncology challenges supported through regional alliance support – longer term workforce development	•UHDB is in Tier 1 for cancer performance so monitored on a weekly basis by the national team. •Development of UHDB tumour site recovery action plans (with support from NHSEI IST team) due – Oct-23 •LGI Triage pathway developed. Pending full implementation at UHDB. •Gynae Triage in place at RDH. •Urology Triage piloted at RDH. •Investment to develop Derbyshire Pathfinder (Derbyshire Practices Only) to support primary care pathways •Recruitment – to EMCA funded roles ongoing. •IST Support to develop existing recovery action plans. •BPTP development continues. •Data analysis completed with NHSEI support to develop understanding of changes to activity levels. •SSICB Commissioning lead and GP Clinical Lead part of JUCD system workstreams to develop solutions to address this. •SSICB Primary Care Group now in place and UHDB part of this •Skin Recovery focus in place with additional capacity identified and outsourcing planned to support elective and cancer priorities. •Plans to develop Cancer PCN Leads network across JUCD (included connection to Staffordshire practices). December - Turnaround lead in place at UHDB to deliver recovery programme (managed through ICB chaired Elective and Cancer Recovery Group)	4	4	16	4	4	16	2	4	8	September 2024	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Dec-23	Jan-24	Prof Dean Howells Chief Nursing Officer	Monica McAlindon Head of Cancer

Appendix 2 - ICB Risk Register - Movement - December 2023

NHS
Derby and Derbyshire
Integrated Care Board

Risk Reference	Risk Description	Previous Rating (November)			Residual/ Current Risk Rating (December)			Movement - December	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
01	The Acute providers may not meet the new target in respect of 76% of patients being seen, treated, admitted or discharged from the Emergency Department within 4 hours by March 2024, resulting in the failure to meet the ICB constitutional standards and quality statutory duties, taking into account the clinical impact on patients and the clinical mitigations in place where long waits result.	5	4	20	5	4	20	↔	The Derby and Derbyshire Clinical Navigation Hub (CNH) and Single Point of Access (SPoA) went live on 20th November 2023.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager	Risk 01
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	↔	Winter funding allocated to operationalise PCN-run Acute Respiratory Infection hubs December 2023 – March 2024.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care	Risk 03
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	↔	Industrial Action again pressuring the EPRR team and completion of tasks.	Helen Dillistone - Chief of Staff	Chris Leach, Head of EPRR	Risk 05
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	5	4	20	↑	The reason for the risk score increase is the very high likelihood of the system reporting a deficit position for 2023/24 and that there will be a significant, recurrent deficit.	Keith Griffiths, Chief Financial Officer	Darran Green, Acting Operational Director of Finance	Risk 06
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	↔	The HR team are transferring a number of files to Scarsdale so that current admin resources in the team can commence scanning.	Helen Dillistone Chief of Staff	James Lunn, Head of People and Organisational Development	Risk 07
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	3	9	↓	Not seeing the amount of harm originally thought and the ICB is assured that the harm processes in place are robust and are being monitored at Provider Board level.	Prof Dean Howells Chief Nursing Officer	Letitia Harris Clinical Risk Manager	Risk 09
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 current risk score 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.	Helen Dillistone Chief of Staff	Suzanne Pickering Head of Governance	Risk 11
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	↔	ICB Staff Consultation on structures ongoing.	Helen Dillistone Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement	Risk 13
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	↔	It is not clear yet whether there will be any impacts on the ICB from the delegation of Specialised Services.	Helen Dillistone Chief of Staff	Chrissy Tucker - Director of Corporate Delivery	Risk 15

Risk Reference	Risk Description	Previous Rating (November)			Residual/ Current Risk Rating (December)			Movement - December	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
16	Risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.	4	3	12	4	3	12	⇔	The consultation period runs until 7th January 2024 and the HR team are collating feedback received and responding to individual questions.	Helen Dillistone Chief of Staff	James Lunn, Head of People and Organisational Development	Risk 16
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	⇔	Continue to align with 24/25 Operational Plan development for potential public/stakeholder involvement in Quarter 4.	Helen Dillistone Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement	Risk 17
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	⇔	The ICB continues to supply weekly updates to PCNs via Primary Contracting Team and any queries escalated to NHSE for response.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care	Risk 18
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	⇔	Connex Voluntary Community and social Enterprise (VCSE) has been launched supporting 10 discharges per week into the High Peak.	Dr Chris Weiner Chief Medical Officer	Jo Warburton Dan Webster	Risk 19
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	⇔	No plans to reduce the number of contingency hotels within the city or county - therefore no change in risk.	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children	Risk 20
21	There is a risk that contractors may not be able to fulfil their obligations in the current financial climate. The ICB may then have to find alternative providers, in some cases at short notice, which may have significant financial impact.	3	4	12	3	4	12	⇔	Contracts with the 4 NHS JUCD providers still remain unsigned along with out of area NHS provider contracts where DDICB is an associate.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Lana Davidson Senior Contract Manager	Risk 21
22	National funding for the 23/24 pay award and 22/23 one off payments excluded all staff who were not on NHS payrolls. Consequently staff employed by DHU, NHS subsidiary bodies, in PFI arrangements and Primary care were not eligible. Consequently there is a an increasing risk of legal challenge as well as real, emerging loss of morale for over 4500 staff across the Derbyshire system which could affect recruitment and retention of critical frontline colleagues.	5	5	25	4	4	16	⇩	Individual organisations are now able to apply for payments.	Keith Griffiths, Chief Financial Officer	Keith Griffiths / Darran Green	Risk 22
23	There is a risk to Joined Up Care Derbyshire (JUCD) performance against the Cancer Standards, including 28 Day Faster Diagnosis Standard, 62 Day Waits and 104+ days due to an increase in referrals from Staffordshire into UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.	4	4	16	4	4	16	⇔	Turnaround lead in place at UHDB to deliver recovery programme (managed through ICB chaired Elective and Cancer Recovery Group).	Prof Dean Howells Chief Nursing Officer	Monica McAllindon Head of Cancer	Risk 23

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th January 2024

Item: 125

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 – Dean Howells, Chief Nursing Officer • Performance – Michelle Arrowsmith, Chief Strategy and Delivery Officer • Workforce - Linda Garnett, Interim Chief People Officer • Finance – Keith Griffiths, Chief Finance Officer
Paper purpose	Decision ☐ Discussion ☐ Assurance ☒ Information ☐
Appendices	Appendix 1 – Integrated Assurance and Performance Report Appendix 2 – JUCD System Finance Report to 30th November 2023
Assurance Report Signed off by Chair	Not Applicable
Which committee has the subject matter been through?	Finance and Estates Committee: 19 December 2023 Quality and Performance Committee: 21 December 2023 People Services Collaborative Delivery Board: 19 December 2023

Recommendations

The ICB Board are recommended to **NOTE** the Month 8 performance Operational Plan update against the plan commitments and targets.

Purpose

Update the ICB Board on the:

- month 8 performance against the 2023/24 operational plan objectives/commitments, quality standards workforce and finance;
- progress against our winter plan (H2) which we submitted to NHSE in November and how we are coping with the winter pressures.

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 4th May 2023. The report attached represents the current assessment (M08 position) based on published data.

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.

In October, we undertook a progress review to assess performance against our earlier projections and forecasts, test the assumptions underpinning our original plan, and test our winter preparedness (H2) in line with NHSE guidelines and new requirements. The process involved:

- reviewing how performance was going in relation to the operational targets for planned care, cancer, and urgent & emergency care;
- recasting the forecast delivery position for the targets, for the period October 23-March 24, which involved a review and revision to the underpinning demand and capacity assumptions, as necessary; and
- setting out the 'how', by summarising the key actions we would be implementing to achieve the recast forecasts and projections.

The results of this work were shared with the board and submitted to NHSE in November.

As part of the work to nationally address the significant financial challenges created by industrial action, NHSE has since (Dec) directed ICBs to focus on achieving financial breakeven by the end of the financial year by setting out immediate actions systems will take to protect specific areas of provision while achieving breakeven (The Reset).

Report Summary

The summary below highlights the key areas to note, and additional information can be found in the supporting appendices as at M08 (Nov/Dec). It is based on NHSE nationally published and validated data.

Quality

CQC: DHU Out of Hours (North Derbyshire) services were inspected by CQC in October 2023 and the final report was published on the 25th December which rated the service as 'Outstanding'. The leadership, governance and culture within the service were noted to drive improvements to deliver high-quality person-centred care.

UHDB Stroke Services remain challenged by clinical workforce issues within Stroke care Services (also a national issue). Improvement plan commenced in April 2023 and relate directly to recommendations following the Royal College of Physicians review in November 2022 (report dated July 2023). This includes an increase in medical consultant capacity, improved therapies, increased specialist nursing input, and relocation of the stroke rehabilitation unit to the Florence Nightingale Community Hospital (FNCH) which will provide a therapy-led service with consultant input.

Ellern Mede (Derby): East Midlands Provider Collaborative Commissioning Hub completed a focused quality visit at Ellern Mede Derby in response to a number of concerns. Following the focused quality visit, EMPC placed Ellern Mede on Enhanced Surveillance and informed DDICB in December 2023. CQC conducted an unannounced inspection and monthly quality oversight meetings are being held to review progress of the Quality Improvement Plan with DDICB & LA representation. EMPC attended the January 2024 System Quality Group Meeting to provide oversight assurance to system partners. Ongoing monitoring will be through the MH.LD&A Quality Subgroup.

Operational Performance

Planned Care and Cancer

- The reduction in 78+ week wait stagnated, as numbers continue to tip into this category but industrial action (7 patients) and the usual December leave/holidays meant no further reduction despite outsourcing to the private sector. Elective care beds have been ringfenced and a theatre capacity recovery plan is in development.
- Cancer 62+ day waits have reduced, although PET scan access remains an issue and South Yorkshire changes pose a threat. Improvement actions include increased nurse triage,

endoscopy insourcing, cross-site working and revised approaches to managing PTLs, MDTs and internal escalations. Industrial Action resulted in 16x 62day delays and 121x 1st outpatients.
- Diagnostic performance is improving, with CDC programme timescales on track. Diagnostics are always sensitive to rises in demand from urgent and planned care though.

Urgent and Emergency Care
- The system hasn't met the A&E 4hr target for the first time this financial year. Likewise, bed occupancy is now higher than plan with escalation beds being used.
- Average category 2 response times remain above target but are improving.
- More inappropriate attendances/admissions have been avoided through 111 performance and successful schemes including the Urgent Care Community Response and the Home Visiting Service.

Mental Health, Learning Disabilities and Autism
- Perinatal: Capacity is in place to achieve national standard (10%) however referral and DNA rates are having impact on performance.
- Dementia diagnosis rate: Continue to exceed national standard, however against a backdrop of significant waiting times and rise in demand.
- CYP access - In period performance not on track with trajectory due to more than anticipated demand which is significantly outstripping capacity Plans to recover performance by end Q4. Due to data capture issues (CRH and national) reported performance is below actual. Data issues resolved with CRH, national issues should be resolved by end of Q4 as such we believe we will show recovered position by end Q1 24/25.
- MH Out of area placements: Off trajectory. Continued pressure in MH Acute flow. Additional crisis alternative all mobilised however due to IA continued use of OAP in place. RAP in place within DHcFT.
- LD&A Transforming Care Program: Achieving in year trajectory as at end Nov. Recovery action plan and assurance oversight remains in place to support achievement of national requirement.
- SMI Annual Health Checks – continued under performance against standard however increase in comparison to last years achievement. Expect to see improvement within Q4 as per historical trends.
- LD Annual Health checks: Action plan in place with Primary care to enable targeted support.

Primary Care
- Demand remains high, with number of appointments offered significantly exceeding pre-pandemic levels.
- Winter support package agreed and issued to practices including funding for ARI hubs and some support if practices have to divert staff from QOF to cope with urgent winter demand.
- Successfully completed phase 1 of Cloud Based Telephony programme with all practices with analogue telephone system moved to digital

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 report attached at Appendix 3, is therefore summarized in two parts:
- M8 position against plan (tables 1a-d)
- Actual workforce position/ pay-bill compared to establishment (table 2a). This aims to provide the most reasonable overview based on the current mechanisms that are in place.

In addition, given the increasing level of scrutiny on agency spend and usage the report includes a breakdown against the four main KPIs:
- Total Agency Spend
- Agency spend as a % of total staff spend

- % of Off Framework shifts
- % non price cap compliant shifts

It is recognised that the report focuses on alignment between workforce and the finance pay-bill but there is further work required to ensure a triangulated view alongside activity which will be progressed as part of the planning round for 2024/25.

2023/24 Workforce Plan Position Month 8 (NHS Foundations Trusts, including EMAS)

At M8, all organisations, except for DCHS are above plan against the total (substantive, bank and agency) workforce position by 1,256.43WTEs. Compared to M7, there was an increase in substantive positions (134.79WTEs), the majority of this increase was observed in Registered Nursing, Midwifery and Health Visiting staff (86.0 WTEs), Allied Health Professionals (27.27WTEs) and Support to Ambulance Staff (21.82 WTEs). During this same period there was a decrease in both bank (-129.65 WTEs) and agency usage (-47.68WTEs), however there wasn't a corresponding reduction in spend. This is due to the timings of timesheet receipt and subsequent invoice processing.

Whilst overall agency usage has declined compared to the previous month, the position remains above plan, with only DHcFT having an agency position below plan. A significant proportion of the agency position is due to the changes in EMAS reporting (225wte actual against a plan of 20wte). 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 is recognised as a separate component when looking at the overall agency position.

As at M8 there has been a 5.4% growth in the total workforce since M12 (1,546 WTEs). It is important to note that the M12 starting position was already above plan by 497WTEs. Appendix 3, table 1c demonstrates the point at which the system began to observe a variance to plan; notably when industrial action first commenced which was further compounded by the M12 actual out-turn position being greater than the M1 baselines.

Primary Care data is one month behind Trust reporting. At M7, the total primary care workforce was 121WTE below M6's plan. The gap was observed mainly from GPs excluding registrars (46 WTE) and Nurses (26 WTE). It is recognised that the level of detail available to provide a comprehensive view of primary care is not evident. Discussions continuing 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.

Total Workforce establishment V M8 actuals (WTEs) comparison to pay-bill (£)

As a system, work continues to improve workforce and finance pay bill alignment and in the absence of the national requirement for monthly establishment plans, local arrangements have been put in place, to monitor the workforce plan against the actual staffing levels that we have the budget for (i.e. costed WTE establishment). The M8 position is an overspend against the pay budget of £6.2m with 810wte over-establishment (total workforce).

It has been identified that there is inconsistency in the number of WTEs being recorded (contracted V worked) e.g. CRH record medics doing 14 sessions as 1.4WTEs whereas UHDB record this as 1WTE (comparatively this suggests less capacity at UHDB but on the other hand this is inflating the associated costs). This appears to be due to different interpretations of the PWR guidance (both could be argued as correct). Therefore, this is also an area is being further investigated and if any changes in approach are deemed necessary then the impact (positive and negative) needs to be fully understood before making any changes.

Whilst there were plans for bank and agency usage, temporary staffing (particularly agency) is generally more costly in comparison to substantive staff and the system is overspent in both these areas. The total overspend on temporary staffing (Bank and Agency) at M8 is £10.5 (YTD £31.2m). However, the M8 total pay pill overspend is £6.2m (YTD £27.8m). This initial high-level analysis would therefore suggest that there is an underspend on substantive staff due to the number of vacancies reported in table 2a (1,286 wte). Additional controls have been put in place in relation to agency and vacancies, which are beginning to demonstrate impacts (e.g. UHDB and DHcFT reduction in agency as a result of admin and clerical exit strategies).

It is not yet possible to make a direct correlation between the pay-bill and the actual WTEs and therefore through the joint workforce and finance improvement (JWFI) work there is an ask to breakdown all pay elements including sickness, maternity, non-contractual pay enhancements, overtime etc in order to ascertain where there may be other pay costs impacting on the pay-bill overspend.

Agency KPIs

In M8 JUCD agency cost amounted to 3.3% of total pay costs, 0.4% under the national target of 3.7%. This change in position compared to M7 is due to timing of payments.

The current agency spend is above the planned spend of £26.3m, resulting in a £12.3m overspend. However, it is only at 78% of the annual cap of £38.7m (an underspend of £8.5m).

Risks

- Further ongoing industrial action will continue to impact on the pay-bill position, particularly with regards to the ability to significantly reduce the need for temporary staffing which will incur greater costs.
- Ongoing re-banding issues (HCAs and potentially other bands) resulting in significant increases in the pay bill.

Finance

As of 30th November 2023, the JUCD year to date position is £49.2m deficit against a £11.5m planned deficit, a £37.7m overspend against the plan. The main factors driving this are industrial action, excess inflation and the change in policy for the revenue cost of capital. The unmitigated likely case year end forecast for 2023/24 is a deficit of £47.3m which reflects these pressures that were not known at the time of planning and also pressures on delivering the agreed plan, including efficiencies. The worst-case scenario of a £129.2m deficit includes additional risks related to not delivering the agreed JUCD Operational Plan, such as, pressures on capacity and activity, drugs costs, and income reduction.

The system efficiency delivery is £1.2m ahead of plan year to date, split into £18.6m behind plan on recurrent efficiencies and £19.8m over plan on non-recurrent efficiencies. Unless planned levels of recurrent efficiencies can be delivered, it will impact in future years. The efficiencies have been phased based on an increasing rate of delivery as the year progresses and at month eight, there is a total of £6.6m of schemes that are still in the opportunity phase. Therefore, it is important that the continued development of schemes is prioritised to support the delivery of the current forecast position of breakeven. As a result of the improvement of fully developed schemes to £122.5m, the assurance on delivery of the planned £136.0m of efficiencies is increasing but we do not yet have full assurance.

With only four months of the year remaining, it is becoming increasingly difficult to provide assurance that the JUCD will report the breakeven position that was set out in our plan. However, whilst discussions were still taking place nationally about the costs of industrial action and inflation, NHSE

directed the ICS should hold its year end breakeven forecast. At a recent meeting with the NHSE National team the most likely outturn was discussed and the £47.3m deficit was a figure that the National team recognised as a genuine likely position which will be reported at month nine. There was a push to improve this if at all possible and it was agreed as a System that every opportunity to improve the out-turn position will be identified and considered.

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**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
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.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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 The papers are provided for information only and therefore have no financial impact.		**Has this been signed off by a finance team member?** 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.					

Integrated Assurance and Performance Report

December 2023

Dr Chris Clayton ICB Chief Executive Officer
Prof Dean Howells, Chief Nurse Officer
Michelle Arrowsmith, Chief Strategy & Delivery Officer
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

NHS Derby and Derbyshire Integrated Care Board

Key Messages1					
#	Concern or Issue	Programme/Speciality i.e. Maternity, cancer	Organisation/Place / System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
1	Safety	Infection Prevention and Control	System-wide	NHSE HCAI Objectives for 2023/24 are predicted to exceed trajectory at both acute trust and System level.	As a Derbyshire System (data for December 2023 not complete at time of reporting): ▪ CDT performance is currently 27% over trajectory. Performance largely affected by acute trust cases, ▪ MRSA blood stream infections – 12 cases reported against a zero tolerance (equal split acute and community), ▪ Number of Gram-negative infections reported are increasing. • Recovery plans remain in place. Post infection reviews are not identifying any new learning. Themes include inconsistent compliance with IPC measures, antibiotic stewardship, and environmental cleanliness. • Assurances obtained relating to the implementation Trust focused recovery action plans are obtained at each Trust's internal IPC Committees, and IPC System Assurance Group. • CRH and UHDB remain on enhanced monitoring and support as per the NHSE Midlands IPC escalation matrix. • A two-day NHSE (Midlands) led visit took place at UHDB on 04 and 05 December 2023. (Similar support to CRH has already been completed). Improvements observed since in both practice and governance with good engagement from staff at all levels. • Acute trusts are seeing increases in outbreaks associated with winter e.g., norovirus and respiratory illness. Risk-based management of outbreaks is in place to expedite recovery whilst minimising disruption to flow.
2	Waiting Times	Cancer	UHDB	Increasing number of two week wait (2ww) referrals is impacting on wait time for various tumour sites, potentially affecting outcomes. Further impact caused by the increasing influence of COVID on staff availability, elective capacity and patients needing to cancel at short notice due to having COVID themselves.	• UHDB are at level 1 monitoring for cancer waits. This is recorded on the Trust's extreme risk register, with controls in place to mitigate. Internal governance processes in place which includes oversight of harm review processes and outcomes. • ICB quality monitoring and oversight takes place via monthly Clinical Quality Review Group meetings, and ICB attendance at the Derbyshire ICS Cancer Transformation Board. • Wider oversight of harm is now governed through both System Quality Group, and System Quality and Performance Committee.

Quality of Care, Access and Outcomes – position against plans, key risks and mitigations: Quality and Safety – Key Issues

Derby and Derbyshire Integrated Care Board

#	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
					Key Messages 2
3	Safety	**Maternity**	**UHDB**	High Perinatal Mortality Quality and Safety of Maternity services National Report Compliance Maternal Morbidity	• The stillbirth rate in November 2023 remained above the MBRRACE rate of 3.6/1000 (2023). Reported neonatal death rate for November 2023 continues to demonstrate a decrease. • The extended perinatal mortality thematic review has been completed and the final report is expected in February 2024. • Following the CQC rating of inadequate in November 2023 monthly reporting on the section 31 and 29a regulations and tier 3 oversight by the ICB continues. The Trust has developed a collaborative partnership with all 5 HIE's to help develop a supportive action plan. This collaborative group meet biweekly and are attended by representatives from the HEI's and the Trust. • Following a positive review, Nottingham University will continue to offer placements at UHDB for the students undertaking a midwifery degree. The NMC will be undertaking a review with UHDB in February/March 2024. NHS Midlands and the NHS England maternity improvement advisors are supporting UHDB to meet the requirements of the maternity improvement programme. • The Ockenden insight visit, and review has been deferred until March 2024 on the request of UHDB due to the current weekly CQC assurance, CNST submission, NMC practice learning inspections in December and February and the need to progress the maternity improvement plan. • Rate of third- and fourth-degree tears has consistently decreased since June 2023 but remains above the national average but is not an outlier and remains consistent. Education for medical staff was increased when the peak occurred in June 2023. • The rate of postpartum haemorrhage has remained above the national average of 31/1000. The maternity improvement plan in place includes several quality improvements for management of obstetric haemorrhage however this remains an area of concern.
			CRH	Rising Perinatal Mortality rates Maternal Morbidity Compliance with National Reports	• The stillbirth rate increased November 2023 to the highest rate reported in the last 3 years. The neonatal death rate rose to 0.36/1000 live births. Both rates are below the MBRRACE (2023) national averages. Due to the rising rates, they will be monitored for themes. • The rate of third- and fourth-degree tears has remained consistently above the national average of 24/1000 and has on occasion been an outlier. Postpartum haemorrhage (PPH) rates are now stabilising and the rate in November 2023 was below the national average of 31/1000. Both third- and fourth-degree tears and PPH are monitored through the perinatal quality and safety group with deep dives requested in response to any arising concerns. • In December, the LMNS conducted an insight visit and review of Ockenden compliance and this had improved to 78%.

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 3

#	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
4	Safety	Stroke	UHDB	Trusts remain challenged by clinical workforce issues within Stroke care Services (also a national issue).	• The Trust have provided assurance that improvement plans, commenced in April 2023, are in place and relate directly to recommendations following the Royal College of Physicians review in November 2022 (report dated July 2023). This includes an increase in medical consultant capacity, improved therapies, increased specialist nursing input, and relocation of the stroke rehabilitation unit to the Florence Nightingale Community Hospital (FNCH) which will provide a therapy-led service with consultant input. • 64% have been completed. Relocation to FNCH will take place early January 2024 and newly appointed specialist nursing staff will commence end of January 2024. • Recruitment of medical staff is ongoing. Quality will be monitored via monthly Clinical Quality Review Group meetings. Stroke is one of the eight priority areas for the Trusts clinical strategy discussions.
5	Safety	East Midlands Provider Collaborative CYP CAMHs Unit	Ellern Mede (Derby)	In August 2023, representatives from the EMPC Commissioning Hub completed a focused quality visit at Ellern Mede Derby in response to concerns from both the Host and Placing Case Managers, patient safety incidents and CQC whistleblowing. Following the focused quality visit, EMPC placed Ellern Mede on Enhanced Surveillance and informed DDICB in December 2023.	• CQC conducted an unannounced inspection which identified several actions required. • Monthly quality oversight meetings are being held to review Ellern Mede's progress of their Quality Improvement Plan with DDICB & LA representation. • No new admissions at present. • EMPC attended the January 2024 System Quality Group Meeting to provide oversight assurance to system partners. Ongoing monitoring will be through the MH.LD&A Quality Subgroup.
6	Safety	Out of Hours	North Derbyshire out-of-hours services	CQC carried out an announced comprehensive inspection at Ashgate Manor (DHU) between 15-17 October 2023. Inspection conducted due to the length of time since previous inspection, in line with the Care Quality Commission's inspection priorities.	Report published 25/12/2023 which rated the service as Outstanding. Inspectors found that: • The provider had clear systems to manage risk. • The leadership, governance and culture within the service drove improvements to deliver high-quality person-centred care. • The provider routinely and proactively reviewed the effectiveness and appropriateness of the care it provided • Leaders strove to deliver and motivate staff to succeed. • Feedback from people who used the service, those who were close to them, and stakeholders, was continually positive about the way staff treated people.
7	Safety	Primary Care	Old Station Surgery	Previous comprehensive inspection 2015, practice was rated good overall. Reinspected November 2023, overall, the practice is rated as Requires Improvement with one breach of regulations. The provider must establish effective systems and processes to ensure good governance in accordance with the fundamental standard of care.	• The Primary care quality team are in contact with the practice and will gain assurance through review of practice action plan in response to areas highlighted.

Quality of Care, Access and Outcomes – position against plans, key risks and mitigations: Quality and Safety – Key Issues

Derby and Derbyshire Integrated Care Board

<table>
<tr><th colspan="6">Key Messages 4</th></tr>
<tr><th>#</th><th>Concern or Issue</th><th>Programme/Specialty i.e. Maternity, cancer</th><th>Organisation/Place/ System Wide</th><th>Concern/Issue identified, Description/Impact</th><th>Proposed mitigation/Action being taken/Key Learning Points</th></tr>
<tr><td>8</td><td>Safety</td><td>Primary Care</td><td>Brailsford and Hulland MP</td><td>CQC previously inspected Brailsford & Hulland Medical Practice in June 2021 Following this they were given an overall rating of Inadequate.

In November 2021 CQC carried out an announced inspection. Following this they were given an overall rating of Requires Improvement.

The practice was due a CQC inspection during October 2023.</td><td>• South Dales Health partnership has now stepped down from running the Brailsford and Hulland Medical Practice and Henmore Health, the Surgery are the new incoming partnership.
• Primary Care Quality Team in contact with incoming provider and meeting arranged to discuss CQC preparedness and Quality and safety of services post partnership change.
• CQC have been fully informed throughout the process.</td></tr>
<tr><td>9</td><td>Individualisation</td><td>PHB</td><td>JUCD</td><td>The Operational Planning Guidance required ICBs to submit trajectories via their ICS for the number of Personal Health Budgets to be in place by the end of 2023/24.</td><td>The new ICB CNO has now met with the regional NHSE Personalised Care Leads to outline the current position and challenges at system level since central funding ceased.
DDICB submitted PHB Trajectories on behalf of the ICS with performance monitored against them. As of the end of Q2 2023/24:
• 771 Children & Young People with a PHB
• 2096 Adults with a PHB
• 124 PHBs via Direct Payment
• 5 via Third Party
• 2738 via Notional Budget
<table>
<tr><th></th><th colspan="5">Trajectories</th></tr>
<tr><td>Year</td><td>19/20</td><td>20/21</td><td>21/22</td><td>22/23</td><td>23/24</td></tr>
<tr><td>PHB Target</td><td>1, 080</td><td>1.620</td><td>2,160</td><td>2,700</td><td>3,240</td></tr>
<tr><td>PHB Actual</td><td>.</td><td>.</td><td>1,877</td><td>2,687</td><td>2,967 (at Q2)</td></tr>
</table>
• PHBs default for all CHC home care packages and C&YP with Continuing Care needs.
• Personal Wheelchair budgets are also default.
• Pre the Covid-19 pandemic Derby & Derbyshire CCG (now ICB) also offered non-CHC personal health budgets for individuals with long term conditions, learning disabilities and mental health issues and complex needs. This offer was put on hold during the pandemic with a full review of all PHBs agreed through this route then undertaken. Although a refreshed local offer has not yet been agreed ad hoc exceptional circumstances PHBs and PHBs to support hospital discharge have been approved through the ICB.
• An opportunities and options for expansion PHB deep dive paper is due to be presented to the JUCD Quality & Performance Committee.</td></tr>
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Quality of Care, Access and Outcomes – position against plans, key risks and mitigations: Quality and Safety – Key Issues

Derby and Derbyshire Integrated Care Board

LEARNING AND SHARING - best practices, outcomes

Publication of CQC Inspection of DHU Out of Hours (North Derbyshire) on the 25th December which rated the service as 'Outstanding'.
UHDB have now strengthened their governance for harm review processes for all patients experiencing long waits for treatment. This is following a review of their policy and acknowledging that one process does not meet the requirements for all types of long waiting patients, enabling Divisions to localise the policy where required. This provides additional assurance for patient safety for the population of Derbyshire.

Performance

Michelle Arrowsmith, Chief Strategy & Delivery Officer
Dr Deji Okubadejo, Non-Executive Member

Operational Plan Summary

NHS
Derby and Derbyshire
Integrated Care Board

Planned Care and Cancer

- The reduction in 78+ week wait stagnated, as numbers continue to tip into this category but industrial action (7 patients) and the usual December leave/holidays meant no further reduction despite outsourcing to the private sector. Elective care beds have been ringfenced and a theatre capacity recovery plan is in development.
- Cancer 62+ day waits have reduced, although PET scan access remains an issue and South Yorkshire changes pose a threat. Improvement actions include increased nurse triage, endoscopy insourcing, cross-site working and revised approaches to managing PTLs, MDTs and internal escalations. Industrial Action resulted in 16x 62day delays and 121x 1st outpatients.
- Diagnostic performance is improving, with CDC programme timescales on track. Diagnostics are always sensitive to rises in demand from urgent and planned care though.

Urgent and Emergency Care

- The system hasn't met the A&E 4hr target for the first time this financial year. Likewise, bed occupancy is now higher than plan with escalation beds being used.
- Average category 2 response times remain above target but are improving.
- More inappropriate attendances/admissions have been avoided through 111 performance and successful schemes including the Urgent Care Community Response and the Home Visiting Service

Mental Health, Learning Disabilities and Autism

- Perinatal: Capacity is in place to achieve national standard (10%) however referral and DNA rates are having impact on performance.
- Dementia diagnosis rate: Continue to exceed national standard, however against a backdrop of significant waiting times and rise in demand.
- CYP access - In period performance not on track with trajectory due to more than anticipated demand which is significantly outstripping capacity. Plans to recover performance by end Q4. Due to data capture issues (CRH and national) reported performance is below actual. Data issues resolved with CRH, national issues should be resolved by end of Q4 as such we believe we will show recovered position by end Q1 24/25.
- MH Out of area placements: Off trajectory. Continued pressure in MH Acute flow. Additional crisis alternative all mobilised however due to IA continued use of OAP in place. RAP in place within DHcFT.
- LD&A Transforming Care Program: Achieving in year trajectory as at end Nov. Recovery action plan and assurance oversight remains in place to support achievement of national requirement.
- SMI Annual Health Checks – continued under performance against standard however increase in comparison to last years achievement. Expect to see improvement within Q4 as per historical trends.
- LD Annual Health checks: Action plan in place with Primary care to enable targeted support.

Primary Care

- Demand remains high, with number of appointments offered significantly exceeding pre-pandemic levels.
- Winter support package agreed and issued to practices including funding for ARI hubs and some support if practices have to divert staff from QOF to cope with urgent winter demand.
- Successfully completed phase 1 of Cloud Based Telephony programme with all practices with analogue telephone system moved to digital

Provider Specific Issue of Note

- **UHDB:** UHDB remain in NHSE Tier 1 for elective and cancer recovery.

Operational Plan Summary

Planned Care and Cancer – October Performance

- **The number of people waiting 65 weeks or longer on an incomplete RTT pathway:** 1,741 more patients were waiting 65 weeks or longer than planned during October at an ICB level (UHDB: 2,391 actuals vs. 925 plan; CRH: 317 actual vs. 257 plan)
- **The number of people on a community service waiting list:** A total of 24,573 people were waiting for treatment at the end of October 2023, an improvement of 5.3% since August.
- **Cancer waits longer than 62 days:** At the end of November the average wait at CRH was largely in line with the forecast for the period (47 vs 50), while at UHDB 466 were waiting longer than 62 days against a planned forecast of of 352.
- **75% of cancers diagnosed within 28 days of referral:** During October CRH met the target of diagnosing 75% of cancers within 28 days of referral while UHDB is currently achieved 65%.
- **Diagnostics:** Based on the 7 tests measure CRH is at 87% and UHDB are at 80%.
  (7 tests include: MRI / CT / Non-Obstetric Ultrasound / Echocardiography / Colonoscopy / Flexi Sigmoidoscopy / Gastroscopy)

Urgent and Emergency Care – November Performance

- **4 hr A&E:** For Nov CRH achieved a performance of 59.9% on average (against an operational plan trajectory of 67.0%) while UHDB achieved 67.6% (in line with an operational plan trajectory of 67.0%).
- **Urgent Community Response:** The Urgent Community Response Service continues to meet and exceed the operational plan trajectory (>80% vs 70%) .
- **General and Acute Bed Occupancy:** Bed Occupancy for November is above the national 92% target for both providers. CRH is at 96.2% and UHDB at 96.1%.
- **Category 2 999 response times:** The November performance has improved but remains above plan. The national standard is 30 mins Derbyshire has an average of 41 minutes.

Mental Health, Learning Disabilities and Autism

- **IAPT, perinatal, adult SMI contacts**: Achieving and exceeding the planned trajectory for al l 3 metrics for the reported quarter.
- **Dementia diagnosis rate:** Exceeding national target and planned performance as at end of September
- **CYP access -** national and local data capture issues resulting in position reporting as under requirements (NHSE aware). 12 month rolling total so will recover position by 24/25
- **MH Out of area placements:** Off trajectory. Av Los higher than national requirement resulting in high occupancy levels and increase use of AMH out of areas beds. Increase demand for PICU services above contracted capacity.
- **LD&A Transforming Care Program:** Achieving in year trajectory as at end Nov. Recovery action plan and assurance oversight remains in place to support achievement of national requirement.
- **LD Annual Health checks:** Broadly in line with planned trajectory for Q2 (24.38% vs 24.45%). Action plan in place with Primary care to enable targeted support.

Primary Care

- Demand remains high and is currently outstripping capacity (684,853 appointments (increase 17% from 2019 and 4811 home visits from the Aging Well Support Programme).
- No additional winter related funding identified yet though we have developed a contingent plan should funding become available.

Maternity

- N/A

Provider Specific Issue of Note

- **UHDB:** UHDB remain in NHSE Tier 1 for elective and cancer recovery. Key actions/updates for this are included below.
- **CRH:** N/A

Planning Compliance with Operational Plan

Derby and Derbyshire
Integrated Care Board

Area	Objective	Level	Operational Plan / Local Target	Full Year OP Target Profile	M07/Q2 OP Target Profile	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Comment
Primary Care	Increase General Practice appointment activity		Operational Plan	6,707,340	700,409	471,753	538,841	568,802	536,175	549,860	635,504	684,853		
	Increase referrals into Community Pharmacy Consultation Services (Quarterly Target)		Operational Plan	39,197	9,373	*2,568*	*2,494*	*2,309*	*2,304*	*1,981*	*1,888*			
	Recover dental activity to pre-pandemic levels (Quarterly Target)		Operational Plan	1,531,764	382,941	*854,394*								This is YTD dental activity at 04/12/23. this represents 47.5% 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		64.5%	66.3%	66.4%	67.1%	67.7%	68.0%	68%	68%		
	Provide access for 28,294 people to receive IAPT in 23/24 (Quarterly Target)	ICB	Operational Plan	28,294	7008	2,265	4,700	7,205	2,370	4,895	7,355	2720		Rolling total each quarter
	Increase the number of women accessing specialist perinatal services in 2023/24 (Quarterly Target).	ICB	Operational Plan	2,757	546	260	365	465	535	595	660	740		
	Increase the number of children and young people accessing a mental health service (Quarterly Target).	ICB	Operational Plan	52,481	12,600	10,630	10,720	11,205	11,545	11,660	11,750	11870		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	10,972	11,730	11,685	11,690	11,635	11,530	11,520	11,590		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%	24.5%	2.7%	6.7%	11.5%	15.7%	20.6%	24.38%	29%		Qtr 2 target missed by 0.07% - 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	46	45	49	48	42	47	43	39		Revised targets have been agreed with the Regional Team. The revised target for October is:
	Reduce the number of children who are autistic, have a learning disability or both who are in inpatient beds	ICB	Operational Plan	3	5	6	7	4	3	2	2	5		Adults - 41 C&YP - 3
	Reduce out of area placements - Bed Days	DHCFT	Operational Plan	736	1,196	555	1,200	2,065	785	1,675	2,675			Rolling total each quarter

*Figures in italics are **provisional** - Unavailable data is marked as n/a*
** Provisional data is unpublished by NHSE*

Key to RAG Ratings
On Plan
Close to Plan
Off Plan

Planning Compliance with Operational Plan

NHS Derby and Derbyshire Integrated Care Board

Area	Objective	Level	Operational Plan / Local Target	Full Year OP Target Profile	M07/Q2 OP Target Profile	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	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		80%	77.0%	77.8%	78.2%	79%	78%	77%	80%		
		UHDB	Operational Plan		71%	66.9%	70.0%	71.6%	72%	70%	67%	65%		
	Reduce the number of people waiting longer than 62 days for their first definitive treatment for cancer.	CRH	Operational Plan	43	51	47	48	47	47	53	54	49	47	
		UHDB	Operational Plan	268	387	473	453	310	366	416	516	458	466	
Planned Acute Care	No person waiting longer than 65 weeks on an RTT pathway at the end March 2024.	CRH	Operational Plan	0	257	314	313	314	312	342	291	317		
		UHDB	Operational Plan	0	925	1,704	1,924	1,985	2,073	2,572	2,588	2391		
		DDICB	Operational Plan		919	1,813	1,988	2,059	2,143	2,776	2,803	2,660		
	No person waiting longer than 78 weeks on an RTT pathway.	CRH	Not OP targets	0	0	16	14	6	12	14	13	7		
		UHDB	Not OP targets	0	0	144	130	99	112	200	241	299		
		DDICB	Not OP targets	0	0	195	193	129	148	201	230	263		
	No person waiting longer than 104 weeks on an RTT pathway.	CRH	Not OP targets	0	0	0	0	0	0	0	0	0		1 Patient in Sept is at Practice Plus - Barlborough
		UHDB	Not OP targets	0	0	0	0	1	0	0	0	0		
		DDICB	Not OP targets	0	0	3	6	0	2	0	1	1		
	At least 85% of people receive a diagnostic test within 6 weeks by March 2024.	CRH	Operational Plan	85%	78%	82.9%	82.5%	85.1%	84.0%	83.3%	84%	87%		Percentage compliance is based on seven diagnostic tests (MRI / CT / Non Obs Ultrasound / Echocardiography / Colonoscopy / Flexi Sigmoidoscopy / Gastroscopy
		UHDB	Operational Plan	85%	75%	68.1%	70.0%	71.6%	71.1%	70.9%	75%	80%		
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%	65%	67.9%	64.8%	68.8%	70.9%	65.7%	69.1%	63.8%	59.9%	
		UHDB	Operational Plan	76%	64%	66.7%	68.4%	67.7%	71.8%	69.4%	69.4%	67.9%	67.6%	
	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	00:39:33	00:42:31	00:49:27	00:42:48	From December the target has been amended to 39 mins (original target 30 mins) in line with revised trajectory.
		EMAS	Operational Plan	30 Mins	30 mins	00:33:32	00:34:23	00:39:34	00:36:16	00:36:49	00:42:33	00:52:44	00:41:02	
	Both Acute Trusts to operate at an average general and acute occupancy rate of 92%.	CRH	Operational Plan	88.97%	88.6%	94.2%	94.5%	94.0%	92.4%	91.8%	93.3%	94.6%	96.2%	The operational plan targets for November are 84% CRH and 90% UHDB. Both Trusts are above the operation plan target and the national 92% target.
		UHDB	Operational Plan	92.89%	92.5%	89.8%	93.3%	94.0%	92.2%	91.7%	92.5%	94.0%	96.1%	
	At least 70% of referrals into the Urgent Community Response Service to be responded to within 2 hours.	ICB	Operational Plan		70%	67%	90%	89%	91%	91%	*88%*			The DCHS value for Nov is not showing in the national data. The local data is showing 80% achievement for Nov
	Increase virtual ward capacity.	ICB	Operational Plan	255	215	120	120	120	136	152	157	157	157	Month end snapshot
	Increase virtual ward utilisation.	ICB	Local Target	80%	75%	33.0%	26.0%	60.0%	22.0%	38%	48%	41%	52%	

Planning Compliance with Operational Plan

Derby and Derbyshire
Integrated Care Board

Area	Activity Metric	Level	Operational Plan / Local Target	Full Year OP Target Profile	M07/Q2 OP Target Profile	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Comment
Community Data	D2A - The number of people discharged by location and discharge pathway per month	ICB	OP Activity Measure		7,133	7,585	8,360	8,378	8,654	8,525	8,096	8,138	8,324	
	D2A - Pathway 0 - Non-complex discharge		OP Activity Measure		6,383	6,989	7,676	7,652	7,943	7,834	7,422	7,464	7614	
	D2A - Pathway 1 - Home with Support		OP Activity Measure		472	300	381	384	380	382	376	394	380	
	D2A - Pathway 2 - Intermediate Care		OP Activity Measure		212	236	256	276	259	250	243	232	268	
	D2A - Pathway 3 - 24-hour care placement		OP Activity Measure		66	60	47	66	72	59	55	48	62	
	Community Waiting List - Quarterly Target	ICB	OP Activity Measure	24,026		24,352	23,483	24,186	21,865	25,971	24,703	24,573		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	3081	3,770	3,242	2,724		Full year target is the Mar 23 waiting list position Red / Green highlights indicate monthly position in comparison to previous month
	Community Waiting List by weeks - 1-2 weeks			2,372		2,360	2,124	2,304	2046	1,961	2,003	1,923		
	Community Waiting List by weeks - 2-4 weeks			3,126		2,688	3,184	3,231	3236	3,240	2,991	3,021		
	Community Waiting List by weeks - 4-12 weeks			6,813		6,956	6,590	6,368	6417	7,672	6,787	6,667		
	Community Waiting List by weeks - 12-18 weeks			1,581		2,198	2,458	2,594	2369	2,841	2,879	3,271		
	Community Waiting List by weeks - 18-52 weeks			4,500		4,413	4,493	4,994	3781	4,860	5,118	5,429		
	Community Waiting List by weeks - over 52 weeks			978		1,124	1,291	1,478	935	1,627	1,683	1,538		
	Community Waiting List by weeks - Unknown			399		353								

CRHFT Activity Measures Operational Plan

NHS Derby and Derbyshire Integrated Care Board

CRH

Data Extracted from NHS Futures - Operational Planning Tool - Activity and Performance

Provider	Subject	Measure Name		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
CRH	Elective	Elective day case spells - E.M.10a	2023/24 Actuals	2,154	2,493	2,439	2,317	2,396	2,346	
			2023/24 Plans	2,289	2,421	2,326	2,690	2,378	2,463	2,683
		Elective ordinary spells - E.M.10b	2023/24 Actuals	255	330	343	308	357	323	
			2023/24 Plans	321	385	373	393	389	364	414
	Outpatients	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance - E.M.32g	2023/24 Actuals	6,160	7,110	7,128	6,649	6,662	6,474	
			2023/24 Plans	6,841	6,922	6,440	7,401	6,467	7,485	8,225
		Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance - E.M.32h	2023/24 Actuals	17,896	19,565	19,759	18,609	18,731	18,525	
			2023/24 Plans	18,325	19,551	18,238	20,038	17,997	19,978	21,764
	A&E	A&E - Type 1 - E.M.13a	2023/24 Actuals	5,365	5,697	6,487	7,573	7,128	7,262	7,488
			2023/24 Plans	5,673	5,762	5,700	5,925	5,720	5,661	5,787
		A&E - Other - E.M.13b	2023/24 Actuals	2,552	3,067	2,192	1,185	1,364	1,233	1,423
			2023/24 Plans	2,668	2,841	2,765	2,685	2,479	2,673	2,776
		A&E - Total - E.M.13	2023/24 Actuals	7,917	8,764	8,679	8,758	8,492	8,495	8,911
			2023/24 Plans	8,341	8,603	8,465	8,610	8,199	8,334	8,563
	Non Elective and Emergency Care	Non-elective spells with a length of stay of 1 or more days - E.M.11b	2023/24 Actuals	2,158	2,170	2,290	2,342	2,251	2,160	
			2023/24 Plans	2,131	2,187	2,143	2,111	2,101	2,076	2,097
		Non-elective spells with a length of stay of zero days - E.M.11a	2023/24 Actuals	1,369	1,602	1,615	1,602	1,511	1,557	
			2023/24 Plans	540	555	567	590	467	537	485

Provider	Subject	Measure Name		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
CRH	RTT	New RTT pathways (clock starts) - E.M.20	2023/24 Actuals	4,766	5,735	5,521	5,353	5,337	5,164	
			2023/24 Plans	3,443	3,941	3,864	4,030	4,019	3,778	3,811
		Number of 52+ week RTT waits - E.B.18	2023/24 Actuals	1,211	1,242	1,183	1,184	1,190	1,223	
			2023/24 Plans	1,698	1,665	1,605	1,547	1,488	1,421	1,353
		Number of 65+ week RTT waits - E.B.20	2023/24 Actuals	314	313	314	312	342	291	
			2023/24 Plans	467	452	417	382	347	302	257
		RTT completed admitted pathways - E.M.18	2023/24 Actuals	326	411	508	360	390	379	
			2023/24 Plans	660	789	593	659	510	524	643
		RTT completed non-admitted pathways - E.M.19	2023/24 Actuals	3,964	4,426	4,685	4,173	4,307	4,464	
			2023/24 Plans	4,673	4,802	4,468	5,036	4,333	4,629	5,337
		RTT waiting list - E.B.3a	2023/24 Actuals	25,108	25,638	25,294	26,015	26,133	26,436	
			2023/24 Plans	24,595	24,672	25,081	25,989	26,554	25,276	24,087

UHDBFT Activity Measures Operational Plan

Derby and Derbyshire
Integrated Care Board

UHDB
Data Extracted from NHS Futures - Operational Planning Tool - Activity and Performance

Provider	Subject	Measure Name	Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
UHDB	Elective	Elective day case spells - E.M.10a	2023/24 Actuals	8,443	9,212	9,338	8,697	9,319	8,889	
			2023/24 Plans	9,414	10,404	9,909	10,404	10,900	10,900	10,404
		Elective ordinary spells - E.M.10b	2023/24 Actuals	955	1,150	1,221	1,155	1,218	1,180	
			2023/24 Plans	1,089	1,204	1,146	1,204	1,261	1,261	1,204
	Outpatient	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance - E.M.32g	2023/24 Actuals	25,844	30,877	32,174	29,772	30,013	30,307	
			2023/24 Plans	30,681	33,910	32,296	33,910	35,525	35,525	33,910
		Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance - E.M.32h	2023/24 Actuals	62,923	73,183	73,399	69,924	73,697	69,913	
			2023/24 Plans	64,583	71,382	67,983	71,382	74,781	74,781	71,382
	A&E	A&E - Type 1 - E.M.13a	2023/24 Actuals	14,480	15,992	15,999	15,491	16,534	20,278	21,591
			2023/24 Plans	15,398	16,029	15,799	15,443	14,567	14,585	15,018
		A&E - Other - E.M.13b	2023/24 Actuals	12,831	14,370	14,170	14,435	12,088	9,904	10,501
			2023/24 Plans	8,612	9,377	9,181	9,341	8,584	8,398	9,118
		A&E - Total - E.M.13	2023/24 Actuals	27,311	30,362	30,169	29,926	28,622	30,182	32,092
			2023/24 Plans	24,010	25,406	24,980	24,784	23,151	22,983	24,136
	Non Elective and Emergency Care	Non-elective spells with a length of stay of 1 or more days - E.M.11b	2023/24 Actuals	4,997	5,227	5,396	5,204	5,249	5,223	
			2023/24 Plans	4,733	4,891	4,733	4,891	4,891	4,733	4,891
		Non-elective spells with a length of stay of zero days - E.M.11a	2023/24 Actuals	2,521	2,678	2,723	2,808	2,772	2,906	
			2023/24 Plans	2,805	2,898	2,805	2,898	2,898	2,805	2,898

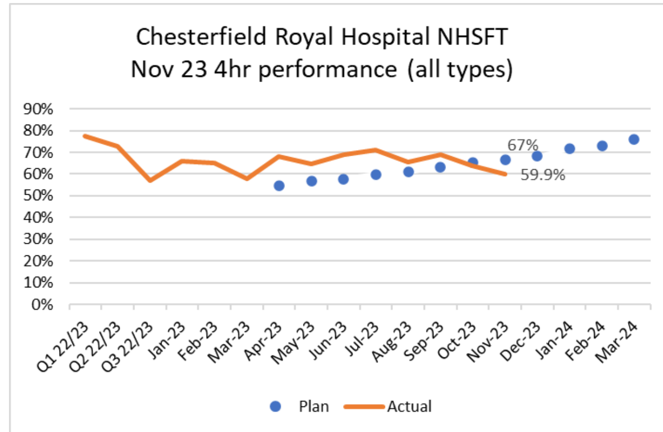
Provider	Subject	Measure Name	Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
UHDB	RTT	New RTT pathways (clock starts) - E.M.20	2023/24 Actuals	19,474	22,704	23,166	22,769	22,589	21,289	
			2023/24 Plans	18,729	21,518	20,367	20,399	21,583	22,022	21,467
		Number of 52+ week RTT waits - E.B.18	2023/24 Actuals	6,218	6,654	7,049	7,226	7,392	7,538	
			2023/24 Plans	6,698	6,469	6,273	6,063	5,882	5,744	5,554
		Number of 65+ week RTT waits - E.B.20	2023/24 Actuals	1,704	1,924	1,985	2,073	2,572	2,588	
			2023/24 Plans	2,156	1,935	1,729	1,511	1,304	1,135	925
		RTT completed admitted pathways - E.M.18	2023/24 Actuals	3,200	3,610	3,829	3,155	3,459	3,127	
			2023/24 Plans	4,522	4,857	4,756	5,405	4,591	4,696	5,025
		RTT completed non-admitted pathways - E.M.19	2023/24 Actuals	11,835	14,038	14,086	12,987	13,164	13,556	
			2023/24 Plans	13,306	14,100	13,475	14,913	13,345	13,915	15,078
		RTT waiting list - E.B.3a	2023/24 Actuals	109,698	110,032	110,690	110,973	114,652	112,816	
			2023/24 Plans	110,285	107,883	105,275	100,337	99,113	97,611	94,048

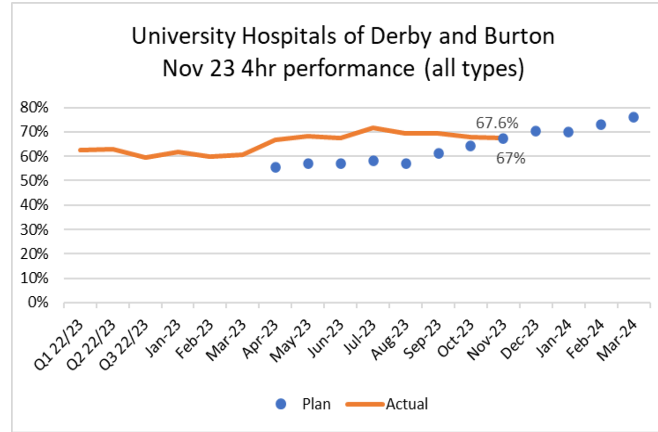
Independent Sector Activity Measures Operational Plan

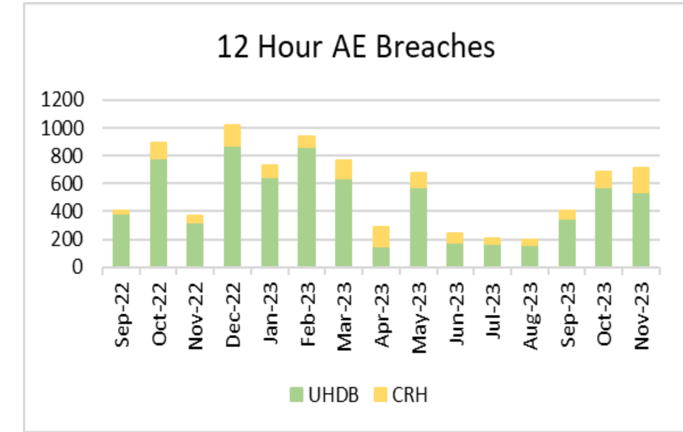
Derby and Derbyshire
Integrated Care Board

Provider	Subject	Measure Name	Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
ISP	Diagnostic Tests	Diagnostic Tests - All	2023/24 Actuals	245	225	276	289	283	207	
			2023/24 Plans	350	385	427	405	427	405	426
	Elective	Elective day case spells	2023/24 Actuals	1,050	1,145	1,282	1,317	1,110	1,132	
			2023/24 Plans	816	907	998	952	998	952	998
		Elective ordinary spells	2023/24 Actuals	178	174	175	177	200	214	
			2023/24 Plans	204	227	249	238	249	238	249
	Outpatient	Consultant-led first outpatient attendances (Spec acute)	2023/24 Actuals	1,482	1,808	1,821	1,815	1,677	1,793	
			2023/24 Plans	1,326	1,473	1,621	1,547	1,621	1,547	1,621
		Consultant-led first outpatient attendances with procedures (Spec acute)	2023/24 Actuals	201	206	221	184	197	174	
			2023/24 Plans	170	188	206	197	206	197	206
		Consultant-led follow-up outpatient attendances (Spec acute)	2023/24 Actuals	2,872	3,345	3,421	3,300	3,413	3,413	
			2023/24 Plans	2,328	2,588	2,847	2,718	2,847	2,718	2,847
		Consultant-led follow-up outpatient attendances with procedures (Spec acute)	2023/24 Actuals	375	422	370	425	451	388	
			2023/24 Plans	306	338	374	356	374	356	374

Urgent & Emergency Care







A&E 4hr target: UHDB met and exceeded the Operational Plan target achieving 67.6% against a target of 67.3%, CRH had a target of 66.7% but achieved 59.9%.

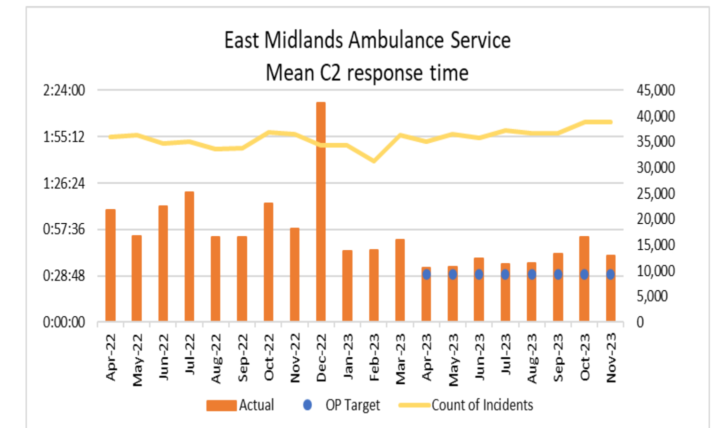
12-hour Trolley breaches in November 2023 - 173 at CRH / 538 at UHDB, a further significant increase on the October position for CRH but a reduction at UHDB

A key focus is in achieving and exceeding the 76% national target by March 2024.
Both Acute sites have Co-located type 3 services at the ED front door to support flow management & performance improvement, with a similar arrangement at Burton proposed. RDH and CRH have been visited by NHSE and advised on designation and data reporting.
Both Acute focused on ED to SDEC flow and flow directly into SDEC, specifically frailty response and referrals from GPs and Nurses. Discussions have started on SDEC flow to community services to avoid inappropriate admissions through Team Up.
Both Acute sites and ICB reviewing Type 1 performance/data tracking methods to ensure appropriate benchmarking with other systems

Ambulance C2 Response time: In November, the East Midlands Ambulance Service saw an improvement to 41 minutes for C2 response times, against an operational plan target of 30 mins. (*Target amended to 39 minutes in line with revised trajectory*)

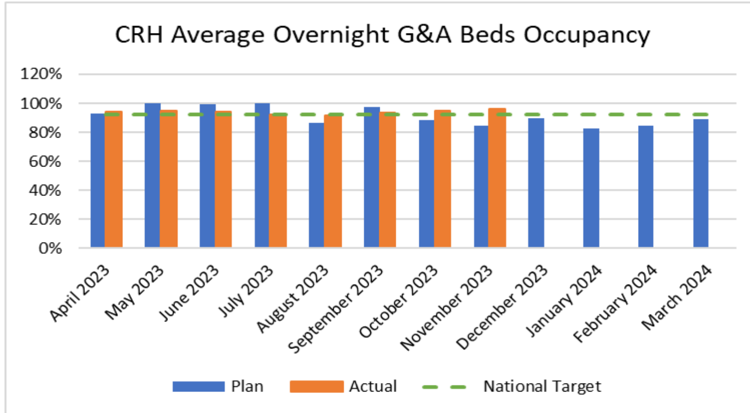
Ambulance Handover delays: RDH is showing an increase in the time lost to ambulance delays in November, CRH is showing an improvement on the October position. However, for both providers there have been fewer hours lost to delay when comparing this financial year to last – despite there being more ambulance arrivals.
UHDB are showing an increase in average handover time in May / Sept / October and November.

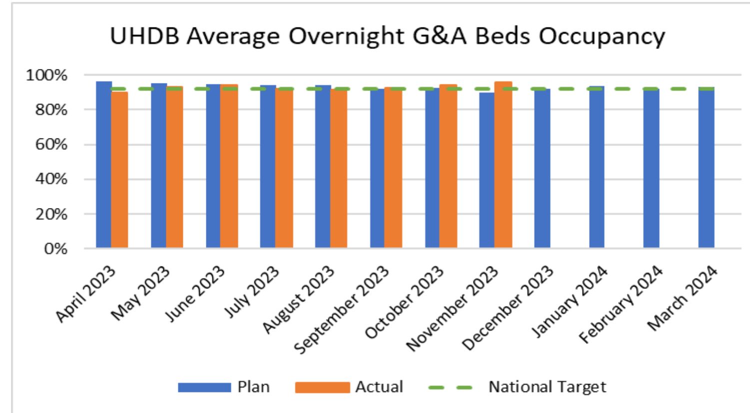
Work is ongoing to improve the ambulance response time to achieve the 30min target.
Ambulance UECC transformation team, through Local Specialist Paramedic Hubs (to be fully in place by end of November), is assisting with the introduction of a clinical navigation hub (CNH) Single Point of Access (SPoA) telephone number from 20th November. The CNH will filter out patients who don't need to attend ED diverting them to an alternative pathway including UCR, SDEC, VW, UTC, Pharmacy, Self Care reducing pressure at the front door.
Daily monitoring of handover delays, with a monthly improvement meeting with Acutes to discuss performance

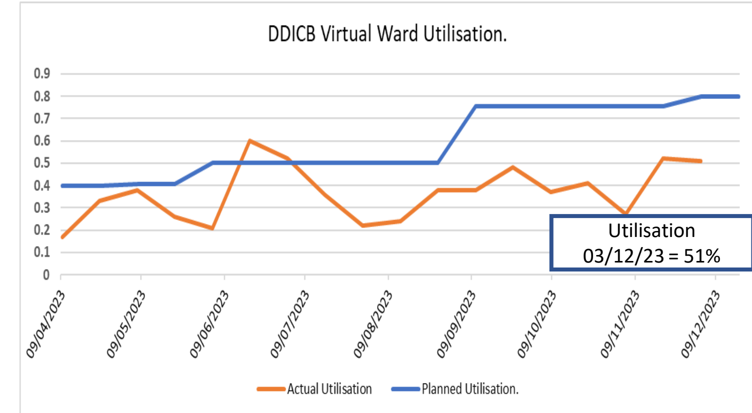


Urgent & Emergency Care

NHS Derby and Derbyshire Integrated Care Board







Bed Occupancy:
The current national target is 92%. In November CRH achieved 96.2% and UHDB achieved 96.1%.

Virtual Wards: As at the 3rd December 2023 the capacity for virtual ward stood at 157, against a target of 255. Utilisation at the 3rd December was 51%.

Key Actions
Discharge Improvement;
County Council's P1 transformation will increase to 15 new P1 starts by Feb 24
Community Response Team (CRT) will increase by 7 new starts by Dec 23
County Council's brokerage increase by 6 starts Dec
Additional staff investment to reduce delays in CRH and UHDB and focus on discharge 59

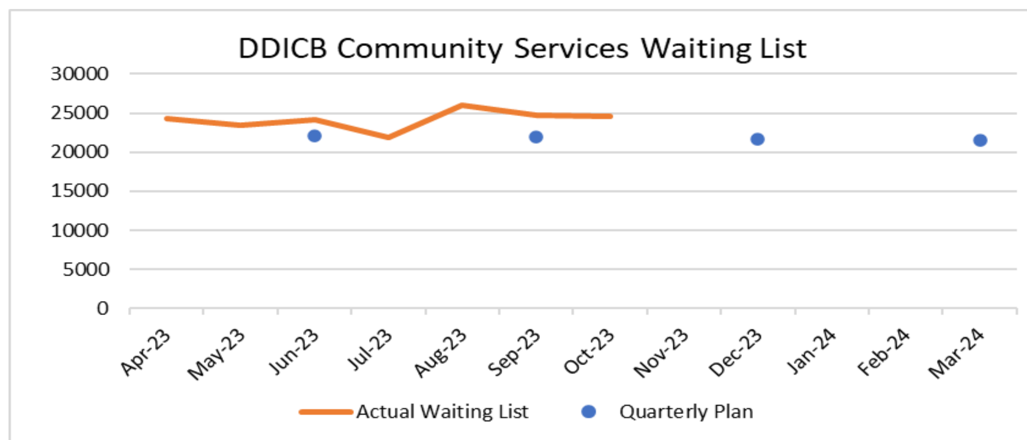
Virtual Wards;
Working with respiratory pathway providers to understand additional patient cohorts that could be admitted to the virtual ward to alleviate seasonal pressure including Royal Primary Care (step up respiratory support) Derbyshire Healthcare and acute medicine at Royal Derby Hospital.
DOCCLA working with new pathways to provide telehealth support
Clinical summit review to take place on the 14/12/2023

Mental Health Crisis Response;
Recognised as a key UEC driver – UEC colleagues MH teams to build a collaborative approach to crisis response in particular the Crisis response vehicles and 111 Press 2 for Mental Health (soft launch scheduled for December 2023).

Community Care

Derby and Derbyshire Integrated Care Board

Community Waiting Lists



Services with highest percentage waiters over 18 weeks - October 2023			
Service	Total Waiting List	Waiting list above 18 weeks	% Waiting list above 18 weeks
(CYP) Community paediatric service	2,206	1,796	81%
(A) Podiatry and podiatric surgery	6,676	3,235	48%
(CYP) Therapy interventions: Speech and language	945	301	32%
(A) Neurorehabilitation (multi-disciplinary)	596	130	22%
(A) Nursing and Therapy support for LTCs: Respiratory/COPD	431	85	20%
(A) Therapy interventions: Physiotherapy	6,138	1,122	18%

The community service waiting list at the end of October 2023 is 24,573, a slight reduction on last month. However, it it is still higher compared to when we started this financial year (24,026 as at end of March 2023) and above the Operational plan target.
In October 25% of those waiting exceed 18 weeks, the main areas are Community Paediatric and Adult Podiatry service.

Discharge Activity

D2A Hospital Discharge Pathway Activity		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
The number of people discharged by location and discharge pathway per month	Target	6,770	7,040	7,926	8,491	7,095	7,258	7,133	7,805
	Actual	7,585	8,360	8,378	8,654	8,525	8,096	8,138	8,324
Pathway 0 - Non-complex discharge	Target	6,080	6,314	7,220	7,710	6,406	6,581	6,383	7,169
	Actual	6,989	7,676	7,652	7,943	7,834	7,422	7,464	7,614
Pathway 1 - Home with Support	Target	357	432	433	494	386	424	472	364
	Actual	300	381	384	380	382	376	394	380
Pathway 2 - Intermediate Care	Target	270	243	214	217	253	202	212	225
	Actual	236	256	276	259	250	243	232	268
Pathway 3 - 24-hour care placement	Target	63	51	59	70	50	51	66	47
	Actual	60	47	66	72	59	55	48	62

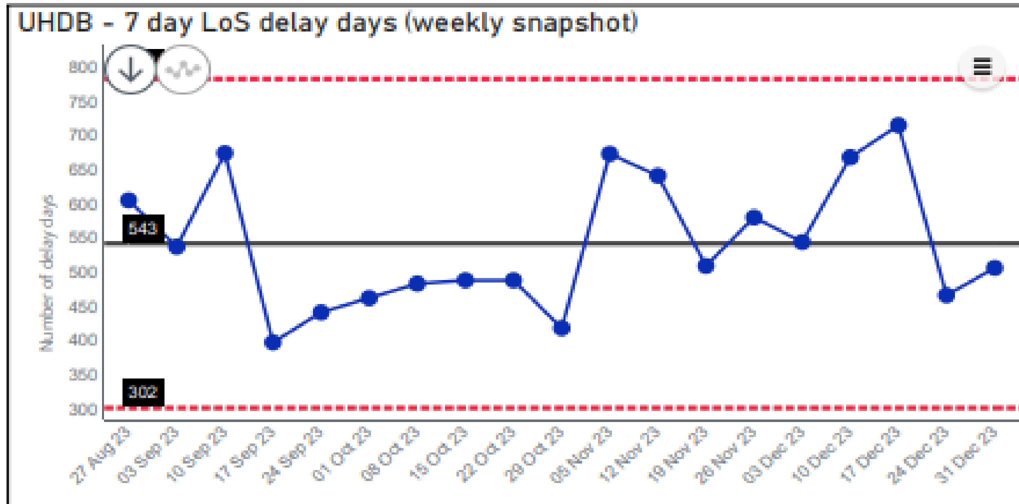
Non-complex discharge activity is consistently performing and is above plan, except for Pathway 1 & 3 discharges.

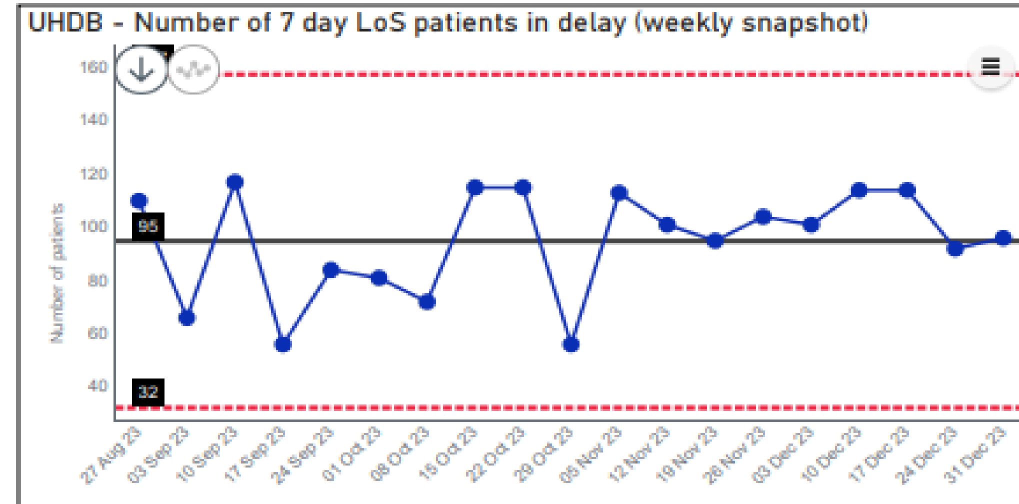
Length of Stay Weekly Snapshot – Weekly Delays Data (UHDBFT)

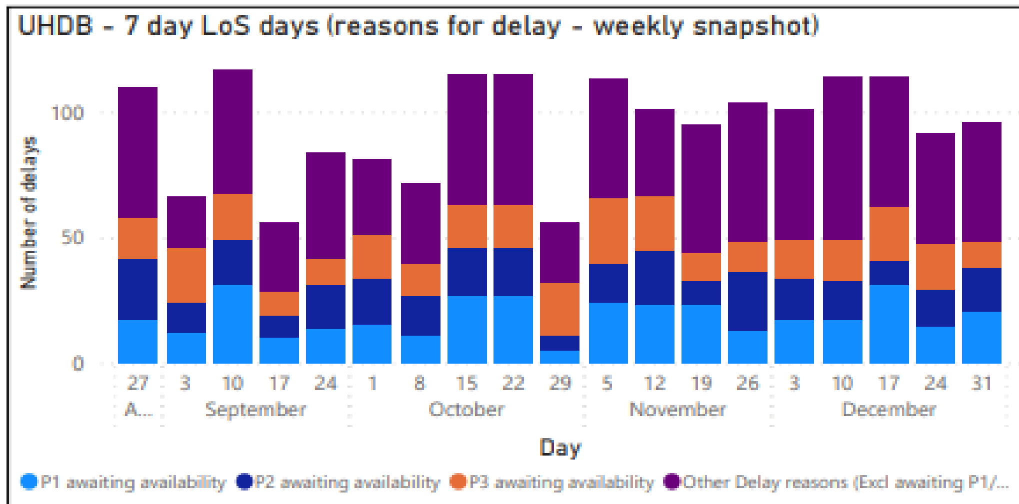
NHS Derby and Derbyshire Integrated Care Board

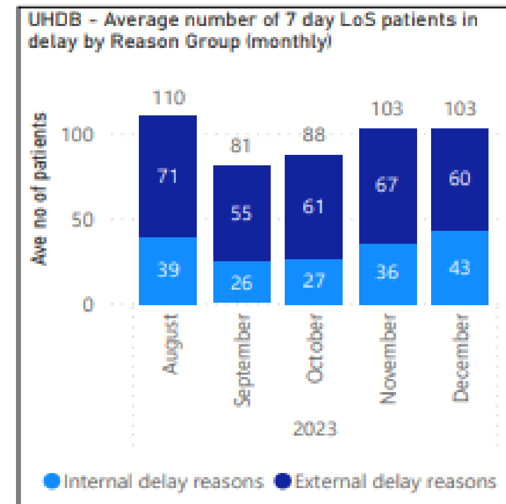
21/08/2023 31/12/2023

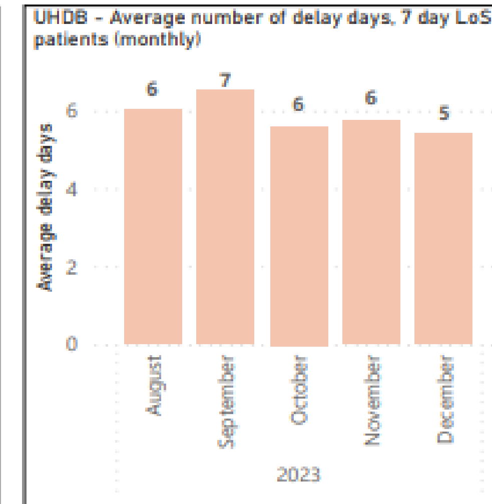
Acute delays - UHDB (7 day + LoS)







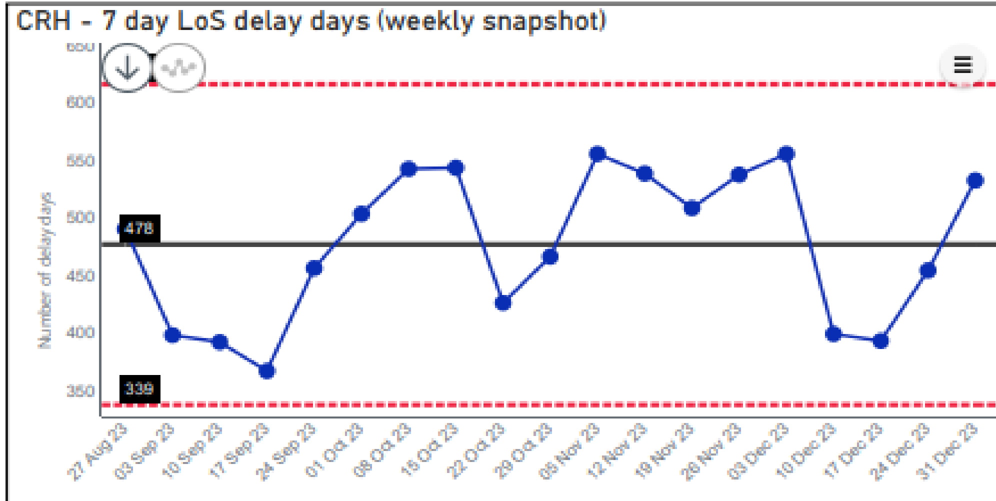


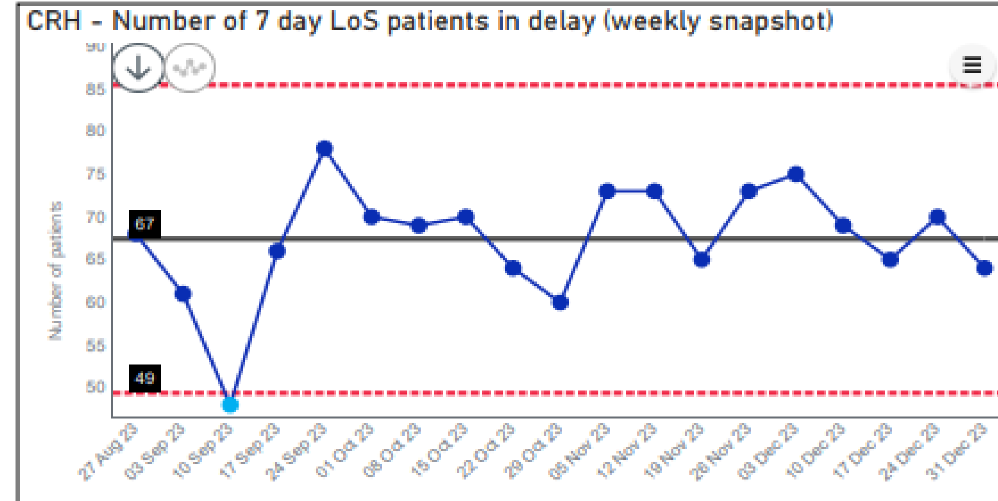


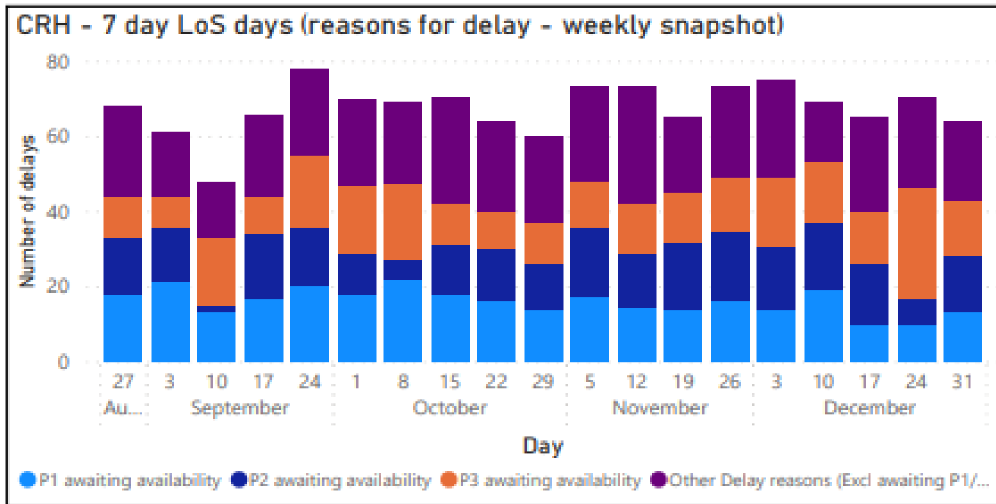
Length of Stay Weekly Snapshot – Weekly Delays Data (CRHFT)

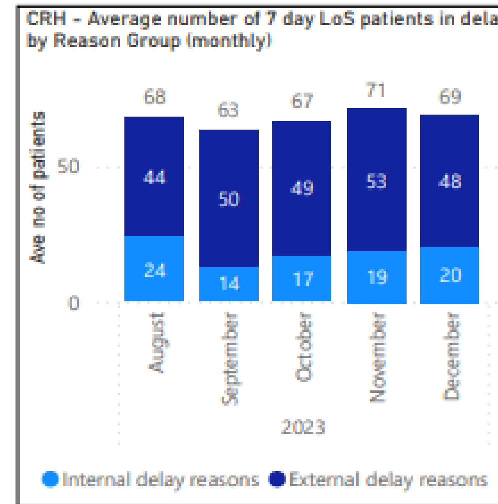
21/08/2023 31/12/2023

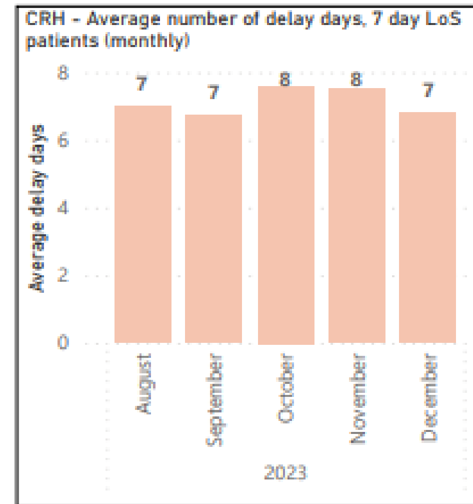
Acute delays - CRH (7 day + LoS)











Planned Care & Cancer

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Elective care waits of more than 78 weeks should be eliminated from April 2023, from August, this activity started to increase.

Objective	Level	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
No person waiting longer than 78 weeks on an RTT pathway.	CRH	16	14	6	12	14	13	7
	UHDB	144	130	99	112	200	241	299
	DDICB	195	193	129	148	201	230	263

The 65-Week performance improved between September and October.
CRH have been performing well against the operational plan, UHDB will find it challenging to achieve the target.

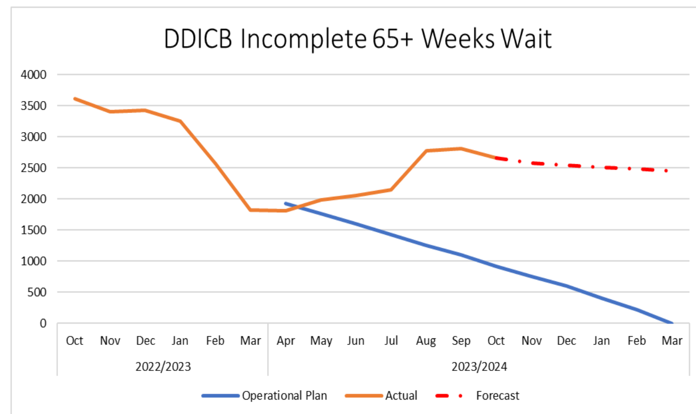
The total incomplete pathway position is also similar with CRH tracking close to the operational plan.
UHDB have submitted a revised winter plan showing a position of 94,667 by Mar 24 (a deterioration of 9,075 on the operational plan).
The current incomplete pathway performance for UHDB (October 23) is 109,606 against a revised plan of 104,019.

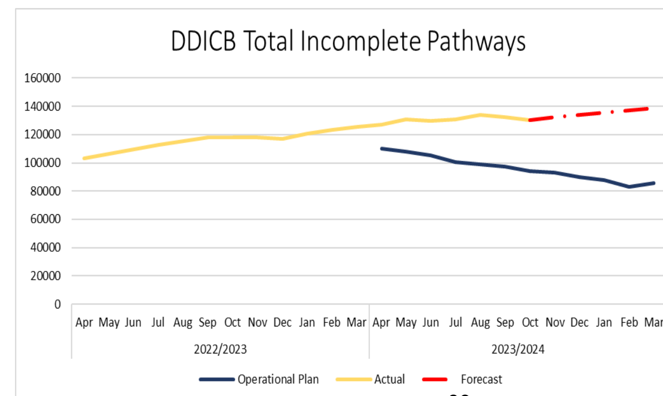
Current actions include:
UHDB

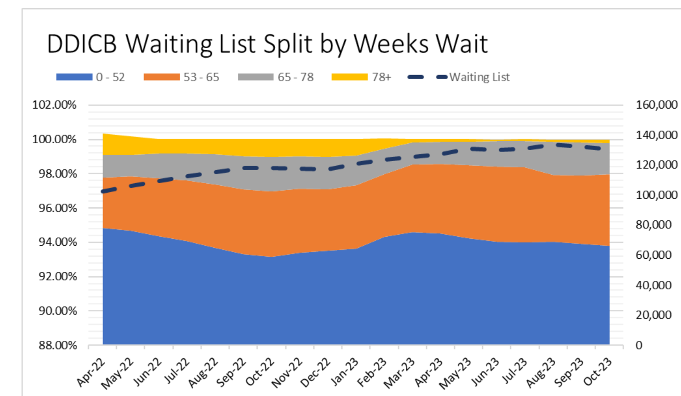
- The return of the orthopaedic ward at RDH but emergency pressures over the winter could put this transition at risk
- Outsourcing and Insourcing contracts that are in place continue with some expanded such as Echo, and new ones have been agreed and are being sought. Medacs have been brought in to support orthopaedics, an insourcing arrangement to boost endoscopy capacity commenced in September and Cardiology are in talks to secure capacity for October.
- Capacity is further being boosted through additional internal sessions where they can be agreed with UHDBs workforce
- The transfer of ASIs to IS providers continues
- Mutual Aid is being used particularly to support orthopaedics

CRH

- Further work is ongoing with theatre capacity and further opportunities for additional theatre lists for specific specialities continues to be reviewed daily.
- Beds for Elective Care will continue to be ring-fenced, however an increase in demand beyond modelled/assumed level for emergency pathways (including COVID) could potentially impact on this during the year – Currently 31 elective beds vs 46 planned.







DDICB Weeks Wait - Oct 23		
Weeks	Total	%
0 - 52	122,383	94%
53 - 65	5,447	4%
65 - 78	2,397	2%
78+	263	0%
Total	130,490	100%

* Forecast is based on underlying trend

Planned Care & Cancer

Exit Criteria

- The system has an agreed clear and credible Elective Improvement plan in place against the NOF drivers, that has been signed off by the board and agreed with NHSE. This agreed recovery plan fully addresses the root cause of the areas of concern and includes an agreed improvement trajectory, which the system can demonstrate delivery against.
- Maintain 0 104-week waiters across the ICB population
- Deliver the reduction in 78 and 65-week backlog in line with an agreed system trajectory and this is maintained
- No provider in Tier 1 or tier 2 escalation as a result of delivery of the 78-week backlog elimination.
- Deliver the improvement in value weighted activity in line with an agreed system trajectory.

Key Updates (03/12/2023)

- UHDB have appointed **an Elective turnaround lead** who is working with ICB lead to develop Elective Recovery Plan. Initial key actions around strengthening internal governance, and developing a greater understanding of demand and capacity and impact of mitigating actions.

Performance this month (03/12/2023)

	CRH	UHDB
78 Week	• Potential breaches for end of December are: • Confirmed 104-week breaches = 1 AND 78- week breaches = 8 • Under review 78-week breaches = 2 • Our ambition is to aim for zero breaches at the end of December	• December position currently holds a risk of 92-140 patients. • This forecast is concentrated in T&O and excludes the impact of IA • Mitigations include - additional Medacs capacity, Mutual Aid at Spire Nottingham & CRH and insourcing options for soft tissue work.
65 Week	• There are 154 more patients waiting than expected against the revised trajectory (1.835 vs 1,680) and a reduction of 144 when compared to the previous week 92.8% of pathways have been validated over 12 weeks and all over 26 weeks. Forecasting is suggesting we will have Zero patients left at the end of March 2024.	• +65 week cohort = 2,149. All outstanding 65-week OPA's are forecast to be booked into December with the exception of Derm, ENT, Rheum, Urology, Gynae & endocrine) that will be booked into January 2024.

Planned Care & Cancer

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New cancer standards are in place, which have dropped the Cancer 2 week wait measure and consolidated the 31day and 62day measures.

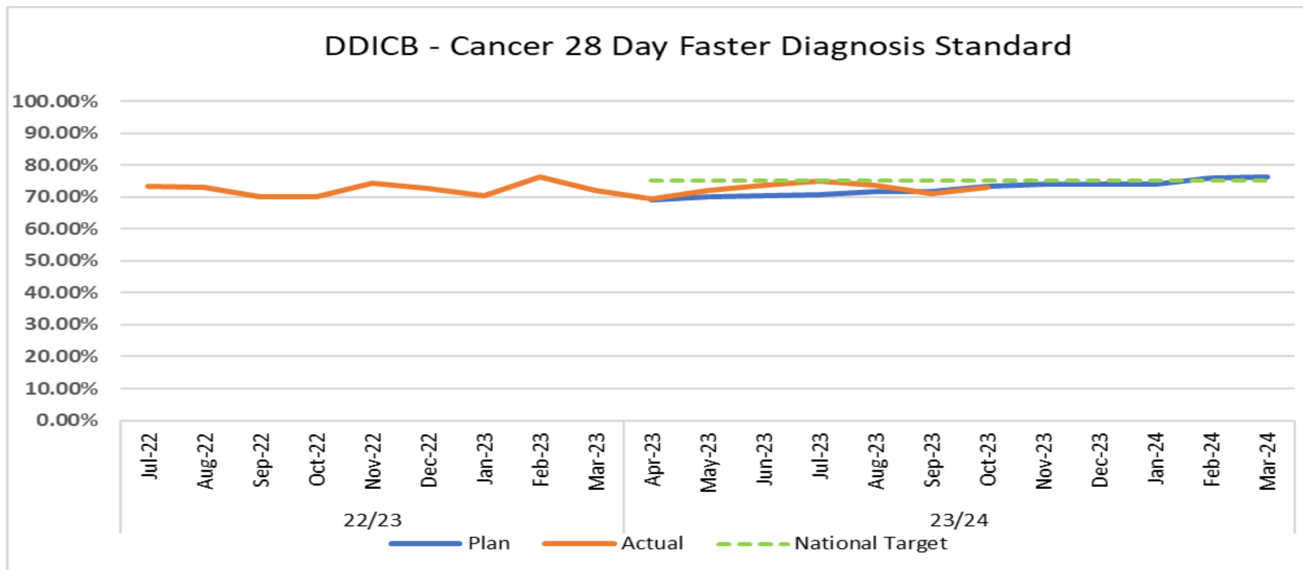
28 Day Faster Diagnosis (target 75%): CRH in October achieved 80%, above the national 75% target. UHDB achieved 65% (UHDB is projecting to achieve 75% by March 24).

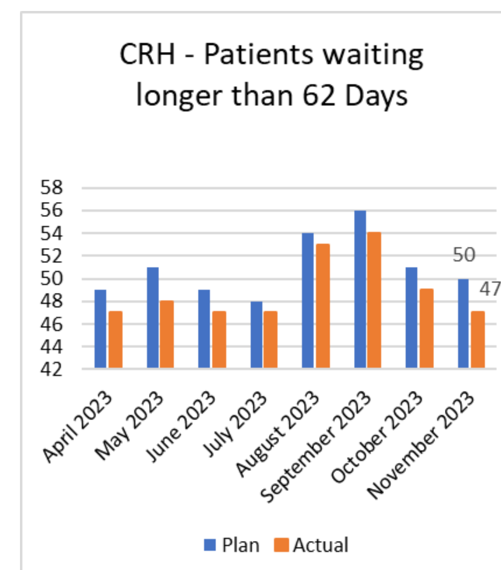
31 Day Cancer Wait: CRH performance for October was 87.9%, UHDB was 85.8%

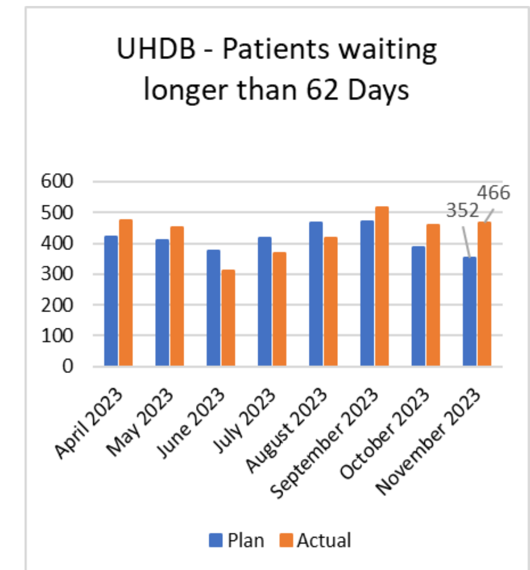
Cancer 62 Day Backlog: CRH has 47 patients against a target of 50 / UHDB has 466 patients against a target of 352 (November data).

62 Day Cancer Wait: In October CRH achieved 71% and UHDB achieved 53.2%.

Indicator		Currency	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Increase % of Lower GI suspected cancer referrals with an accompanying FIT result	ICB	Actual	74%						
		Plan	63%	63%	63%	63%	65%	65%	70%







Diagnostics

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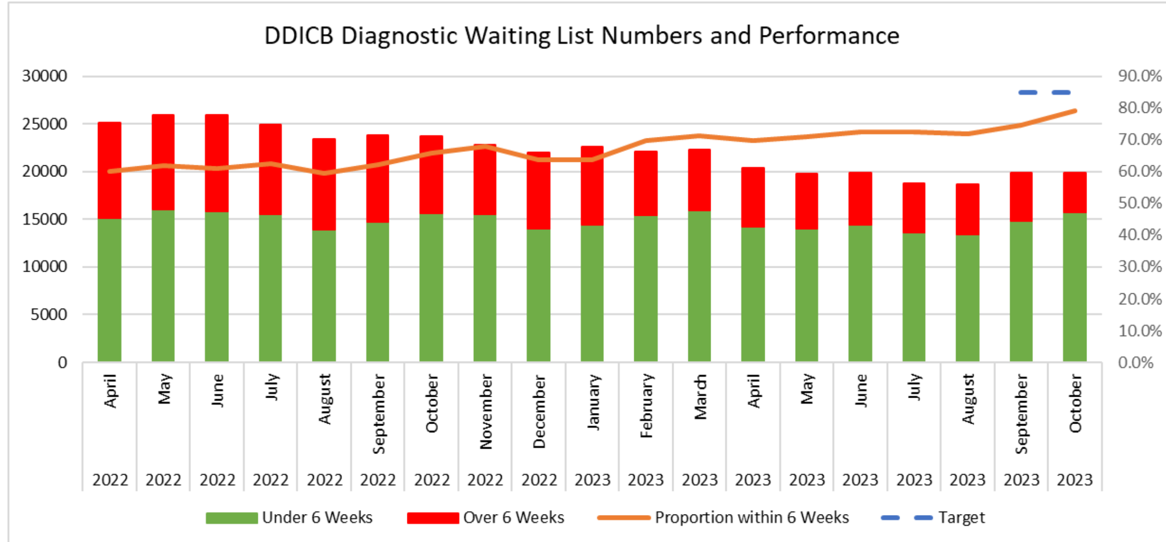

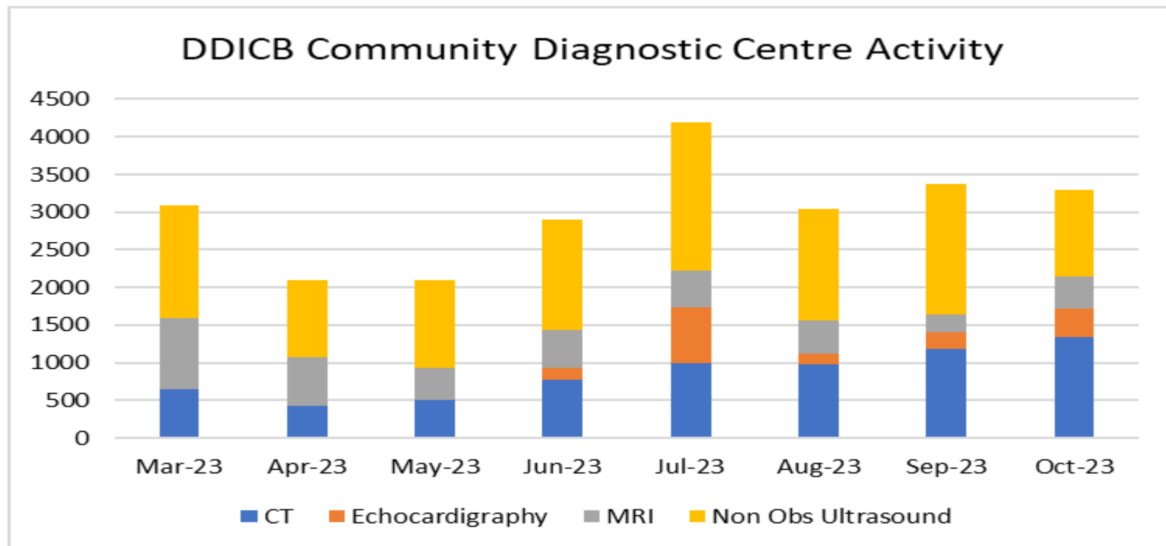

The Operational Plan target is to increase the percentage of patients that receive a diagnostic test within six weeks to 95% by March 2025. The expectation is for the ICB to be at 85% by March 2024.

Current ICB performance is at 79.25%.
Echocardiography has the highest volume of activities waiting over 6 weeks.

Community Diagnostic Centre activity is approx. 3,000 tests per month.

UHDB have agreed an extension of the insourcing contract for Echo activity as well as enhanced rates for internal staff to boost capacity.

Endoscopy insourcing commenced in the middle of September which will provide 6-7 all day sessions (12-14 lists) which will boost capacity considerably.
October numbers are showing this is having a material impact on Colonoscopy and Flexi Sigmoidoscopy activity.

Mental Health, Learning Disabilities & Autism Services

Areas of focus

Improving the performance against the aims of the Transforming Care Program (LD&A)

Reducing Inflow
- LD&ASC Support and Intervention Team (SIT) continues to support hospital avoidance. Demonstrable evidence of preventing admissions going into hospital
- Enhanced Community Support (ESC) workstream co-led with revised action plans on Local Area Emergency Protocol, Dynamic Support Register and Care and Treatment Reviews progressing well. Meetings with regional partners where shared learning has been discussed.
- Dynamic Support Register re-design well under way with soft launch/start date 1st January 2024:
  - focus on MDT function at the centre of the MDTs to be guided by set templates ensuring discussions are outcome focussed
  - C&W Tool to be replaced by a localised risk stratification matrix, placing more emphasis on joint professional judgement.
  - Digital DSR / centralised referral system to be explored further early 2024
  - DSR MDTs will align/link in with funding processes / SEAL

Improving Flow
- Lead coordinating all the AMH, out of area locked rehabs/ATU and spec com beds and plan repatriation back to Derbyshire. Including setting up community services for these individuals including contracting linking in with ICB.
- Major success in November in complex discharge from locked rehab of individual with LoS of 1818 days
- Non-clinical in reach extending scope to include mobilisation of a high intensity/high frequency service user expediting discharge from AMH
- Key working – targeted resource for 0-25 yrs 'Go live' – progressing well
- Development work on what an optimising bedded offer for LD & ASC in Derbyshire finalising workshops and learnings to take forward for testing

Expediting complex discharges / Improving outflow
- Pilot of ASD case management for 6 months support for high intensity and High ED/acute frequency patients – JD completed and out for advert
- To eliminate MFFDs due to placement availability, system work to improve provider capacity and capability. Stratification and discharge planning workshop being scheduled as soon as possible (latest w/c 6th Nov) for all ATU, Locked Rehab & Secure inpatients and community placements where a new solution may be needed. This will then feed into the new revamped Joint Solutions meeting where said plans will be reviewed to ensure continued progress & links are made to strategic commissioning as needed.
- Central provider contact & correspondence list now in place

Recovering the MH Out of Area Placements Performance and Improving MH Inpatient flow

Reducing Inflow
- Processes reviewed and refreshed to ensure all admissions reviewed by Crisis team in line with gatekeeping standards
- Crisis Cafes mobilised in Buxton, Swadlincote's and Ripley to support individuals requiring urgent support along with provision of safe haven and crisis houses in Chesterfield and Derby to provide alternatives to admission
- Processes to be further developed in community team to enable Clozaril initiation within community (avoiding hospital admissions)
- Implementation of case load management tools to increase capacity within community teams to support greater level of community capacity to undertake tertiary prevention, follow-up and reduce readmissions
- Focus on reduction of admissions for people with LD & ASD into AMH through transforming care program (see above)

Improving Flow / Outflow
- Processes reviewed and refreshed to ensure all admissions are purposeful and provide therapeutic care
- Roll out of training to ensure care provided meets trauma informed principles
- Recruitment of senior lead to focus on Urgent Care Pathway and ensure robust links with community capacity to further develop in-reach models to expedite discharges and improve flow

Constitutional Standards – Urgent Care

Derby and Derbyshire
Integrated Care Board

ICB Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire ICB				Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England		
					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
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Nov-23	↑	71.7%	74.3%	55	71.8%	77.6%	98	71.6%	73.1%	27	69.1%	72.7%	98
		A&E 12 Hour Trolley Waits	0	Nov-23					173	731	40	538	2,679	20	42,854	258,333	40

EMAS Dashboard for Ambulance Performance Indicators

	Area	Indicator Name	Standard	Latest Period	East Midlands Ambulance Service Performance (NHSD&DICB only - National Performance Measure)				EMAS Performance (Whole Organisation)			EMAS Completed Quarterly Performance 2023/24				NHS England		
					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	Current Month	YTD	consecutive months non-compliance
Urgent Care	Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Nov-23	→	00:09:01	00:08:44	41	00:08:46	00:08:42	40	00:08:36	00:08:36			00:08:32	00:08:26	31
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Nov-23	→	00:15:46	00:15:15	2	00:15:40	00:15:44	29	00:15:30	00:15:38			00:15:08	00:15:01	3
		Ambulance - Category 2 - Average Response Time	00:18:00	Nov-23	→	00:42:48	00:40:07	40	00:41:10	00:39:42	41	00:35:56	00:38:37			00:38:30	00:34:52	40
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Nov-23	→	01:28:41	01:26:05	40	01:25:59	01:25:39	40	01:17:42	01:23:32			01:22:07	01:14:42	32
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Nov-23	→	06:39:52	06:18:55	40	06:24:05	06:05:36	40	05:15:07	05:55:04			05:25:46	04:47:29	32
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Nov-23	→	04:59:50	04:52:18	32	05:20:32	04:59:11	32	04:28:26	04:41:20			06:04:54	05:49:51	32

111 Indicators

Area	Indicator Name	Standard	Latest Period	DHU Performance	
				Direction of Travel	Current Month
111 Key Indicators	Abandonment Rate	5%	Sep-23	↑	3.5%
	Average Speed of Answer	00:00:27	Sep-23	↑	00:00:48

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

Derby and Derbyshire
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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
Planned Care	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Oct-23	↑	54.9%	56.0%	69	54.3%	58.6%	54	53.4%	53.4%	70	58.2%	58.5%	92
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-23	↑	8,107	54,337	45	1,390	8,623	43	7,467	49,544	44	377,618	2,693,764	198
		Number of 78 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-23	↑	263	1,359	31	7	82	31	299	1,225	31	10,506	67,089	31
		Number of 104 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-23	↔	1	13	2	0	0	0	0	0	0	190	2,278	31
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Oct-23	↓	23.34%	28.15%	65	22.72%	23.13%	43	20.11%	29.16%	44	24.67%	26.06%	122
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of All Referrals	75%	Oct-23	↑	72.9%	72.5%	8	80.5%	78.3%	0	65.4%	68.9%	27	71.1%	71.8%	8
	31 Days Cancer Waits	First & Subsequent Treatments Administered Within 31 Days Of Decision To Treat	96%	Oct-23	New Indicator	86.2%	86.2%	1	87.9%	87.9%	1	85.8%	85.8%	1	89.4%	89.4%	1
	62 Days Cancer Waits	First Definitive Treatment Administered Within 62 Days Of All Referrals	85%	Oct-23	New Indicator	58.4%	58.4%	1	71.0%	71.0%	1	53.2%	53.2%	1	63.1%	63.1%	1
	Cancelled Operations	% Of Cancelled Operations Rebooked Over 28 Days	N/A	2023/24 Q2	Unable to report due to system access issues				38.7%	41.2%		26.9%	31.7%		23.0%	23.1%	

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 8 (including EMAS)

Derby and Derbyshire Integrated Care Board

Tables 1a-1d: 2023/24 Workforce Plan Position Month 8

- The total workforce across all areas (substantive, bank and agency) was 1252.42WTE above plan at M8.
- Compared to M7, there was an increase in substantive positions (134.78WTE) and there was a decrease in both bank (-129.65 WTE) and agency usage (- 47.68WTE).
- The majority of this increase was observed in Registered Nursing, Midwifery and Health Visiting staff (86.0 WTEs), Allied Health Professionals (27.27WTEs) and Support to Ambulance Staff (21.82 WTEs).
- Table 1c aims to demonstrate the overall growth trend. As at M8 there has been a 5.4% growth in the total workforce since M12 (1,546 WTEs). It is important to note that the M12 starting position was already above plan by 497WTEs. The chart demonstrates the point at which the system began to observe variance to plan; notably when industrial action first commenced which was further compounded by the M12 actual out-turn position being greater than the M1 baselines (this is an important lesson going into next years planning round).
- For Primary care in table 1d, the total workforce was 121WTE below plan of M7.

Tables 2a and 2b: Workforce establishment V M8 actuals (WTE) comparison to pay-bill (£)

- As a system, work continues to improve workforce and finance pay bill alignment.
- Table 2a aims to demonstrate the pay costs associated with the workforce plan staff in post actuals (note this is with the recognition that there is some misalignment between ESR and finance ledger systems, but the differences are generally within acceptable tolerance levels). At M8 the system is £6.2m overspent on the pay-bill with 810 WTEs over the total establishment (substantive, bank and agency).
- It has been identified that there is inconsistency in the number of WTEs being recorded (contracted V worked) e.g. CRH record medics doing 14 sessions as 1.4WTEs whereas UHDB record this as 1WTE (comparatively this suggests less capacity at UHDB but on the other hand this is inflating the associated costs). This appears to be due to different interpretations of the PWR guidance (both could be argued as correct). Therefore, this is also an area which needs further investigation and if any changes in approach are deemed necessary then the impact (positive and negative) needs to be fully understood.
- Whilst there were plans for bank and agency usage, temporary staffing (particularly agency) is generally more costly in comparison to substantive staff and the system is overspent in both these areas. The total overspend on temporary staffing (Bank and Agency) at M8 is £10.5 (YTD £31.2m). However, the M8 total pay pill overspend is £6.2m (YTD £27.8m). This initial high-level analysis would therefore suggest that there is an underspend on substantive staff due to the number of vacancies reported in table 2a (1,286 wte).

Workforce Summary: Month 8 (including EMAS)

Derby and Derbyshire
Integrated Care Board

Agency KPIs

In M8 JUCD agency cost amounted to 3.3% of total pay costs, 0.4% under the national target of 3.7%. This change in position compared to M7 is due to timing of payments.

The current agency spend is £30.2m, which is above the planned spend of £26.3m, resulting in a £12.3m overspend. However, it is only at 78% of the annual cap of £38.7m (an underspend of £8.5m).

Actions

- As well as the plans to hold substantive workforce growth to year end as set out on slide 7, all Trusts continue to make concerted efforts to reduce agency usage.
- Additional controls have been put in place in relation to agency and vacancies, which are beginning to demonstrate impacts (e.g. UHDB and DHcFT reduction in agency as a result of admin and clerical exit strategies).
- Through the joint workforce and finance improvement (JWFI) work, as part of the 20245/25 baseline revisions, Trusts have been asked to breakdown all pay elements including sickness, maternity, non-contractual pay enhancements, overtime etc in order to ascertain where there may be other pay costs impacting on the pay-bill overspend and to determine where there are opportunities to reduce this where appropriate.

Risks

- Further ongoing industrial action will continue to impact on the pay-bill position, particularly with regards to the ability to significantly reduce the need for temporary staffing which will incur greater costs.
- Ongoing re-banding issues (HCAs and potentially other bands) resulting in significant increases in the pay bill.

Table 1a: 2023/24 Workforce Plan Position Month 8 (NHS Foundation Trusts, including EMAS)

Derby and Derbyshire
Integrated Care Board

ICB Total	Reporting Period: Nov 2023					
	Month 8			Trend		
	Plan	Actual	Variance from plan	Previous month	Changes in actual vs previous month	Trend (Actual) previous 12 months
Workforce						
Total Workforce (WTE)	28,970.48	30,226.91	-1,256.43	30,269.46	↓	
Substantive (WTE)	27,547.11	28,131.31	-584.20	27,996.52	↑	
Bank (WTE)	1,163.90	1,581.47	-417.57	1,711.12	↓	
Agency (WTE)	259.47	514.13	-254.66	561.81	↓	
Cost						
Pay Cost (£'000)	123,245	129,470	-6,225	122,775	↓	

* 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.

Note: A process to rebase the plans to reflect the revised out-turn positions is underway.

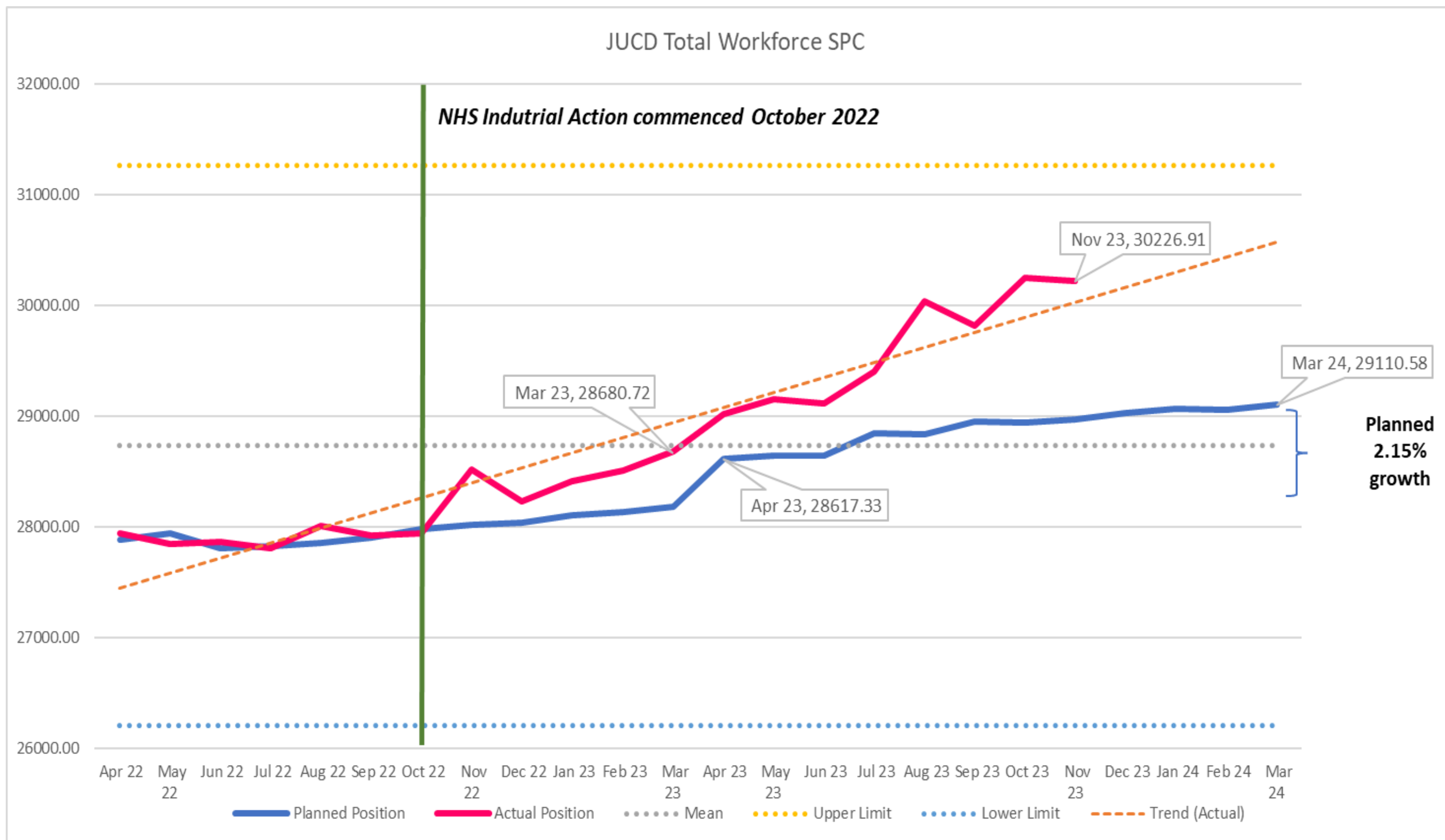
Table 1b: 2023/24 Workforce Plan Position Month 8 – Provider Breakdown

Derby and Derbyshire
Integrated Care Board

		Plan	Actual	Variance from plan	Supporting Provider Narrative
CRH	Workforce (WTE)				At M8 the majority of the substantive growth is observed in nursing - filling vacancies based on establishment set by safer staffing requirements. The drivers for bank/agency usage are vacancies, high levels of sickness, high acuity and operational pressures. Outturn forecast position: Increase substantive workforce by 28WTE to 4,597 but will hold overall WTE through reducing bank and agency at 5,080.
	Total Workforce	4,707.68	5,080.56	-372.88	
	Substantive	4,311.22	4,569.79	-258.57	
	Bank	295.20	375.52	-80.32	
	Agency	101.26	135.25	-33.99	
	Cost (£)				
	Pay Cost (£'000)	£19,755	£21,917	-£2,162	
DCHS	Workforce (WTE)				Substantive: Changes appear insignificant between M7 and M8; continued to see a reduction. Small increases relate to existing funded gaps, and other changes relate to turnover. Bank: Overall reduction of bank staff, any increase in M8 (support to AHPs) is to cover short-term last-minute absences. Agency: Overall reduction of agency usage in M8 due to a slightly improved absence rate during that period. Outturn forecast position: No additional growth in substantive WTEs, having seen a reduction from M7 to M8, the position is likely to end at 3,686.
	Total Workforce	3,830.41	3,807.43	22.98	
	Substantive	3,760.25	3,681.13	79.12	
	Bank	45.55	95.70	-50.15	
	Agency	24.61	30.60	-5.99	
	Cost (£)				
	Pay Cost (£'000)	£14,018	£14,108	-£90	
DHcFT	Workforce (WTE)				Outturn forecast position: An increase of 133wte by end of March, taking the position to 3,055 WTEs. This is due to vacancies in the pipeline for investment areas such as 'Living Well' and some long standing clinical vacancies, primarily nursing consistent with commitments made within delivering the MHIS. Additional vacancy controls are being applied which will reduce growth into 2024/25.
	Total Workforce	3,129.93	3,144.85	-14.92	
	Substantive	2,923.07	2,928.50	-5.43	
	Bank	160.05	182.63	-22.58	
	Agency	46.81	33.72	13.09	
	Cost (£)				
	Pay Cost (£'000)	£12,934	£13,527	-£593	
EMAS	Workforce (WTE)				Outturn forecast position: EMAS were not required to make a resubmission and due to the additional investment backed growth; it is assumed that the plan will remain the same.
	Total Workforce	4,238.47	4,514.28	-275.81	
	Substantive	4,165.81	4,233.96	-68.15	
	Bank	52.66	55.26	-2.60	
	Agency	20.00	225.06	-205.06	
	Cost (£)				
	Pay Cost (£'000)	£17,413	£17,471	-£58	
UHDB	Workforce (WTE)				Outturn forecast position: No further growth from the M8 position and is likely to outturn at 12,717 WTEs.
	Total Workforce	13,063.98	13,679.79	-615.80	
	Substantive	12,386.75	12,717.93	-331.18	
	Bank	610.44	872.36	-261.92	
	Agency	66.79	89.50	-22.70	
	Cost (£)				
	Pay Cost (£'000)	£59,433	£62,447	-£3,014	

The supporting provider narrative this month is based on the H2 financial reset position, where measures have been put in place to limit substantive workforce growth planned for the remainder of this year. A process to rebase the plans to reflect the revised forecaste out-turn positions is underway.

Table 1c: Workforce Growth Trent (Total WTEs)



The 2023/24 plan was based on growth of 2.15% (615WTEs). As at M8 there has been a 5.4% growth in the total workforce since M12 (1,546.18 WTEs). There are various factors impacting this position e.g. the uptick in the August position is due to the F1 rotational trainees and there has also been growth in NQN's and NQM's, in September/October as they qualify. This is in addition to any in-year investment backed growth and the impact of industrial action.

The chart demonstrates the point at which the system began to observe variance to plan; notably when industrial action first commenced which was further compounded by the M12 actual out-turn position being greater than the M1 baselines.

The overall financial pressures are well known, therefore there is a need to better articulate what the workforce growth is delivering in terms of services and performance.

Workforce Total WTE	Baseline 2019	2022 - 2023												2023 - 2024											
		Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12
		Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Planned		27,885	27,949	27,811	27,825	27,854	27,907	27,982	28,020	28,044	28,103	28,134	28,184	28,617	28,642	28,645	28,849	28,838	28,948	28,949	28,974	29,029	29,067	29,064	29,111
Actual	**25,944**	27,945	27,849	27,868	27,811	28,011	27,924	27,946	28,524	28,233	28,413	28,512	28,681	29,022	29,154	29,117	29,394	29,779	29,818	30,269	30,226				
Variance		60	-100	57	-14	157	17	-36	504	189	310	378	497	405	512	472	544	941	870	1,320	1,252				

A process to rebase the plans to reflect the revised forecast out-turn positions as described on the previous slide is underway.

Table 1d: 2023/24 Primary Care Workforce (Month 7)

Derby and Derbyshire Integrated Care Board

The data below provides a high-level overview of the primary care data to plan. Discussions are ongoing to develop this further to provide a better understanding of primary care workforce.

Data Source: GP Commissioning Team	Baseline	Actual			Plan	Actual			Plan	Actual	Plan	Plan
Primary Care	Staff in post outturn	Q1			Q1	Q2			Q2	Q3	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	As at the end of	As at the end of
	(31-Mar-23)	Apr-23	May-23	Jun-23	Jun-23	Jul-23	Aug-23	Sep-23	Sep-23	Oct-23	Dec-23	Mar-24
Workforce (WTE)	Total WTE	Total WTE			Total WTE	Total WTE			Total WTE	Total WTE	Total WTE	Total WTE
Total Workforce	3,378	3,359	3,369	3,377	3,439	3,381	3,424	3,416	3,548	3,427	3,614	3,647
GPs excluding registrars	766	748	740	742	767	736	762	756	795	749	789	778
Nurses	364	353	354	353	365	349	343	341	363	337	363	361
Direct Patient Care roles (ARRS funded)	465	505	499	514	510	527	547	548	580	558	636	669
Direct Patient Care roles (not ARRS funded)	282	270	268	267	286	267	268	271	290	273	293	298
Other – admin and non-clinical	1,502	1,485	1,509	1,501	1,512	1,501	1,503	1,500	1,519	1,509	1,532	1,542

Summary

- At M7, the total workforce was 121WTE below M6's plan. The gap was observed mainly from GPs excluding registrars (46 WTE) and Nurses (26 WTE).

Caveats to the data:
Primary Care data is up to M7 due to the data availability from GP team.
Only quarterly plan is available, so we would compare the nearest quarter end numbers for workforce gap data.
Some months may include backdated info as PCNs tend to submit claims as and when they receive them as they have to wait for third party invoices therefore WTE fluctuates WTE on the claims include temporary, agency, CVS and trust staff – not just PCN employed staff
The info received for ARRS is a month in arrears

Table 2a: Total Workforce establishment V M8 actuals (WTEs) comparison to pay-bill (£)

	Data Source: Provider Finance Return (PFR)						Data Source: Finance - Deputy DoFs				Data Source: Provider Workforce Returns (PWR)			
	M8 Pay Budget	M8 Pay Actual	M8 Pay Variance	YTD Pay Budget	YTD Pay Actual	YTD Pay Variance *	Establish-ment (as per Finance) **	Staff in Post (Substantive) M8 Actual	Vacancy ***	Vacancy Rate ***	Bank M8 Actual	Agency M8 Actual	Net Staffing (Substantive, Bank & Agency Total) M8 Actual	Establish-ment V Actual Variance
	£'000	£'000	£'000	£'000	£'000	£'000	WTE	WTE	WTE	%	WTE	WTE	WTE	WTE
ICB Total	123,245	129,470	-6,225	997,436	1,025,277	-27,841	29,417	28,131	1,286	4.37%	1581	514	30,227	-810
CRH	19,755	21,917	-2,162	162,020	172,689	-10,669	4,652	4,570	82	1.77%	376	135	5,081	-429
DCHS	13,710	14,108	-398	109,170	111,672	-2,502	3,812	3,681	131	3.43%	96	31	3,807	5
DHcFT	12,934	13,527	-593	102,146	106,817	-4,671	3,013	2,929	84	2.80%	183	34	3,145	-132
EMAS ^	17,413	17,471	-58	137,859	128,644	9,215	4,358	4,234	124	2.85%	55	225	4,514	-156
UHDB	59,433	62,447	-3,014	486,241	505,455	-19,214	13,582	12,718	864	6.36%	872	89	13,680	-98

Notes:
*Reflects the **gross** staff costs (as agreed with Finance colleagues) but it is noted that there may be 'recoveries in respect of staff costs netted off expenditure' which would change the reported finance committee overspend position. ** For the purpose of this comparison exercise the vacancy numbers are based on the
** The establishment figures do not include the full impact of all the required efficiencies and subsequent impact on workforce consistently across all Trusts
*** 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 slight variance in the figures compared to those submitted in PWR and this is because of the establishment figures being extracted from the finance ledger whereas the vacancy actuals submitted on PWR are derived from ESR.
^ Due to PWR changes, EMAS paramedics (overtime and 3rd party) are now being recorded in the agency WTE but it is noted that these have specific funding associated with the roles and not agency in the same sense as other providers

In the absence of the national requirement for monthly establishment plans, local arrangements have been put in place, to monitor the workforce plan against the actual staffing levels that we have the budget for (i.e. costed WTE establishment). The M8 position is an overspend against the pay budget of £6.2m with 810wte over-establishment (total workforce).

It is not yet possible to make a direct correlation between the pay-bill and the actual WTEs and therefore through the joint workforce and finance improvement (JWFI) work there is an ask to breakdown all pay elements including sickness, maternity, non-contractual pay enhancements, overtime etc in order to ascertain where there may be other pay costs impacting on the pay-bill overspend.

2023/24 Month 8 JUCD Agency

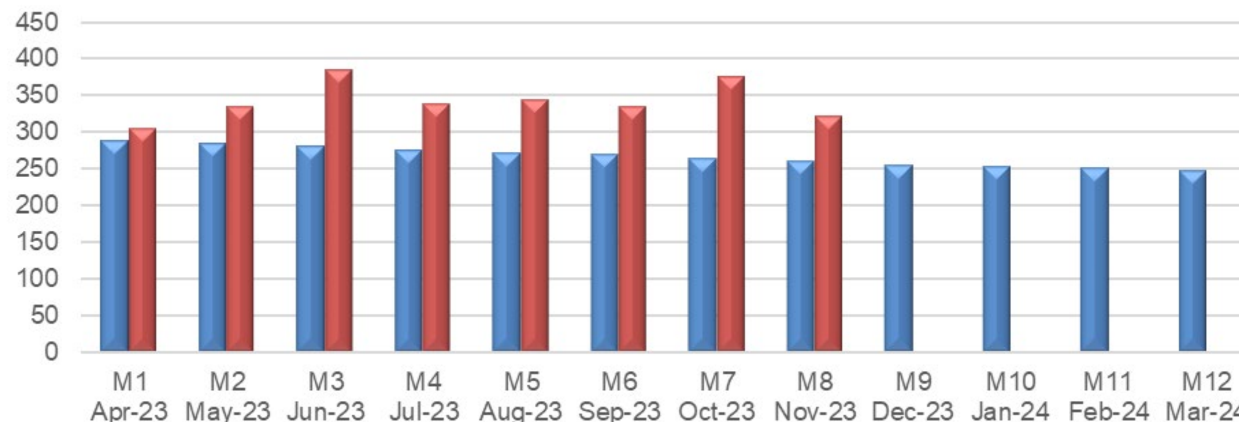
KPI Summary:

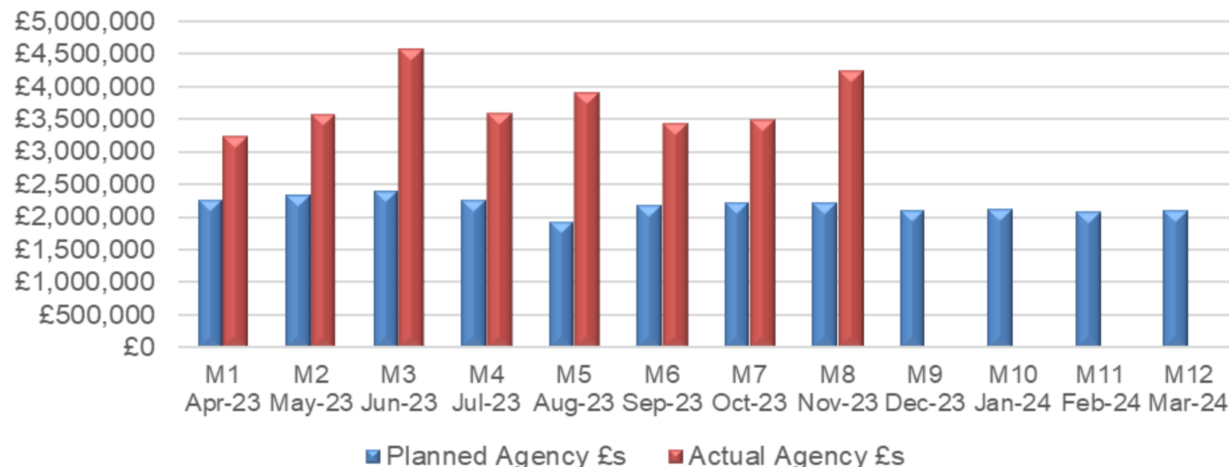
- In M8 JUCD agency cost amounted to 3.3% of total pay costs, 0.4% under the national target of 3.7%
- JUCD planned to spend £2.2m on agency staff in M8. The actual spend was £4.2m. This is an overspend against plan of £2.0m, an increase of £759k on the previous month (note some of this spend in-month relates to the previous month and is due to timesheets/invoice processing timelines)
- YTD JUCD planned agency usage was £17.9m, the system has spent £30.2m which is an overspend £12.3m
- Current agency spend is above the planned spend of £26.3m, resulting in a £12.3m overspend. However, it is only at 78% of the annual cap of £38.7m (an underspend of £8.5m).
- Off framework usage was 42 shifts in M8, 0.9% of total agency shifts (4.3% YTD).
- There were 2,961 non price cap compliant shifts, 64.3% of the total agency shifts (51.2% YTD).
- Admin and Estates came to 405 shifts in M8, 8.8% of total agency shifts (24.2% YTD). YTD the total Admin and Estates agency usage appears to be distorted due the EMAS position which equates to 8,108 out of a total of 11,638 for all providers. The YTD Admin and Estates position for EMAS is 70% of the total admin and estates usage.

Actions:

- Further investigation is ongoing to understand the factors for the high-level of off framework and Admin and Estates usage (particularly EMAS).
- Further work is also underway to enable a more granular breakdown of the data to ensure consistency with regards to the highest paid/longest serving agency workers.
- The analysis work being undertaken to investigate the factors for agency usage and spend, is informing the targeted actions in the system Agency Reduction Plan.

M8 JUCD Agency Breakdown:





Finance

Keith Griffiths, Chief Finance Officer
Jill Dentith, Non-Executive Member

The following slides summarise the information supplied in the SFEC report

Month 8 System Finance Summary – Financial Position

NHS Derby and Derbyshire Integrated Care Board

As of 30th November 2023, the JUCD year to date position is a £37.7m overspend against the plan

YTD overspend main drivers include excess inflation (£20.8m), industrial action (£8.3m) and revenue cost of capital (£2.0m)

Other challenges include difficulty in delivering cash releasing efficiencies, increased demand for services and workforce capacity issues

Forecast position reported by the system at month 8 is a breakeven position

I&E Position by Provider Month 08 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	(3.2)	**(3.2)**	0.0	0.0	**0.0**
Chesterfield Royal Hospital	(3.6)	(15.4)	**(11.8)**	(0.0)	0.0	**0.0**
Derbyshire Community Health Services	0.2	(2.8)	**(3.1)**	(0.0)	0.0	**0.0**
Derbyshire Healthcare	0.8	(2.6)	**(3.4)**	0.0	(0.0)	**(0.0)**
EMAS	(0.0)	1.5	**1.5**	0.0	0.0	**0.0**
University Hospital of Derby and Burton	(9.0)	(26.7)	**(17.8)**	0.0	(0.0)	**(0.0)**
JUCD Total	**(11.5)**	**(49.2)**	**(37.7)**	**(0.0)**	**(0.0)**	**0.0**

Month 8 System Finance Summary – Risk

NHS
Derby and Derbyshire
Integrated Care Board

Risks to achieving the year end position are areas outside the system control as well as those that prevent delivery of the operational plan

Most likely scenario includes £37.6m risk for excess inflation and £8.3m for industrial action

Worst case of £129.2m includes additional efficiency risk, non-recurrent income differences and further pay pressures

Position of £47.3m overspend is recognised by NHSE as the genuine likely outturn for the system

JUCD remains committed to deliver the best possible position it can

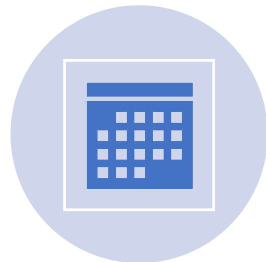
Month 08 Position	2023/24 Organisations Forecast Range		
Organisation	Best Case £m's	Likely Case £m's	Worst Case £m's
NHS Derby and Derbyshire ICB	0.0	17.6	(21.4)
Chesterfield Royal Hospital	0.0	(23.2)	(34.0)
Derbyshire Community Health Services	0.0	(3.0)	(3.7)
Derbyshire Healthcare	0.0	(5.0)	(6.5)
East Midlands Ambulance Service	0.0	4.2	(1.1)
University Hospitals of Derby And Burton	0.0	(38.1)	(62.6)
JUCD Total Surplus/(Deficit)	0.0	(47.3)	(129.2)

Month 8 System Finance Summary – Efficiencies

NHS Derby and Derbyshire Integrated Care Board

The annual efficiency plan is to deliver £136m. Year to date the achievement is £1.2m ahead of a planned £83.3m, with a forecasted £4.4m over plan by the end of the year

£129.4m of plans are fully developed or in progress, with £6.6m still needing to be developed further



Recurrent efficiencies are £18.6m behind plan to date, forecast to increase to £21.4m by the end of the year. There is a need to identify recurrent transformational change.

There is a possibility that cash releasing efficiencies will not be achieved making it difficult to ensure sufficient cash is available to meet our contractual liabilities

Efficiencies by Provider Month 08 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	28.6	32.3	**3.7**	44.2	48.6	**4.4**
Chesterfield Royal Hospital	9.5	8.0	**(1.5)**	15.7	15.7	**0.0**
Derbyshire Community Health Services	6.1	6.0	**(0.1)**	9.2	9.2	**0.0**
Derbyshire Healthcare	5.8	5.5	**(0.3)**	8.8	8.8	**0.0**
EMAS	7.4	7.7	**0.3**	11.2	11.2	**(0.0)**
University Hospital of Derby and Burton	25.9	25.1	**(0.7)**	47.0	47.0	**0.0**
JUCD Total	**83.3**	**84.6**	**1.2**	**136.0**	**140.4**	**4.4**

Month 8 System Finance Summary – Capital

NHS
Derby and Derbyshire
Integrated Care Board

- The capital plan is £158.8m, consisting of £102.2m from the National team and £56.7m from the Regional team.
- Despite the 2023/24 System overspend being acknowledged as excess inflation, the capital allocation has been reduced by £1.4m due to the final revenue position reported at year end.
- Expenditure is behind plan to date for neonatal critical care works, the Kings Treatment Centre and Community Diagnostic Centre developments in UHDB, and the ward upgrade programme at CRH. These are projected to achieve the plan by year end.
- The main overspend forecast is for DCHS relating to the Bakewell development.
- UHDB forecast underspend includes £7.3m relating to IFRS 16 costs due to a contract renewal being deferred until 2024/25.
- All of these developments are projected to be on plan by the end of the year.

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	6.0	3.8	2.2	9.7	10.0	(0.2)
Derbyshire Community Health Services	6.2	5.2	1.1	7.2	16.7	(9.5)
Derbyshire Healthcare	45.6	45.2	0.3	68.3	68.2	0.0
EMAS	7.2	6.9	0.3	15.9	17.5	(1.6)
University Hospital of Derby and Burton	22.8	8.5	14.3	57.7	52.1	5.6
JUCD Total	**87.8**	**69.6**	**18.2**	**158.8**	**164.5**	**(5.7)**

Month 8 System Finance Summary – Cash

In 2023/24 the delivery of efficiencies was imperative to meet cash plans. The forecast year end cash balances in the table below assumes each Provider delivers the efficiencies in their plan.

CRH have requested cash support from NHSE/DHSC for quarter three and this has been approved. Further cash support will be required by providers for quarter four.

The ICB is likely to require £30m more cash than the Cash Limit it was given at the start of the year due to the amount of non-recurrent balance sheet and other flexibilities used.

The table below describes the cash forecast for the months leading up to year end. Considering that some cash releasing efficiencies will not be transacted and the expectation that CRH and UHDB's application for cash support will be successful.

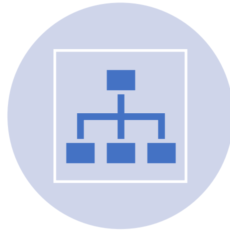
Month 08 Position Organisation	December £m's	January £m's	February £m's	March £m's
Chesterfield Royal Hospital	18.5	17.1	17.1	17.1
Derbyshire Community Health Services	30.6	28.2	27.1	32.2
Derbyshire Healthcare	36.7	32.4	28.0	23.7
East Midlands Ambulance Service	31.6	30.1	28.8	21.3
University Hospitals of Derby And Burton	9.7	5.4	5.6	5.6
JUCD Total Surplus/(Deficit)	127.1	113.2	106.6	99.9

Month 8 System Finance Summary – Workforce

NHS
Derby and Derbyshire
Integrated Care Board

YTD there is an overspend of £26.1m across the system with a small underspend expected by the end of the year.

Achieving the year end underspend position relies on efficiency schemes being implemented.



£12.3m of the overspend to date relates to agency staff covering vacancies and sickness, as well as supporting projects and complex patients.

Challenges with recruitment for key services means having to increasingly rely on temporary staff.

Staff Costs by Provider Month 08 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	162.0	172.7	(10.7)	239.9	232.5	7.4
Derbyshire Community Health Services	170.8	109.5	111.7	(2.2)	164.8	166.8	(2.0)
Derbyshire Healthcare	155.6	102.1	106.8	(4.7)	154.2	162.0	(7.8)
EMAS	198.0	137.9	128.6	9.2	207.6	202.7	4.9
University Hospital of Derby and Burton	750.5	486.2	504.0	(17.7)	724.5	724.6	(0.1)
JUCD Total	**1,528.3**	**997.7**	**1,023.8**	**(26.1)**	**1,490.9**	**1,488.5**	**2.4**

Appendix 2 - JUCD System Finance Report to 30th November 2023 (M08)

1. Introduction

This report details the JUCD System Financial Position as at 30th November 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 30th November 2023, the JUCD year to date position is a £49.2m deficit against a £11.5m planned deficit, a £37.7m overspend against plan. The position is driven by continued pressures outside of the plan from industrial action, excess inflation and pay award.

Table 2.1 below outlines the systems year to date and forecast position at month eight. CRH have an overspend of £11.8m to date with £3.0m of this variance relating to industrial action and £2.7m for excess inflation relating to energy costs and consumables. UHDB also reports an overspend of £17.8m to date, with excess inflation and industrial action pressures contributing to £10.7m of this variance. DHcFT is overspent by a total of £3.4m to date due to patient activity and Out of Area costs. DCHS has small variances across a number of areas giving a total to date of £3.1m overspend. The ICB are reporting an overspend of £3.2m and the main pressures include price increases for prescribing and Better Care Fund contract.

The forecast outturn for all organisations continues to be breakeven at the request of NHSE with the commitment to mitigate the overspends and risks encountered. It is recognised that this is an increasing challenge given the most likely position and with only four months of the year remaining. JUCD remains committed to delivering the best possible position it can recognising the £47.3m deficit discussed with the NHSE National team.

***Table 2.1** JUCD I&E Position Summary as at 30th November 2023*

I&E Position by Provider Type Month 08 Position	Month 8 Planned Variance £m's	Month 8 Actual Variance £m's	Month 8 Variance to Plan £m's	Annual Planned Variance £m's	Annual FOT Variance £m's	FOT Variance to Plan £m's
Chesterfield Royal Hospital	(3.6)	(15.4)	(11.8)	(0.0)	(0.0)	(0.0)
Derbyshire Community Health Services	0.2	(2.8)	(3.1)	(0.0)	0.0	0.0
Derbyshire Healthcare	0.8	(2.6)	(3.4)	0.0	(0.0)	(0.0)
EMAS	(0.0)	1.5	1.5	0.0	0.0	0.0
University Hospital of Derby and Burton	(9.0)	(26.7)	(17.8)	0.0	(0.0)	(0.0)
Other NHS Acute	0.0	0.9	0.9	0.0	0.4	0.4
Other NHS Mental Health	0.0	(0.8)	(0.8)	0.0	(1.5)	(1.5)
Other NHS Community Services	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.1)
Acute Independent Sector	0.0	(0.4)	(0.4)	0.0	(0.9)	(0.9)
Mental Health Independent Sector	0.0	(2.0)	(2.0)	0.0	(2.5)	(2.5)
Community Services Non NHS	0.0	(0.6)	(0.6)	0.0	(1.0)	(1.0)
Continuing Health Care	0.0	(0.4)	(0.4)	0.0	0.0	0.0
Primary Care Prescribing	0.0	(4.6)	(4.6)	0.0	(6.5)	(6.5)
GP Co-Commissioning	0.0	(1.6)	(1.6)	0.0	(2.1)	(2.1)
Other GP Primary Care	0.0	0.9	0.9	0.0	1.1	1.1
Pharmacy	0.0	0.6	0.6	0.0	0.0	0.0
Optometry	0.0	(0.2)	(0.2)	0.0	0.0	0.0
Dental	0.0	4.9	4.9	0.0	6.0	6.0
Other Programmed Services	0.0	(3.4)	(3.4)	0.0	(5.5)	(5.5)
ICB Running Costs	0.0	1.3	1.3	0.0	3.5	3.5
ICB Operational Costs Other Programme	0.0	2.2	2.2	0.0	9.1	9.1
Grand Total	(11.5)	(49.2)	(37.7)	(0.0)	(0.0)	(0.0)

Capital

The forecast position overall on capital is £5.7m overspent on a capital plan of £158.8m. The overspend is predominantly due to the Bakewell and Community Diagnostic schemes managed by DCHS and EMAS's operating lease costs which were not identified by them at planning. Further details on the capital plan are set out below.

Cash

The System's reported annual cash flows reflect the expected delivery of cash-releasing efficiencies. The in-year cashflow will be significantly impacted if they do not occur. CRH have already requested cash support from DHSC which has been approved for quarter three. Further requests from our acute providers will be needed to cover quarter four. The ICB is also likely to require more cash than the Cash Limit it was given at the start of the year due to the amount of non-recurrent balance sheet and other flexibilities used. This is currently estimated to be in the region of £30m and NHSE have been informed.

ERF

There has been further confirmation on the Elective Recovery Fund (ERF) for the year. NHSE were originally withholding 16% of the ICB's ERF allocation. In month seven further details received reduced the amount to c14% withheld and elective targets were reduced (with a floor of 100% of 2019/20 activity) to take account of further industrial action during the year.

In month eight NHSE have confirmed that the baseline adjustments submitted have been approved and will be reflected in the latest performance information. It is expected that the system performance has improved to 100.4% for April to September YTD so there will be no

amount held back. As the activity is above the 100% target the system will receive a small top-up to the allocation.

3. Income and Expenditure Performance

As at 30th November 2023, the year to date system position is a £49.2m deficit against a £11.5m planned deficit, driven by the cost of excess inflation, industrial action and underfunding for the pay award.

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 reflects the £47.3m financial reset deficit that in a recent meeting with NHSE National team has been recognised as the genuine likely outturn for the system. This now includes mitigation for some of the cost pressures which were not anticipated at planning stage. The ICB and EMAS are forecasting a surplus which will support the system bottom line and the ICB surplus includes the Industrial Action allocation received in month eight which will ultimately after system agreement will be a shared with other organisations.

The best case still assumes that forecast out-turn for all organisations continues to be breakeven overall and is reflected in each individual organisation as breakeven. The worst-case scenario incorporates risks related to delivering the JUCD Operational Plan, including efficiency delivery, pressures from backlog of activity and capacity issues.

The System continues to identify and consider every opportunity to improve the year end position.

***Table 3.1** JUCD I&E position best, most likely and worst case forecast position.*

Month 08 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	17.6	(21.4)
Chesterfield Royal Hospital	0.0	(23.2)	(34.0)
Derbyshire Community Health Services	0.0	(3.0)	(3.7)
Derbyshire Healthcare	0.0	(5.0)	(6.5)
East Midlands Ambulance Service	0.0	4.2	(1.1)
University Hospitals of Derby And Burton	0.0	(38.1)	(62.6)
JUCD Total Surplus/(Deficit)	0.0	(47.3)	(129.2)

The year to date variances to plan are shown in the following table, these are predominantly made up of costs which were not a consideration at planning, mainly industrial action and excess inflation, as well as activity and pay pressures.

Table 3.2 *Year to date movement from plan*

Year to Date Movement from Plan Month 08 Position	ICB £m's	CRH £m's	DCHS £m's	DHcFT £m's	EMAS £m's	UHDB £m's	Total £m's
Industrial Action		(3.0)		(0.1)		(5.2)	**(8.3)**
Excess Inflation Above National Guidance	(11.0)	(2.7)	(1.3)	(0.2)	(0.1)	(5.5)	**(20.8)**
Pay Award		(0.7)	(0.1)	(0.1)	(0.6)		**(1.5)**
Efficiencies	8.1	(1.5)	(0.1)	(0.3)		(0.8)	**5.4**
Revenue Cost of Capital		(0.1)		(1.7)	0.3	(0.5)	**(2.0)**
Other	(7.6)	(3.8)	(2.3)	(1.0)	1.9	(5.8)	**(18.6)**
Mitigations	7.3		0.7				**8.0**
Total	**(3.2)**	**(11.8)**	**(3.1)**	**(3.4)**	**1.5**	**(17.8)**	**(37.7)**

Risks

As the year progresses, there are risks to reaching the year-end position currently estimated at £129.2m. They are being categorised into two areas, those that are outside the system's control (excess inflation, industrial action and pay award costs) and those that might prevent the delivery of the Operational Plan, which includes efficiencies. Mitigating these risks is necessary to deliver a breakeven position and it is important for the risks deemed within our control that mitigations are identified as a matter of urgency to enable the delivery of the plan each JUCD Board approved.

The risks that add up to the worst case scenario for JUCD are shown in Table 3.3 below. It includes the costs outside the plan at a risk of £52.4m as well as the risks of £76.8m associated with delivering the Operational Plan. The total risks have reduced by £10.4m in month eight with an improvement for efficiencies partly offset by increased risks for other areas including income.

Table 3.3 *System Identified Risks*

Risk Month 08 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	(23.3)	(4.7)	(1.1)	(0.4)	0.0	(8.1)	**(37.6)**
Industrial Action	0.0	(4.0)	0.0	(0.2)	0.0	(7.0)	**(11.2)**
Pay Award	0.0	(1.0)	(0.1)	(0.2)	(1.2)	(1.2)	**(3.7)**
Outside Plan Total	(23.3)	(9.7)	(1.2)	(0.8)	(1.2)	(16.3)	(52.4)
Efficiencies	(1.9)	(5.4)	0.0	(0.4)	0.0	(6.4)	**(14.1)**
Operational Pressures							
Baseline and Non-Recurrent Income		(5.7)			0.8	(4.3)	**(9.2)**
Capacity & Activity Pressures							**0.0**
Contract Payments							**0.0**
Drugs Costs	(2.7)						**(2.7)**
Increasing Pathway to 103/107%						(1.7)	**(1.7)**
Cost of Cash Support		(1.4)				(0.5)	**(1.9)**
Revenue Cost of Capital				(2.5)		(0.7)	**(3.2)**
Other	6.4	(11.8)	(2.5)	(2.8)	(0.7)	(32.7)	**(44.1)**
Operational Pressures Total	3.7	(18.9)	(2.5)	(5.3)	0.1	(39.9)	(62.8)
Total	**(21.4)**	**(34.0)**	**(3.7)**	**(6.5)**	**(1.1)**	**(62.6)**	**(129.2)**

External Factors

The impact of excess inflation of £37.6m and industrial action at an estimated cost of £11.2m has been significant, mostly being felt within the acute providers. The cost of industrial action estimate only includes the direct cost implication and does not include additional impacts this may have. The pay award pressures amount to £3.7m where funding has not covered the costs of the uplift.

Efficiencies

The below table tracks the development of the schemes from month seven to month eight. In month eight there are no longer any unidentified schemes, which is an improvement of £7.4m compared with month seven. There are £6.6m of efficiencies still to be formalised into a plan therefore, the development of schemes needs to continue, to support the system's ability to deliver a breakeven financial position.

Table 3.4 *System Efficiency Plan Development*

System Efficiencies Month 08 Position	Fully Developed £m's	Plans in Progress £m's	Opportunity £m's	Unidentified £m's	Total £m's
Annual Total - at Month 7	108.0	10.1	10.5	7.4	136.0
Annual Total - at Month 8	122.5	6.9	6.6	0.0	136.0
Total Movement	**14.5**	**(3.2)**	**(4.0)**	**(7.4)**	**(0.0)**

Table 3.5 below sets out the month eight efficiencies by organisation and the actual delivery against those plans. The year to date position includes over-delivery for the ICB and EMAS which is partly offset by under-delivery for CRH and UHDB. The ICB are forecasting to achieve £4.4m above plan by the end of the financial year with other providers committed to delivering a break even position.

Table 3.5 *System Efficiency Delivery – NHSE Submitted Financial Report*

Efficiencies by Provider Month 08 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	28.6	32.2	**3.7**	44.2	48.6	**4.4**
Chesterfield Royal Hospital	9.5	8.0	**(1.5)**	15.7	15.7	**0.0**
Derbyshire Community Health Services	6.1	6.0	**(0.1)**	9.2	9.2	**0.0**
Derbyshire Healthcare	5.8	5.5	**(0.3)**	8.8	8.8	**0.0**
EMAS	7.4	7.7	**0.3**	11.2	11.2	**(0.0)**
University Hospital of Derby and Burton	25.9	25.1	**(0.7)**	47.0	47.0	**0.0**
JUCD Total	**83.3**	**84.5**	**1.2**	**136.0**	**140.4**	**4.4**

The below table shows the split of the efficiency delivery between recurrent and non-recurrent.

Table 3.7 *YTD and Full Year Efficiencies split recurrent and non-recurrent*

Efficiencies by Provider - YTD Month 08 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	14.0	14.6	14.0	18.2	0.0	3.6
Chesterfield Royal Hospital	7.2	2.3	3.1	4.9	(4.1)	2.6
Derbyshire Community Health Services	4.6	1.5	2.0	4.0	(2.6)	2.5
Derbyshire Healthcare	4.4	1.5	0.9	4.6	(3.5)	3.2
EMAS	6.1	1.3	5.9	1.8	(0.2)	0.5
University Hospital of Derby and Burton	18.3	7.6	10.0	15.1	(8.2)	7.5
JUCD Total	54.6	28.8	35.9	48.6	(18.6)	19.8

Efficiencies by Provider - 23/24 Month 08 Position	Full Year Plan £m's		Full Year Forecast £m's		Forecast Variance £m's	
	Recurrent	Non-Recurrent	Recurrent	Non-Recurrent	Recurrent	Non-Recurrent
NHS Derby and Derbyshire ICB	23.9	20.3	22.7	25.9	(1.2)	5.6
Chesterfield Royal Hospital	11.9	3.8	6.2	9.5	(5.7)	5.7
Derbyshire Community Health Services	7.0	2.2	3.2	6.0	(3.8)	3.8
Derbyshire Healthcare	6.6	2.2	1.8	7.0	(4.8)	4.8
EMAS	9.2	2.0	9.0	2.2	(0.2)	0.2
University Hospital of Derby and Burton	33.1	13.8	27.4	19.6	(5.8)	5.8
JUCD Total	91.7	44.3	70.3	70.1	(21.4)	25.8

The recurrent efficiencies that have been delivered to date are £35.9m and this is £18.6m behind plan. This is a further deterioration of £3.1m from the recurrent amount reported in month seven and highlights that non-recurrent efficiencies are supporting the in-year position which will increase the pressure going into 2024/25. However the full year forecast does show the recurrent delivery picking up to 77% of the planned recurrent delivery in comparison to 66% year to date.

There is a need to identify and mobilise recurrent transformational change to move the system to a financially sustainable position.

As the committee are aware, there is an expectation that the ePMO system is used for reporting on system efficiencies. The Financial Sustainability Board has requested that all organisations fully utilise the opportunities section of the ePMO system so that there can be greater assurance on the full 2023/24 efficiency plan being delivered. The table below shows the current forecast delivery reflected on the ePMO system. The system is currently forecasting to deliver £133.9m against the £136m target.

Table 3.6 *System Efficiency Delivery Forecast – ePMO*

Activity Type (Fin Year 2023-24) Month 08 Position	Annual Target Value £'m	Annual Forecast £'m	Annual Forecast £'m
NHS Derby and Derbyshire ICB	44.2	48.6	4.4
Chesterfield Royal Hospital	15.7	10.7	(5.0)
Derbyshire Community Health Services	9.2	9.1	(0.0)
Derbyshire Healthcare	8.8	7.8	(0.9)
East Midlands Ambulance Service	11.2	11.2	0.0
University Hospitals of Derby And Burton	47.0	46.5	(0.4)
JUCD Totals	136.0	133.9	(2.0)

4. Provider Collaborative

Common Factors Across All Providers

The impact of excess inflation and industrial action has been significant with the most marked impact felt within the acute providers. This is against an incredibly challenging context of COVID backlog recovery, managing waits, increasing levels of acuity and challenges with patient flow through the different parts of the health and care system.

This challenging operating environment has made it difficult to deliver the required level of cash releasing efficiencies with an increasing reliance on technical and non-recurrent measures. In response to the financial reset, providers have reviewed further flexibilities to close the efficiency gap in year although there remains a significant recurrent gap as we head into the planning process for 2024/25.

The planned junior doctors strikes during December and January will put further strain on our already stretched system as we head into the final four months of the financial year. UHDB are already declaring OPEL 4 status due to levels of demand and availability of beds which is earlier than would be the case in a normal year.

Sector Specific Issues

Acute
There is a continued need to rely on temporary staffing to support key clinical services where there remain significant challenges around recruitment and supply. These include Trauma & Orthopaedics, Maternity and Cancer services.

Similarly, services formally recognised as fragile such as ophthalmology and CAMHS are experiencing pressures in this area. The JUCD provider collaborative continues to develop options to make the position more sustainable in the medium and long term both from an operational and clinical perspective but also to improve their financial sustainability. Progress on this workstream is overseen by the Provider Collaborative Leadership Board.

General inflationary pressures are being experienced across all categories of non-pay, but issues at UHDB noted with PPE, which was provided free of charge during the pandemic, alongside increasing demand for insulin pumps and other devices.

Drugs costs in both acute providers were previously under a pass through arrangement, now a block arrangement, have risen materially in year. The additional cost after eight months sits with the acute providers pending a review at planning of the method of contract remuneration in 2024/25.

Part of our planning assumption was to generate £15m in year above plan from new allocations becoming available. This risk was shared by CRH, UHDB and the ICB evenly and to date only £2.1m has been identified leaving a pressure in all three organisations.

Community

The DCHS UTCs are continuing to see unprecedented levels of demand which in turn means additional staffing capacity is required to ensure patient needs can be appropriately met and supports the system’s overall urgent care pathway capacity which remains under significant pressure.

Increased demand being experienced in our community nursing services with a particular pressure point being reported as Derby City which in turn is causing budgetary pressures in terms of staffing requirements and specific non pay items such as dressings.

Mental Health, Learning Disabilities & Autism

Within DHcFT, workforce capacity remains challenging and high levels of agency spend driven by the increasing complexity of patient presentations and an increased need for 1:1 observation on the wards.

Challenging Behaviour pathway patients, which include children, young adults and adults, are materially higher than pre covid levels. Funding for this essential extra care remains uncertain with costs of around £0.15m being incurred on a monthly basis against a plan that assumed no acute intervention.

Revenue

As previously reported, NHSE have confirmed that the previously agreed level of revenue funding for major capital schemes will now only cover the depreciation costs and not the PDC. This has led to a reduction in income for the system of c£3.5m with the material impact being DHcFT and UHDB.

5. Activity, Workforce and Finance Triangulation

Workforce

JUCD is reporting an overspend of £26.1m year to date detailed in table 5.1 below.

Table 5.1 *Workforce Costs from Provider Finance Return*

Staff Costs by Provider Month 08 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	162.0	172.7	(10.7)	239.9	232.5	7.4
Derbyshire Community Health Services	170.8	109.5	111.7	(2.2)	164.8	166.8	(2.0)
Derbyshire Healthcare	155.6	102.1	106.8	(4.7)	154.2	162.0	(7.8)
EMAS	198.0	137.9	128.6	9.2	207.6	202.7	4.9
University Hospital of Derby and Burton	750.5	486.2	504.0	(17.7)	724.5	724.6	(0.1)
JUCD Total	**1,528.3**	**997.7**	**1,023.8**	**(26.1)**	**1,490.9**	**1,488.5**	**2.4**

CRH has an overspend of £10.7m to date but is expecting to be underspent by the end of the financial year with efficiencies due to be implemented. The main pressures to date are industrial action and covering vacancies. UHDB also has a £17.7m overspend to date relating to bank and agency cover for industrial action and sickness, with the level of costs expected to reduce later in the year.

The table below outlines the Agency Staff costs year to date and forecast outturn.

Table 5.2 *2023/24 Agency Staff Plan*

Agency by Provider Month 08 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	6.4	9.8	(3.4)	9.1	10.4	(1.3)
Derbyshire Community Health Services	1.4	0.9	0.9	(0.0)	1.3	1.3	(0.0)
Derbyshire Healthcare	7.6	3.5	6.7	(3.1)	5.3	9.1	(3.8)
EMAS	0.7	0.6	1.0	(0.4)	0.8	1.2	(0.4)
University Hospital of Derby and Burton	14.5	6.5	11.8	(5.3)	9.8	13.3	(3.6)
JUCD Total	39.7	17.9	30.2	(12.3)	26.3	35.3	(9.1)

The year to date overspend of £12.3m is an increase of £2.0m compared with month seven. The variance is expected to reduce by the end of the year for CRH and UHDB.

The total month on month expenditure for agency staff is shown in the table below.

Agency Staff Expenditure	Month 2 YTD Actual £m's	Month 3 YTD Actual £m's	Month 4 YTD Actual £m's	Month 5 YTD Actual £m's	Month 6 YTD Actual £m's	Month 7 YTD Actual £m's	Month 8 YTD Actual £m's
Non-Medical Clinical Staff	2.9	4.9	6.1	7.7	9.4	10.9	12.3
Medical and Dental Staff	3.7	6.1	8.3	10.3	11.8	13.5	16.0
Non-Medical Non-Clinical Staff	0.2	0.4	0.7	1.0	1.2	1.6	1.9
Total	6.8	11.4	15.0	18.9	22.4	25.9	30.2

CRH and UHDB have seen increasing costs for agency staff providing vacancy cover. UHDB has also incurred additional costs in supporting one-off projects. The main costs for DHcFT have been incurred in relation to a complex eating disorder patient.

6. Capital

The table below summarises the capital budget from NHSE of £158.8m this consists of £102.2m from the National team and £56.7m from the Regional team.

The IFRS16 allocation for Derbyshire has been agreed at £9.3m, against a commitment of £9.8m. This leaves Derbyshire with a shortfall of £0.5m to fund from their ICS allocation, currently the system has identified £0.3m towards this funding gap.

The system remains behind plan year to date relating to delays in the Neonatal critical care works, the Kings Treatment Centre and the Community Diagnostic Centre developments at UHDB and the ward upgrade programme at CRH.

All of these developments are projected to be on plan by the end of the year.

Table 6.1 *Capital plan for the system*

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	6.0	3.8	2.2	9.7	10.0	(0.2)
Derbyshire Community Health Services	6.2	5.2	1.1	7.2	16.7	(9.5)
Derbyshire Healthcare	45.6	45.2	0.3	68.3	68.2	0.0
EMAS	7.2	6.9	0.3	15.9	17.5	(1.6)
University Hospital of Derby and Burton	22.8	8.5	14.3	57.7	52.1	5.6
JUCD Total	87.8	69.6	18.2	158.8	164.5	(5.7)

Three out of the five Trusts are forecasting an adverse variance to plan, the overall overspend is mainly due to DCHS, relating to the Bakewell and Community Diagnostic schemes and EMAS, who did not identify operating leases in accordance with IFRS 16 requirements at planning stage. UHDB are offsetting this with a benefit from the Roche contract which was due for renewal in 2023/24 but has been deferred until 2024/25.

7. Cash

The table below shows the cash balance to be £37.8m more than plan at the end of November and is expected to be £3.8m less than plan by the end of the financial year. The figures in the table below assume that the full planned level of cash releasing efficiencies are achieved. UHDB continue to project a cash balance lower than plan and CRH now also expect to have £2.8m less than planned by the end of the year.

Table 7.1 *Cash Balances (assuming full delivery of planned efficiencies)*

Provider Cash Month 08 Position	Opening Balance 01/04/23 £m's	Cash Plan Month 08 £m's	Cash Balance Month 08 £m's	Cash Variance Month 08 £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	20.9	8.9	19.9	17.1	(2.8)
Derbyshire Community Health Services	37.3	29.1	29.8	0.8	34.1	35.2	1.2
Derbyshire Healthcare	53.9	28.2	41.1	12.9	23.7	23.7	0.0
EMAS	18.2	21.0	33.5	12.5	13.7	13.7	0.0
University Hospital of Derby and Burton	48.4	39.4	42.2	2.8	35.6	33.4	(2.2)
JUCD Total	178.0	129.6	167.5	37.8	127.0	123.2	(3.8)

The probable cash balances are forecast below, and this table takes into account the risks in the position and the possibility that cash releasing efficiencies will not be achieved. In this table the cash amounts for CRH and UHDB include an assumption that applications, as per the national process, for cash support for quarter four will be successful.

Table 7.2 *Month by Month Cash Forecast*

Month 08 Position Organisation	December £m's	January £m's	February £m's	March £m's
Chesterfield Royal Hospital	18.5	17.1	17.1	17.1
Derbyshire Community Health Services	30.6	28.2	27.1	32.2
Derbyshire Healthcare	36.7	32.4	28.0	23.7
East Midlands Ambulance Service	31.6	30.1	28.8	21.3
University Hospitals of Derby And Burton	9.7	5.4	5.6	5.6
JUCD Total Surplus/(Deficit)	127.1	113.2	106.6	99.9

The ICB is also likely to require and estimated £30m more cash than the limit it was given at the start of the year. This is due to the amount of non-recurrent balance sheet and other flexibilities used in achieving the 2023/24 financial position. NHSE have been informed of the situation.

8. Recommendations

The Board are asked to **NOTE**:

- The variance to plan at the end of month eight.
- The risks driving most likely and worse case forecast positions that requires urgent action to mitigate, that must be driven by the Boards of each JUCD organisation.
- The remaining gap on efficiency plans and the need to go further to mitigate operational risks.
- The cashflow problems facing the ICB and acute providers.
- Forecast overspends on capital.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th January 2024

Item: 127

Report Title	University Hospitals of Derby and Burton Foundation Trust Maternity Care Assurance Report
Author	Sarah Noble, Director of Midwifery, UHDBFT Guy Tuxford, Interim Divisional Director, UHDBFT
Sponsor (Executive Director)	Stephen Posey, Chief Executive Officer, UHDBFT Dean Howells, Chief Nursing Officer, DDICB
Presenter	Stephen Posey, Chief Executive Officer, UHDBFT Dean Howells, Chief Nursing Officer, DDICB
Paper purpose	Decision ☐ Discussion ☒ Assurance ☐ Information ☐
Appendices	Appendix 1 – University Hospitals of Derby and Burton Foundation Trust Maternity Care Assurance Report
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 University Hospitals of Derby and Burton Foundation Trust Maternity Care Assurance Report.

Purpose

This report provides an update on the current situation with regard to maternity services at the University Hospitals of Derby and Burton (UHDB). The report provides a brief overview of the recent history within maternity care at UHDB; updates on existing challenges, including the recent CQC inspection; describes the improvements being targeted and the approach to delivery.

Background

UHDB maternity services had experienced a cluster of maternal deaths and an increased number of "near misses" between June 2021 and August 2022. In response, the Trust proactively requested an independent learning review into seven serious maternal incidents; in addition to the standard internal governance investigations. Derbyshire Integrated Care System (ICS) accepted the request and commissioned the Healthcare Safety Investigation Branch (HSIB), now known as the Maternity and Newborn Safety Investigation Programme (MNSI), to conduct the review to support open and transparent learning, HSIB published their independent thematic report in February 2023. A further thematic review was commissioned by the Trust in March 2023 to look back at all perinatal deaths reviewed using the national Perinatal Mortality Review Tool (PMRT) between January 2020 and March 2023. Supplementary to this, the Trust was inspected by the Care Quality Commission in Summer 2023, and was subsequently rated as Inadequate within the domains of Safe and Well Led.

Derby and Derbyshire Integrated Care Board

Report Summary
This report summarises the background and context of the status of the Maternity Service at UHDB, as well as key operational challenges that are prevalent within the service and important in contextualising the current position with ensuring Quality and Safety, with particular attention to Perinatal Mortality. The report will highlight findings from recent investigation reports and the CQC inspection which occurred in 2023. The report articulates what interventions the Trust is making in terms of improving outcomes including an appraisal of the support received from the NHS England Maternity Safety Improvement Programme, as well as steps being taken within the Trust to progress the Maternity and Neonatal Improvement Programme which was commissioned within the Trust in Spring 2023.

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**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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**

<table>
<tr><td colspan="5">Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable</td></tr>
<tr><td>Yes ☐</td><td>No☐</td><td>N/A☒</td><td>Risk Rating:</td><td>Summary:</td></tr>
<tr><td colspan="5">Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable</td></tr>
<tr><td>Yes ☐</td><td>No☐</td><td>N/A☒</td><td colspan="2">Summary:</td></tr>
</table>

<table>
<tr><td colspan="4">Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:</td></tr>
<tr><td>Better health outcomes</td><td>☒</td><td>Improved patient access and experience</td><td>☐</td></tr>
<tr><td>A representative and supported workforce</td><td>☐</td><td>Inclusive leadership</td><td>☐</td></tr>
<tr><td colspan="4">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?</td></tr>
<tr><td colspan="4">Not applicable to this report.</td></tr>
</table>

<table>
<tr><td colspan="6">When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?</td></tr>
<tr><td>Carbon reduction</td><td>☐</td><td>Air Pollution</td><td>☐</td><td>Waste</td><td>☐</td></tr>
<tr><td colspan="6">Details/Findings
Not applicable to this report.</td></tr>
</table>

Appendix 1 – University Hospitals of Derby and Burton Foundation Trust Maternity Care Assurance Report

1. Purpose

This report provides an update on the current situation with regard to maternity services at the University Hospitals of Derby and Burton (UHDB). The report provides a brief overview of the recent history within maternity care at UHDB; updates on existing challenges, including the recent CQC inspection; describes the improvements being targeted and the approach to delivery.

2. Background and Context

High profile investigations into failures in maternity care such as the two Ockenden reports in December 2020 and March 2022, East Kent and others, have highlighted the importance of identifying and addressing thematic patterns in the quality of care and in using incidents and near-misses to better identify opportunities for learning. In response, there has been a significant and sustained focus on improving the quality of maternity services across England.

Between June 2021 and August 2022, UHDB maternity services had experienced a cluster of maternal deaths and an increased number of "near misses". In response, the Trust proactively requested an independent learning review into seven serious maternal incidents; in addition to the standard internal governance investigations. Derbyshire Integrated Care System (ICS) accepted the request and commissioned the Healthcare Safety Investigation Branch (HSIB), now known as the Maternity and Newborn Safety Investigation Programme (MNSI), to conduct the review to support open and transparent learning. HSIB published their independent thematic report in February 2023. A further thematic review was commissioned by the Trust in March 2023 to look back at all perinatal deaths reviewed using the national Perinatal Mortality Review Tool (PMRT) between January 2020 and March 2023. The final report was received in December 2023, further details will be shared later in this report.

UHDB also commissioned a diagnostic report from the NHSE Maternity Improvement Team which was received in February 2023. Although there were several recommendations, no immediate safety actions were identified. The Trust did not meet the entry criteria for the intensive support programme, however, recognising the pace of improvement required, made a request to the regional Chief Midwifery Officer (CMO) to be considered for entry onto the maternity safety support programme (MSSP) on a voluntary basis. This was so support and expertise could be accessed in a more formal and structured way. This was accepted and formal voluntary entry to the programme was notified to the organisation in May 2023. Midwifery and Obstetric Improvement Advisors (MIAs) from the MSSP were allocated and have been working with the Trust since the early part of last year. This has been valuable in supporting the Division in developing the Maternity and Neonatal Improvement Programme (MNIP).

On the 15 and 16 August 2023, the Trust was inspected by the Care Quality Commission at Royal Derby Hospital (RDH) and 22 August 2023 at Queens Hospital Burton (QHB). UHDB was subsequently rated inadequate for Safe and Well Lead; following the inspection the Trust was issued with enforcement notices under Sections 31 and 29A of the Health and Social Care Act 2008 in which conditions were placed on the Trust's registration as a service provider in respect of a regulated clinical activity. In response to the Section 31 regulation, the Trust submitted an action plan detailing the immediate, short and medium-term actions on the 31 August 2023 and progress against both enforcement notices are detailed later in this report.

3. Current Challenges

Midwifery staffing

The ability to recruit and retain midwives has been a significant challenge for UHDB in recent months. However, following a significant recruitment campaign, the position has improved significantly in the last quarter of this financial year from a vacancy rate of 12% to 3.97% with a further 25 midwives due to start between January and March 2024, with leavers taking the vacancy to <1% based on the last Birth Rate Plus (BRP) safe midwifery staffing recommendations from 2021. The new BRP review has commenced in quarter 4, with the findings anticipated at the end quarter 1 2024/25.

International recruitment has played a significant role in the recovery of the necessary workforce. Of the initial cohort of 12 Internationally Recruited Midwives (IRM), recruited in 2023, two are working as Registered Midwives, six have passed their OSCE and are awaiting NMC registration and remaining colleagues are due to take their OSCE's in the coming weeks. A further cohort of 12 IRM arrived on the 20 November 2023 and their OSCE training is planned for January 2024. A review is currently underway with the practice development midwives in terms of the current level of support and supernumerary status of the IRM to ensure they receive the correct level of education, support, development, and supervision.

As part of the maternity safety case there has been further investment into maternity leadership roles to strengthen the capacity and capability for midwifery leaders. The capacity and capability of midwifery leaders was noted in the CQC findings.

Medical Staffing

The maternity department currently has a significant challenge with non-consultant grade medical staffing levels, particularly at the Royal Derby site. This is driven predominantly by gaps in the allocation of Registrar provided to the service by Health Education East Midlands (HEEM), within a national context of a shortage of Obstetrics and Gynaecology trainees. This challenge is compounded by the fact that, of the registrars that have been allocated to the service for this educational year, a small cohort of these registrars do not participate, or do not participate fully, in on-call duties. This is multifactorial dependant on the individual clinician.

The current position regarding middle grade medical gaps against the on-call roster is a deficit of 6.8 WTE against establishment, an improvement from a deficit of 9.8 WTE doctors in November. This is driven by vacancies against Deanery allocation that the service has been unable to backfill despite repeated attempts to recruit. The Business Unit is conducting another round of interviews for Senior Clinical Fellows on the 23rd and 24th January, however with the withdrawal of the candidate successful in December, it is unlikely that the WTE gaps on the rota will positively change in February and will remain, at best, a 6.8 WTE deficit. The latest trajectory against new starters and recruitment round for the future indicates that the Business Unit can expect to have a full compliment of junior medical staff in post and on the emergency rota by April 2024. However, this is on the basis that in that period of time, the service does not receive any more resignations, which may happen as some senior trainees fall in scope of qualifying for Certification of Completion of Training (CCT) in the early part of the year.

A consequence of this shortfall is the requirement for consultant colleagues to fill rota gaps in order to ensure that there is sufficient doctor cover to maintain safe staffing levels. This impacts on the availability of those consultants on subsequent days.

4. Clinical outcome indicators

The monitoring and improvement of clinical outcomes is naturally a high priority for UHDB. The *MBRRACE –UK Perinatal Mortality Surveillance report for 2021: State of the Nation report*, was published in September 2023.

The key headlines from this report identify the stillbirth rate increased from 3.3 (2020) to 3.54 per 1000 births and the neonatal mortality increased from 1.53 (2020) to 1.65 per 1000 live births, and perinatal mortality increased from 4.85 live births to 5.19 per 1000 in the United Kingdom.

The Trust's perinatal mortality rates per 1,000 births is identified in Table and Chart 1, which show an overall downward trend for the last 6 months falling from 7.13 per 1,000 births in May 2023 to 5.54 in October 2023 before an increase to 6.03 per 1,000 births in November 2023.

Table 1: Trust perinatal mortality rates per 1,000 births

UHDB Perinatal Mortality Rate Per 1,000 Births	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
National Perinatal Mortality Rate	4.86	4.86	4.86	4.86	4.86	4.86	4.86	4.86	4.86	4.86	4.86	4.86	5.19	5.19
12 Month Rolling Rate	5.59	5.75	6.26	6.36	6.65	7.26	7.68	7.34	7.13	6.69	6.20	5.86	5.54	6.03

Chart 1: Trust perinatal mortality rates per 1,000 births

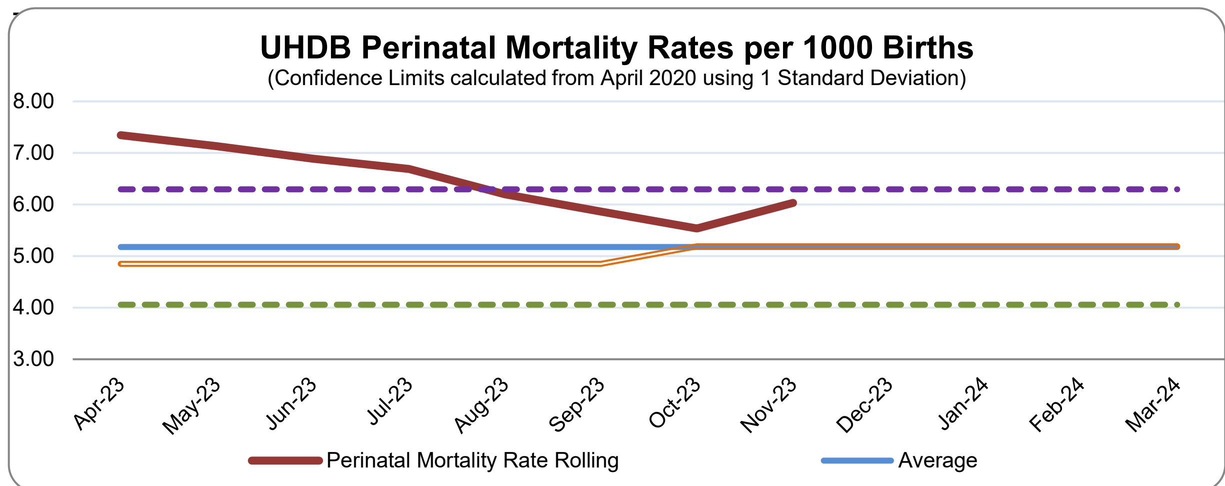


Table 2 and Charts 2 and 3 illustrate the constituent components that are driving the Trusts Perinatal Mortality rates

Table 2: Trust Stillbirth and Neonatal rate per 1000 births

UHDB	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Extended Perinatal Mortality Rate	7.34	7.13	6.89	6.69	6.20	5.86	5.54	6.03
Total Loss - Stillbirth and Neonate	5	5	4	5	0	1	3	8
Stillbirths (number in month)	3	4	3	4	0	1	1	8

Stillbirth Rate per 1000 births	5.2	4.98	4.98	5.0	4.64	4.41	4.08	4.8
Neonatal Deaths (number in month)	2	1	1	1	0	0	2	0
Neonatal Mortality Rate per 1000 births	2.14	2.14	1.9	1.68	1.55	1.44	1.44	1.21

Chart 2: Trust Stillbirth and Neonatal rate per 1000 births

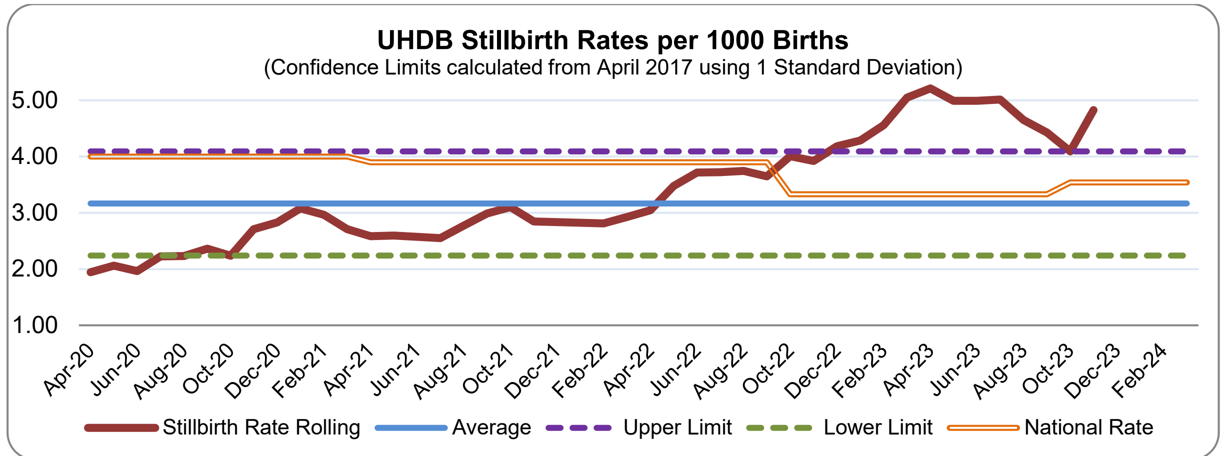
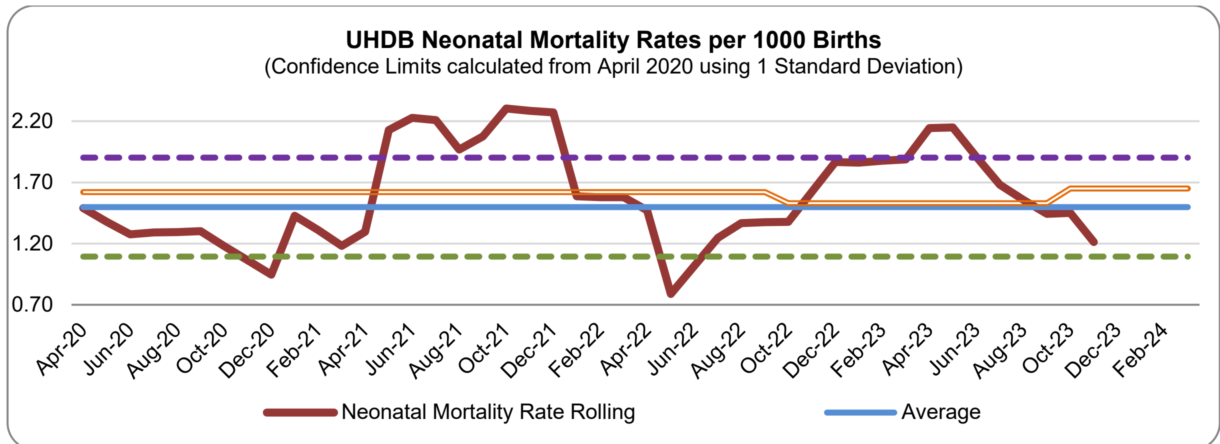


Chart 3: Trust neonatal mortality rate per 1000 births



The stillbirth rate remains high despite some improvement seen in recent months.

Significant work through the Maternity and Neonatal Improvement Programme, where Fetal Monitoring is a priority 1 scheme, is currently underway and being embedded into practice to improve clinical outcomes. This includes improved fetal surveillance where audits demonstrate an improvement in the national standard of hourly fresh eyes compliance, and an improvement in fetal monitoring training compliance which was 85.5% in December.

UHDB recognise that a disproportionate number of stillbirths are linked to non-English speaking mothers, reflecting the national trend. Further work around addressing inequalities in maternity care will be further supported by the Consultant Midwife when they come into post at the end of February 2024.

Further, the Continuity of Carer teams for QHB and RDH are focused on improving care and communication with service users from areas of high deprivation acknowledging the link to ethnicity frequently encountered with this work. As an example, all patient information leaflets

are now translated into the top five languages to aid the vital communication with all patients. A Public Health matron has also joined the maternity team with a developing portfolio of work alongside colleagues in the ICB.

The maternity service are further working with the National Measurement Team to improve how maternity data is analysed and presented to recognise trends at the earliest opportunity.

5. Care Quality Commission Update

As mentioned in Section 2 of this report, the Trust had a maternity service inspection conducted by the Care Quality Commission on the 15 and 16 August 2023 at Royal Derby Hospital (RDH) and 22 August 2023 at Queens Hospital Burton (QHB). The Trust was issued enforcement notices under Sections 31 and 29A of the Health and Social Care Act 2008 and has developed an action plan to discharge the enforcement notices as soon as possible.

The action plan detailed the actions the maternity service is taking in response to fetal monitoring, post-partum haemorrhage (PPH), major obstetric Haemorrhage (MOH), levels of essential to role training compliance in relation to professional obstetric multidisciplinary training (PROMPT) and fetal monitoring, and senior midwifery support in relation to leadership capacity and capability.

The Trust is required to update the CQC regarding the requirements of the Section 31 regulated activity on the last Friday of each month. The trust has submitted updates in line with this requirement.

Areas requiring significant improvement identified in the Section 29A warning notice are detailed in table 3. The requirement was to identify significant improvements in the areas below by the 15 December 2023. The trust submitted a Section 29A action plan to the CQC on the 14 December 2023.

Table 3: Overview of the significant areas for improvement identified in the Section 29A warning notices for RDH and QHB.

Section 29 A	RDH	QHB
Areas of significant improvement required identified	• Safe staffing of the senior midwifery on-call rota • Safety and effectiveness of processes for learning from incidents • Lack of up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. • Effectiveness of governance and risk management processes	• Triage Processes • CTG Monitoring • PPH • MOH • Emergency pool evacuation • Accuracy and effective use of data • Effectiveness of governance and risk management processes

On the 29 November 2023 the CQC reports for QHB and RDH were published in which included an outcome of inadequate for safe and well led for maternity services for both sites.

Within the reports, there were 11 `must do` and 2 `should do` actions for the RDH site and 10 `must do` and 1 `should do` actions for QHB. Some of these duplicated actions already identified through the Section 31 and 29A notices.

Table 4 summarises the CQC actions from the notices and report. This details there was a total of 214 actions identified, with 138 of these actions duplicated, resulting in a total of 76 distinct actions being identified.

Table 4: Overview of the CQC actions as of the December 2023

CQC Areas	Actions Identified	Duplicate Actions	Total Actions
Section 31 RDH	20	0	20
Section 29 RDH	27	27 Duplicate Actions (4 Section 31 and 23 Section 29 QHB)	0
Section 29 QHB	52	25 Duplicate Actions (17 Section 31 RDH and 8 Section 29 QHB)	27
Final Report RDH	45	29 Duplicate Actions (16 Section 29 QHB and 13 Section 31 RDH)	16
Final Report QHB	70	57 Duplicate Actions (24 Section 29 QHB and 33 Section 31 RDH)	13
Total	**214**	**138**	**76**

Table 5 provides an overview of the action summary from early January 2024. This identifies that of the 76 actions, 44 have been completed and 32 remain on track.

Table 5: Overview of CQC Actions as of January 2024

CQC Overview	ACTION SUMMARY AT 05.01.2024		
	Alert	**Advise**	**Assure**
	Outstanding	On track	Complete
	0	**32**	**44**

A Maternity CQC response group was set up in September 2023, chaired by the Chief Executive Officer of UHDB. This group oversees the action plan that has been put in place and takes assurance from the Women's and Children's Division that progress is being made and actions are being delivered and sustained in line with the enforcement conditions imposed on the trust.

6. Nursing and Midwifery Council (NMC) update

In view of the recent CQC ratings the NMC conducted an anticipated monitoring visit, which is expected to be one of four, in relation to the practice environment for midwifery students placed within the Trust and this took place on the 12 to the 14 December 2023. The first of these monitoring visits was undertaken with Nottingham University. The NMC visited both QHB and RDH maternity areas to ascertain "*is this a safe learning environment*". The result was that Nottingham University and UHDB as a partner met all the requisite NMC standards. The report is anticipated to be in the public domain in April 2024. A significant amount of continuous work goes into providing an excellent experience for students and the teams deserved the recognition of this exemplary practice.

The Trust has developed a collaborative partnership with all 4 Approved Education Institutions who place pre-registration midwives at UHDB for the practice component of their degree. UHDB have developed a standardise approach to supporting pre-registration students in practice in accordance with the NMC standards. As the NMC regulates academic institutions and not provider trusts it is anticipated due to the CQC rating and individual exception reports raised that all 4 AEI's will be inspected by the NMC.

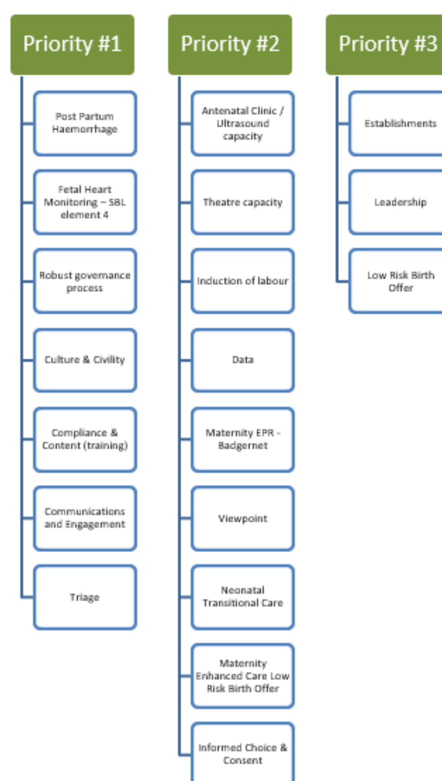
Derby University is scheduled to visit between the 5 and 8th March 2024.

7. Maternity and Neonatal Improvement Programme

In Spring 2023, before the CQC inspection, and in response to the national and local reports and recommendations, the HSIB investigation, and with the support of the NHSE colleagues from the Maternity Safety Support Programme, the Trust initiated a Maternity and Neonatal Improvement Programme (MNIP).

The programme is substantial and includes a range of projects which have been prioritised given the significant resource each one requires. The following diagram outlines the projects being developed and shows the scale of the programme.

Chart 4: Maternity and Neonatal Improvement Programme summary



The programme is governed by a Maternity Improvement Group (MIG) and an executive-led Maternity Oversight Group (MOG) which reports to the Trust's Quality Assurance Committee and the Trust Board.

The themes covered by the projects, and particularly those identified as priority 1, align with those identified in the CQC inspection feedback and report. Engagement from staff is positive with a genuine willingness to improve being demonstrated. The inclusion of Maternity and Neonatal

Voices Partnership (MNVP) representatives on the appropriate groups is being actively discussed so that improvements are both visible to, and created with, service users.

8. Culture and Safety

Culture

A particular feature of the programme and one of the priority 1 projects focuses on 'culture and civility'.

This was identified as a high priority following reference to cultural issues in the HSIB and CQC reports. This project is committed to understanding and improving the culture in the department with a high-level aim to 'to create a compassionate and inclusive culture within the Maternity and Neonatal Services and supporting teams where all staff are treated with kindness and compassion and feel valued irrespective of their role'.

Engagement with this project is really positive with broad engagement from maternity, neonates as well as partners from theatres, anaesthetics and ultrasound. Thus far, the group has reviewed data from a variety of sources including the staff survey and junior doctor training feedback with further sources of intelligence imminent including the SCORE national maternity and neonatal culture survey, due in February 2024, and Improving Performance in Practice (IPIP) commissioned by Derbyshire LMNS. The department also meet regularly with the Freedom to Speak Up (FTSU) team within the Trust to ensure that concerns are being addressed quickly and appropriately but also to enhance the understand of how it's feeling for colleagues working in our teams.

The project group are currently identifying priority issues impacting staff groups across all sites and face-to-face workshops are being arranged to raise the profile of this initiative, discuss behavioural expectations and develop a team charter which will underpin the Trust's ambition around culture.

More broadly, this month UHDB have launched a new Compassionate and Inclusive Leadership Programme, which all senior leaders within in the organisation have been invited to attend. This course provides a framework for how we do things as leaders, from how we behave to how hold ourselves and others to account, and how we set the priorities we are driving forward for our birthing families and colleagues. The programme will also include 'improvement training', which will cover key tools and techniques but, more importantly, the mindset and way of thinking that facilitates and encourages improvement.

As leaders within maternity services and the wider Women's and Children's Division, there is the commitment and determination to ensure that any cultural issues are understood and addressed so that the culture we lead and work within amongst our teams aligns with the values we sign up for when we work for the NHS.

The CQC rating of inadequate, accepted with humility, has been hard hitting and the impact both on staff and families accessing our service must be continually considered and assessed. A constructive working relationship with the CQC, before publication of the report, enabled UHDB to prepare an effective communication and engagement strategy with maternity stakeholders and helped deliver very difficult messages kindly and compassionately and to date there has been no formal concerns raised by any member of the public or service users. Whilst the serious concerns are recognised and the necessary improvements are pursued vigorously, there is a balance to be struck with recognising that most mothers and babies that access UHDB services have a safe and positive experience.

As an example, the positive feedback below was received on 10th January 2024.

"My daughter has been on ward 11, labour, delivery and then neonatal wards. How can you possibly receive a grading of special measures. The staff on these wards work so hard and are so lovely and personal you all helped and supported my daughter and grandson over the days spent at Burton hospital. How dare any politician dumb down the staff and care provided. I feel so outraged at your rating I will contacting my local politician. The fact that staff have to beg for better pay when you see what they do is disgraceful. Please pass this onto the staff of the mentioned wards that they are amazing and very professional, outstanding actually not special measures."

Learning from Incidents

This is a key feature of the improvement work that the department is undertaking and 'Robust Governance' is one of the priority 1 projects within the Maternity Improvement Programme. This project is reviewing the governance structure for the Women's and Children's Division which includes for maternity how risk and incidents are investigated and managed, individually and thematically.

As this project develops, there are specific actions that have been taken to improve processes in this regard. These include:

- weekly teaching meetings for Doctors with this time protected for case learning/feedback;
- learning on a page feedback for individual cases;
- a mandatory Midwifery Study Day for local learning feedback session with midwifery staff from the risk team commences in January and will run monthly;
- the Maternity Quality and Safety Study day provides an annual update to midwifery staff with case scenarios presented;
- the PROMPT and mandatory study day curriculum is based on real cases that have been provided through the risk review process

This will continue to be a priority improvement area for the department in 2024.

9. Recommendations

The Board is asked to note the current position of maternity services at UHDB and the breadth and structure in support of the safety, efficiency and experiential improvements being planned.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th January 2024

Item:128

Report Title	Audit and Governance Committee Assurance Report – December 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 – 11th December 2023

Recommendations

The ICB Board is recommended to **NOTE** the Audit and Governance Committee's Assurance Report for December 2023.

Items to escalate to the ICB Board

Please refer to the report.

Purpose

This report provides the Board with a brief summary of the items transacted at the meeting of the Audit and Governance Committee on the 11th December 2023.

Background

The Audit and 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 and 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**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
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.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Any risks highlighted and assigned to the Audit and 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	☒

<table>
<tr><td colspan="2">A representative and supported workforce</td><td>☐</td><td colspan="2">Inclusive leadership</td><td>☐</td></tr>
<tr><td colspan="6">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?</td></tr>
<tr><td colspan="6">There are no implications or risks which affect the ICB's obligations under the Public Sector Equality Duty.</td></tr>
<tr><td colspan="6">When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?</td></tr>
<tr><td>Carbon reduction</td><td>☐</td><td>Air Pollution</td><td>☐</td><td>Waste</td><td>☐</td></tr>
<tr><td colspan="6">Details/Findings
Not applicable to this report.</td></tr>
</table>

Appendix 1

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Audit & Governance Committee – 11th December 2023

Matters of concern or key risks to escalate	Decisions made
1. The Committee received 2 limited assurance reports from Internal Audit: a. Mental Health Act Assessment Claims – where the ICB needs to agree a more robust validation process with the local authorities who hold the source information. b. Data & Performance Management – which concluded that 'the ICB does not currently have a formally documented and approved performance management framework in place setting out the reporting structures and accountabilities for performance management and data quality across Board and Committee levels. It also does not have up to date and relevant data quality guidance in place setting out how the quality of data it receives from organisations within the system and its own internally generated data is assured.' Action has been agreed to address the recommendations made but recognising the need to ensure that the new organisational structures are in place the agreed date for implementation is not until April 2025. To ensure that impetus is maintained in this important area we have requested interim milestones are identified. 2. The Internal Audit progress report also highlighted a decrease in the timeliness of implementing Internal Audit recommendations. Whilst we recognised that in part this is due to the low number of recommendations, we also note the potential impact on our Head of Internal Audit option. It was agreed that a reminder as to the importance of timely implementation of agreed actions and the importance of agreeing realistic timescales for implementation in the first place, would be appropriate.	1. We approved the following procedures & plans: a. Sight test procedures for display screen equipment users b. Incident response plan c. Adverse weather plan

Appendix 1

Derby and Derbyshire
Integrated Care Board

<table>
<tr><th>Major actions commissioned or work underway</th><th>Positive assurances received</th></tr>
<tr><td>1. The Committee noted the update regarding the deep dive into procurement following the concerns raised in October. This is a significant programme of work that needs to be delivered at pace and we agreed that this needed to be a standing item on the agenda until the work is complete. In addition:
a. We received a useful update on the implementation of the new provider selection regime that comes into effect from January 2024
b. We noted with concern that 310 contracts are due for renewal before the end of March 2024, whilst many of these are in hand the team are reviewing the feasibility of delivering all of this work and the associated potential consequences.
2. We received an update on the organisational restructure arrangements and progress to date.</td><td>1. Received internal audit progress report
2. Received the annual EPRR and Business Continuity report detailing amongst other things the testing undertaken and lessons learnt as a consequence.
3. Received the ICB Corporate Risk Register report and the risks responsible to the Audit and Governance Committee.
4. Received assurance from reviewing the regular reports on:
a. Mandatory training compliance
b. Equality, Diversity and Inclusion – noting the concerns raised by the networks around culture and agreed to link this into the Building Leadership for Inclusion initiative that is currently underway with the Board
c. Losses and special payments, aged debt & write offs
d. Single tender waivers
5. Considered the effectiveness of the current committee particularly with regard to the Terms of Reference, membership, sub group structure and forward planner. Noting the relatively recent restart to the EPRR assurance group we were satisfied that no changes were necessary at this point in time.
6. Received the Month 7 financial position review along with an update on the most current position. We noted all the action that is being taken to address the financial challenges that we face along with the ongoing uncertainty around the impact of further industrial action.</td></tr>
<tr><th colspan="2">Comments on the effectiveness of the meeting</th></tr>
<tr><td colspan="2">We had a good discussion around the key items on the agenda with positive actions agreed as a consequence.
We also agreed that now that the EPRR assurance group is operational again, they can review the detailed testing results and their summary report will provide the committee with the assurance required.</td></tr>
</table>

Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th January 2024

Item: 129

Report Title	Finance, Estates and Digital Committee Assurance Report – November and December 2023
Author	Jill Dentith, Non-Executive Member for Finance, Estates and Digital
Sponsor (Executive Director)	Keith Griffiths, Chief Finance Officer
Presenter	Jill Dentith, Non-Executive Member for Finance, Estates and Digital
Paper purpose	Decision ☐ Discussion ☐ Assurance ☒ Information ☐
Appendices	Appendix 1 – Committee Assurance Report (November) Appendix 2 – Committee Assurance Report (December)
Assurance Report agreed by:	Jill Dentith, Non-Executive Member for Finance, Estates and Digital
Which committee has the subject matter been through?	System Finance, Estates and Digital Committee – 28th November and 19th December 2023

Recommendations

The ICB Board is recommended to **NOTE** the System Finance, Estates and Digital Committee Assurance Report for November and December 2023.

Items to escalate to the ICB Board

The Board need to be aware of the significant financial challenges the Derby and Derbyshire system is facing. Appendices 1 and 2 provide details.

Purpose

This report provides the Board with a brief summary of the items transacted at the meeting of the System Finance, Estates and Digital Committee on the 28th November 2023 and 19th December 2023.

Background

The System Finance, Estates and Digital Committee ensures that the ICB effectively delivers the statutory functions of the ICB.

Report Summary

The System Finance, Estates and Digital Committee's Assurance Reports (Appendix 1 and 2) highlight 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**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
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.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

Yes ☒	No☐	N/A☐

Details/Findings
Cost containment is immensely challenging over the pressured winter period and during a period of industrial action.

Has this been signed off by a finance team member?
Keith Griffiths, Chief Finance Officer

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:**

<table>
<tr><td colspan="6">Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:</td></tr>
<tr><td colspan="2">Better health outcomes</td><td>☒</td><td colspan="2">Improved patient access and experience</td><td>☒</td></tr>
<tr><td colspan="2">A representative and supported workforce</td><td>☒</td><td colspan="2">Inclusive leadership</td><td>☒</td></tr>
<tr><td colspan="6">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?</td></tr>
<tr><td colspan="6">By responding to the national ask to focus on UEC, Cancer and critical elective services there is a risk that health in equalities could be affected. The ICB and partners are continually assessing this to best mitigate any unintended consequences</td></tr>
<tr><td colspan="6">When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?</td></tr>
<tr><td>Carbon reduction</td><td>☐</td><td>Air Pollution</td><td>☐</td><td>Waste</td><td>☐</td></tr>
<tr><td colspan="6">Details/Findings
Not applicable to this report.</td></tr>
</table>

Appendix 1

Derby and Derbyshire
Integrated Care Board

Board Assurance Report

Finance, Estates and Digital Committee – 28th November 2023

Matters of concern or key risks to escalate	Decisions made
The majority of the meeting focused on the system response to the letter from NHS England date 8th November 2023. This letter provided clarity on the funding and actions necessary to manage the financial and performance pressures created by industrial action. This was followed by operational guidance, which explained the specific requirements of the rapid two-week exercise that ICBs and Trusts were asked to undertake in the letter. The exercise was focused on confirming existing plans that Trusts and the ICB have developed and agreed with NHS England, on the assumption that there are no further junior doctor or consultant strikes. Boards were asked to confirm a submission by 22 November and further work was required for a submission on 28 November 2023, following the SFEDC meeting. This work has confirmed a deficit position in relation to the system and within all of our provider Trusts (EMAS excepted). Work continues across the system to try to mitigate the risks and present a better financial position. It is therefore a matter of concern to escalate to the ICB. It should be noted that the predicted deficits had repeatedly been reported publicly (nationally as well as locally) and is a chance to open a dialogue with the national team regarding the additional costs driven by the industrial action and inflation. Critically, the approach being taken focuses on workforce growth and productivity as these drive the costs. Equally, the national team have asked all systems to prioritise UEC, Cancer, and critical elective services over the winter. Accordingly, our approach to this 'financial reset' is to ensure full triangulation across COO's, HRD's and CFO's. It was noted that the national Finance team are meeting with all systems across the country post submission but no date has been confirmed yet for the Derby/ Derbyshire system.	Considering the discussion around the current financial position for the system the risks on the Risk Register and Board Assurance Framework (BAF) relating to SFEDC have been reviewed and the risk scores amended accordingly. These scores will be shared with the Board under the risk and BAF papers.

Appendix 1

Derby and Derbyshire
Integrated Care Board

Major actions commissioned or work underway	Positive assurances received
	The detailed triangulation between operational, workforce and finance directors was acknowledged and demonstrates a good level of knowledge of our position / challenges.

Comments on the effectiveness of the meeting
Although this meeting focused on the financial submission and associated risks there was constructive participation from all those present and a shared ambition to get to an improved financial position for both individual organisations and the wider system.

Appendix 2

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Finance, Estates and Digital Committee – 19th December 2023

Matters of concern or key risks to escalate	Decisions made
Finance and Operational Reset 2023/24 – the Committee discussed details of the latest submission to NHSE of the forecasted system position of a £47.3m deficit. The Committee noted a range of risks to this position, not least the possibility of further industrial action and the impact of the national Health Care Support Worker pay dispute, which if paid in year would add a further c£10m to the above. A meeting with the national team took place on 6th December where the £47.3m was shared. To date no formal response has been received so the working assumption is that the system will have a £47.3m deficit on 31 March 2024. The collective Month 9 reports will now reflect this year end out turn position. **Cash** - The system's reported annual cash flows reflect the expected delivery of cash-releasing efficiencies. The in-year cashflow will be significantly impacted if they do not occur. Several organisations in the system are likely to require more cash than the Cash Limit they were given at the start of the year due to the amount of non-recurrent balance sheet and other flexibilities used. **Workforce** – Delivery of the £47.3m deficit is dependent upon no growth in the workforce (except Mental Health) alongside a reduction in bank and agency spend. This has been agreed by each organisation but will need to be monitored in the light of the industrial action.	**Risk Register** – agreed the increase in risk score for Risk 6 to a score of 20 (5x4) and the reduction in risk score for Risk 22 to a score of 20 (4x4). (DG) **BAF** – agree the increase in risk score for strategic risk 4 to a score of 20. (DG)
Major actions commissioned or work underway	**Positive assurances received**
The Derbyshire Shared Care Record (DSCR) - is a confidential secure computer record. The DSCR is available now and can be accessed from a host system via a single sign on. All records are accessible by default with implied consent and is 'read only' at this point. The system will eventually be read/write.	**Efficiency** - The system efficiency delivery is £1.2m ahead of plan year to date. However, it should be noted that this is split into £18.6m behind plan on recurrent efficiencies and £19.8m over plan on non-recurrent efficiencies. Unless planned levels of recurrent efficiencies

<table>
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System Transformation and Efficiency – the Committee had commissioned a summary report which was well received. The programme RAG rating approach is new and is subject to further validation and discussion with programme leads.

Elective Recovery Fund – the position in relation to cross boarder issues remains. In addition, JUCD performance will be affected by industrial action and / or winter pressures, meaning projected income levels may not be achievable if the current national financial regime for elective activity remains. It was agreed that a report for the February 2024 meeting would be produced reflecting on the 2023/24 position in relation to productivity, whilst also considering the 2024/25 forecast position. (SC)

Workforce returns – a report was requested for presentation at the January 2024 meeting relating to the new workforce returns and in relation to sickness and absence rates. (LG)

Distribution of £12m central monies – On the assumption that the £47.3m year end forecast is unlikely to change, the CFO's will now be meeting to agree the distribution of the additional monies across organisations. This will not reduce the £47.3m, as this money has already been factored in, but it will alter the year end targets for some organisations when compared against the current reported positions.
</td><td>
can be delivered, it will impact in future years. This is a therefore a risk to the system.

Estates – work progresses with development of the system estates strategy. This is taking account of pace of change and cash releasing efficiencies. An update on the RAAC position was broadly positive with further work with primary care estates to understand the full picture.

Digital programme update – a range of digital projects are in hand, but issues regarding national funding streams can be challenging in terms of timescales.

Working together – although there have been challenges agreeing the current system position relating to finance and activity constructive relationships have been developed and strengthened between colleagues in finance, workforce and operations.
</td></tr>
<tr><td colspan="2">Comments on the effectiveness of the meeting</td></tr>
<tr><td colspan="2">The meeting was well attended with those present confirming and challenging information provided and supporting those working on delivery of this challenging agenda.</td></tr>
</table>

Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

PUBLIC SESSION

18th January 2024

Item: 130

Report Title	Quality and Performance Committee Assurance Report – November 2023
Author	Jo Hunter, Director of Quality
Sponsor (Executive Director)	Dean Howells, Chief Nursing Officer
Presenter	Dr Adedeji Okubadejo, Clinical Non-Executive Member and Chair of Quality and Performance Committee
Paper purpose	Decision ☐ Discussion ☐ Assurance ☒ Information ☐
Appendices	Appendix 1 – Committee Assurance Report
Assurance Report Signed off by Chair	Dr Adedeji Okubadejo, Non-Exec Director and Chair of Quality and Performance Committee
Which committee has the subject matter been through?	Quality and Performance Committee – 30th November 2023

Recommendations

The ICB Board are recommended to **NOTE** the Quality and Performance Committee Assurance Report for November 2023.

Purpose

This report provides the Board with a brief summary of the items transacted at the Confidential session of the Quality and Performance Committee on 30/11/23. 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.

Background

This report provides the Board with a brief summary of the items transacted at the meeting of the Quality and Performance Committee on 30th November 2023.

Report Summary

The System Quality and Performance 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**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
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.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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	☒	Inclusive leadership	☐
A representative and supported workforce	☐	Improved patient access and experience	☒

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.

Appendix 1

Derby and Derbyshire
Integrated Care Board

ICB Board Assurance Report

ICB Quality and Performance Committee – 30th November 2023

<table>
<tr><th>Matters of concern or key risks to escalate</th><th>Decisions made</th></tr>
<tr><td>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. It must be noted that here is confidence in the role of the LMNS in oversight and assurance.

Other areas of concern are the continued fragility of Primary Care and the high levels of reported Infection Prevention and Control incidents across JUCD.</td><td>The following items were approved by the Group:
• Update on the ongoing concerns relating to Maternity services: UHDB's full maternity CQC inspection was published 29/11/23. The report shows there are significant actions which CQC are required to receive assurance on. CQC are anticipating a full response to the Section 31 and 29 enforcement actions by the 14th of December 2023. ICB colleagues have been working closely with NHSE. It is anticipated that the CQC will not be in a position to visit UHDB to complete a reassessment on progress until the end of summer 2024. Tier 3 assurance meetings between the ICB and NHSE will be in place for the next six months. This is in addition to the LMNS to seek the level of assurance which is required. The Committee agreed that an update will be presented at each Quality and Performance Committee meeting for the next year and that provider colleagues have an opportunity to contribute to that meeting as and when required.
• Public Health, Health Inequalities Deep Dive: The Committee discussed the feasibility of system reporting and what the report should look like. It was agreed that the progress report would be presented at Quality and Performance committee twice per year.</td></tr>
<tr><th>Major actions commissioned or work underway</th><th>Positive assurances received</th></tr>
<tr><td>Deep Dives</td><td>The following papers were presented for assurance:
• Impact of the difficulty to place complex children when admitted via ED
• Board Assurance Framework
• Review of Forward Planner against the Terms of Reference
• Integrated Performance Report</td></tr>
<tr><th colspan="2">Comments on the effectiveness of the meeting</th></tr>
<tr><td colspan="2">Those present agreed that the meeting had been effective, with sufficient opportunity for discussion and that the papers presented were appropriate.</td></tr>
</table>

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th January 2024

Item: 131

Report Title	People and Culture Committee Assurance Report – December 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 December 2023

Recommendations

The ICB Board are 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 December 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 £2.9bn 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**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
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.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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

Derby and Derbyshire Integrated Care Board

Board Assurance Report

People and Culture Committee – 6th December 2023

<table>
<tr><th>Matters of concern or key risks to escalate</th><th>Decisions made</th></tr>
<tr><td>Freedom to Speak Up (FTSU) - There was concern around GPs FTSU arrangements as they were currently receiving funding for a guardian from outside the practices, but this funding was due to end. It was advised the service was being well used but there was a risk that beyond May there will not be that level of assurance and various options were being considered.</td><td>It was decided to place the GPs FTSU risk on the risk register.

The Committee suggested the People Services Delivery Board or the HRDs regular meetings would be the best forums for sharing FTSU ideas and practice.

As there is a link between patient safety and FTSU it was felt beneficial to connect with Chief Nurses or to reach out to the guardian and ambassadors in each organisation who could possibly assist with making those connections. GPs would like to be involved but do not have a Chief Nurse representative.</td></tr>
<tr><th>Major actions commissioned or work underway</th><th>Positive assurances received</th></tr>
<tr><td>Derby City Integration Work, an initiative between Derby City Council and Derbyshire Community Healthcare Services, was presented to members called 'Community First' and set out the one approach and pooling of funding as well as resources to effectively benefit individuals by looking at those services that overlap to get people home from hospital whilst being flexible whether people have health or social care needs.

The Committee agreed the Chairs of the People Committees need to give their assurance that they are looking at workforce costs and activities with the same level of detail as described in the Workforce Plan.

The Committee felt it would be incredibly valuable to carry out a deep dive on drivers of pay spend. Looking at some of the enablers for reducing pay spend, those not to do with finance but more to do with behaviours.</td><td>• With regard to Freedom to Speak Up arrangements to provide assurance, UHDB were developing a reflection tool which will be put into the public domain.
• The Workforce Plan outlined the increased level of scrutiny around agency costs, agency spend and agency usage with a piece of work starting to bring workforce and finance together but with a need to move forward still with the activity side as the driver.
• Temporary Staffing: Significant agency controls have been put in place and we are at M7 starting to see the impact of those changes. Total agency spends in M7 totalled 2.7% of our total pay costs which is 1% under the national target of 3%.</td></tr>
<tr><th colspan="2">Comments on the effectiveness of the meeting</th></tr>
<tr><td colspan="2">The meeting was well attended and generated a lot of discussion covering several topics as well as outlining the interaction taking place with Local Authority colleagues. There were no attendees from EMAS, DHcFT and DHU</td></tr>
</table>

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th January 2024

Item: 132

Report Title	Freedom to Speak Up Update – General Practice
Author	Clive Newman, Director of Primary Care
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer
Presenter	Margaret Gildea, Freedom to Speak Up Guardian
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?	People and Culture Committee

Recommendations

The ICB Board are recommended to **NOTE** the update on the Freedom to Speak Up (FTSU) role in General Practice.

Purpose

To provide an update to the ICB Board on the FTSU role in General Practice, as requested by the ICB Board on the 16th November 2023.

Background

In 2023/24, the ICB provided non-recurrent funding to the GP Task Force (now Hub Plus) to support the GP Task Force (GPTF) to develop and embed the FTSU role within General Practice.

To support this the GP Task Force employed a 0.4WTE FTSU lead on a fixed-term contract. This paper summarises the outcomes to date and next steps.

Report Summary

The GPTF employed a FTSU lead who has worked to deliver a number of key outcomes as follows:

1. raised awareness of the FTSUG role in General Practice;
2. supported Speak Up Champions in their role and provided skills, competence and confidence across a local network within general practice as well as Acute, Community and Regional best practice;
3. scoped the potential FTSUG support system for all of Primary Care in Derbyshire including General Practice, Optometry, Dentistry and Pharmacy;

4. worked with commissioners and stakeholders to ensure that routes for speaking up are clear, including how issues can be raised, escalated, captured and reported;
5. provided data as a central co-ordinated function within relevant permissions, data protection and GDPR regulations;
6. acted as the FTSU Guardian sensitively supporting Speak Up issues raised, signposting effectively to wellbeing, external support where needed.

In addition, every GP practice received the update from NHSE regarding Lucy Letby and has been able to access support from the GPTF service in regards to policies, processes and listening up cases from any staff member with confidentiality.

Next steps

- The funding was non-recurrent and will come to an end in March 2024. The Hub Plus will be investing to extend the role using their own funds in the short term but will not be able to do this longer term.
- The next steps therefore will be to embed the work within primary care so that individual providers are able to deliver on their statutory obligations, including:
  - more targeted promotion work with management and Partners;
  - working with the NGO to increase resources and specific process/policy for primary care;
  - Hub Plus working with ICB and System partners to bring awareness of leadership behaviours in primary care in terms of good practice and agree escalation routes that are appropriate for Speak Up, leadership and practice culture issues;
  - extending the champion network;
  - continued contact with optometry, dentistry and pharmacy;
  - considering mandated training for FTSU for all Partners, Managers and Staff and Speak Up Policy Audit.

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**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

18th January 2024

Item: 133

Report Title	East Midlands ICB Collaborative Arrangements						
Author	Helen Dillistone, Chief of Staff						
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer						
Presenter	Dr Chris Clayton, Chief Executive Officer						
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information ☒
Appendices	Appendix 1 – ICB Board Briefing, East Midlands ICB Collaborative Arrangements						
Assurance Report Signed off by Chair	N/A						
Which committee has the subject matter been through?	Audit and Governance Committee oversee the transitions arrangements						

Recommendations

The ICB Board are recommended to **NOTE** the attached report.

Purpose

The purpose of the attached report is to brief the Board on the latest developments related to NHSE delegated functions to ICBs.

Background

The East Midland ICBs (Derby and Derbyshire, Leicester Leicestershire and Rutland, Lincolnshire, Northamptonshire and Nottingham and Nottinghamshire) have agreed to collaborate in areas that are most effectively undertaken at scale.

Report Summary

A key operating principle for the collaboration is that working at scale should add value to common goals, whilst retaining local ICB population health sensitivity where appropriate. Distributed leadership across all five members is also a key component.

Scope

The collaborative arrangements cover:

- NHSE delegated commissioning responsibilities to ICBs (pharmacy, optometry, dentistry [PODs])
- Oversight of future NHSE commissioning delegations (including specialised commissioning, vaccinations)
- Other East Midlands-wide commissioning policy (non-specialised, initially assisted reproduction)

- 111 and ambulance commissioning
- Commissioning Committee governance
- Commissioning Support Units
- Strategic partnerships with East Midlands bodies (including Local Government Association, Association of Directors of Adult Social Services, Cancer Alliance, clinical networks)

The paper attached summarises the leadership, governance and hosting arrangements.

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**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
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.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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.					

Appendix 1

ICB Board Briefing

East Midlands ICB Collaborative Arrangements

Purpose and Principles

The East Midland ICBs (Derby and Derbyshire, Leicester Leicestershire and Rutland, Lincolnshire, Northamptonshire and Nottingham and Nottinghamshire) have agreed to collaborate in areas that are most effectively undertaken at scale.

A key operating principle for the collaboration is that working at scale should add value to common goals, whilst retaining local ICB population health sensitivity where appropriate. Distributed leadership across all five members is also a key component.

Scope

The collaborative arrangements cover:

- NHSE delegated commissioning responsibilities to ICBs (pharmacy, optometry, dentistry [PODs])
- Oversight of future NHSE commissioning delegations (including specialised commissioning, vaccinations)
- Other East Midlands-wide commissioning policy (non-specialised, initially assisted reproduction)
- 111 and ambulance commissioning
- Commissioning Committee governance
- Commissioning Support Units
- Strategic partnerships with East Midlands bodies (including Local Government Association, Association of Directors of Adult Social Services, Cancer Alliance, clinical networks)

Leadership and Governance

A tiered committee structure has been established as the mechanism for joint decision making (Appendix 1). Tier 1 is an oversight and strategy setting function, with CEO and Chair membership. Tier 2 undertakes operational commissioning functions and makes most of the commissioning decisions. Although decisions are made jointly, each ICB representative applies local knowledge to the development and approval of decisions. Tier 3 provides subject matter expertise for quality, finance and contracting in support of tier 2 decision making. Tier 3 groups have considerable technical and subject matter expertise.

ICB Boards have delegated POD commissioning decisions to the tiered committee structures, so this function is exercised jointly. ICB Boards can also choose to delegate additional specific decisions to the joint structures. A recent example of this is the outcome of the 111 procurement.

Appendix 1

Hosting Arrangements

Nottingham and Nottinghamshire ICB is the East Midlands host for the POD team and will host the East Midlands Cancer Alliance from April 2024. A hosting agreement is in place and the host responsibilities are:

- Staff transferred to the host (employing) ICB under TUPE arrangements, with shared liability across the five East Midlands ICBs.
- Staff within the hosting arrangements operate on behalf of all five ICBs and commissioning decisions / operations are exercised jointly through the joint governance arrangements.
- The host ICB determines the continuous professional development and provides line management support to the hosted team.

Distributed leadership arrangements

Each ICB contributes to the work of the East Midlands Collaborative through a number of routes:

- Each CEO has specific lead sponsor responsibilities, meaning that they lead collaborative work in their area and can represent the views of all five ICBs. The CEOs meet monthly, alternately in person and via Teams.
- An executive group has been established, with a nominated executive director for each ICB. This group enables discussion and agreement of preferred approaches and helps to gain alignment. The frequency of meetings depends on the work schedule at that time. Lead executives also attend joint working groups with NHSE, particularly concerning delegations and areas of joint working with NHSE.
- Each ICB contributes some of their leadership capacity to support the collaborative. This may be to support the work of their CEO lead sponsor or it may be to provide expertise into the committee tiers.

The collaborative has considered appointing designated programme support capacity, but this has been put on hold considering the current financial and running cost allowance constraints. This will be reconsidered in future months, now that the new CEO is in place for Leicester, Leicestershire and Rutland ICB.

Lead areas are distributed as follows:

ICB	**Lead Area**
Derby and Derbyshire	NHS111, Ambulance Services
Leicester, Leicestershire and Rutland	Specialised Commissioning (linking with Birmingham & Solihull ICB as combined East and West hosting organisation).
Lincolnshire	Broader collaboration with Local Authority, Cancer Alliance and Cardiovascular Disease and Respiratory (CVD-R) Clinical Network and Commissioning Policies
Northamptonshire	Collaborative governance and Commissioning Support Unit arrangements.
Nottingham and Nottinghamshire	Primary Pharmacy, Optometry & Primary and Secondary Dental Services (PODs) and vaccinations.

Appendix 1

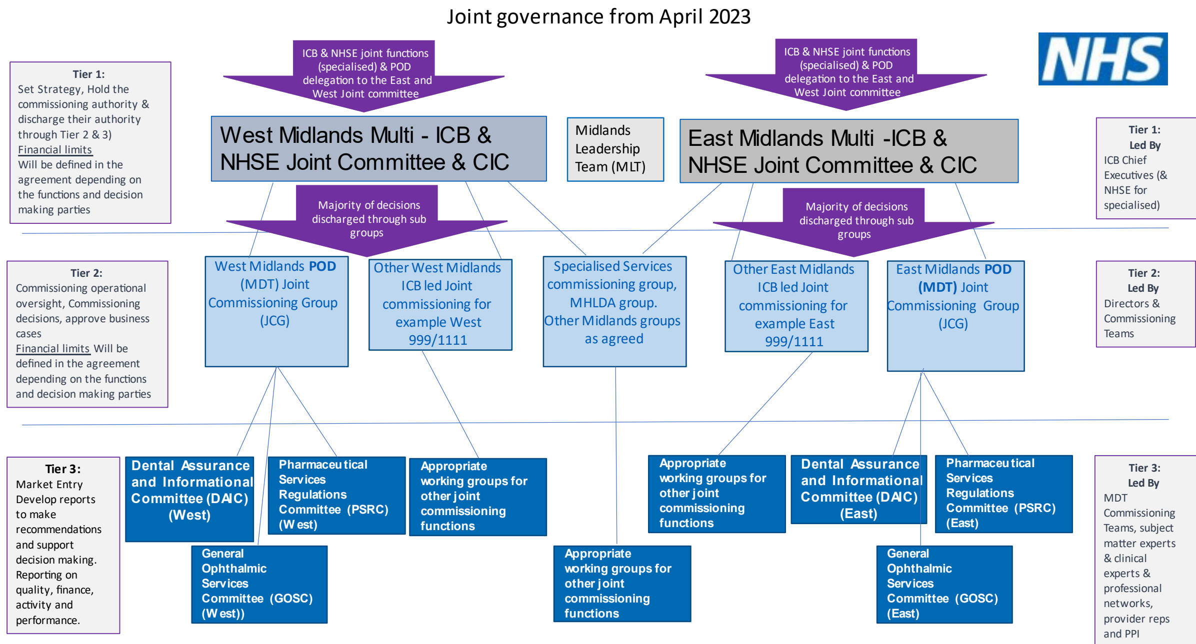
Additional collaborative working

There are some collaborative arrangements across the whole of the Midlands Region. The Midlands Leadership Team meets fortnightly and is chaired by the Regional Director. Members include regional executives and ICB CEOs.

The Midlands Decision Making Network is a membership learning and development collaborative for analyst development and joint analytical programmes.

ICBs are also collaborating at a sub-East Midlands level where this makes sense. For example, Leicester Leicestershire and Rutland ICB formally collaborate with Northampton where this makes sense in terms of shared provider leadership. Nottingham and Nottinghamshire ICB and Derby and Derbyshire ICBs are beginning to collaborate on skills pipelines and workforce planning and meet jointly to consider further opportunities linked to the forthcoming devolution deal.

Appendix 1



Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th January 2024

Item: 134

Report Title	ICB Constitution – approval letter from NHS England						
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 – NHSE Approval Letter of Amendments to Integrated Care Board Constitution						
Assurance Report Signed off by Chair	Not Applicable						
Which committee has the subject matter been through?	ICB Board – 20th July 2023 and 21st September 2023						

Recommendations

The ICB Board are recommended to **NOTE** the approval from NHS England (NHSE) on the amendments to the ICB Constitution.

Purpose

The purpose of the report is to set out the final approval from NHS England on the proposed changes to the ICB Constitution following Board approval in September 2023.

Background

At the ICB Board on the 20th July 2023 and 21st September 2023, the Board approved the amendments required to the ICB Constitution in relation to the consideration of the developing importance of Provider Collaboration at Scale and Place as part of the ICB Constitution.

Following the reshaping of the Executive Team in relation to the formal change of Executive roles and titles, there was also a requirement for these to be amended in the ICB Constitution.

Report Summary

Following the approval of the proposed changes at the ICB Board on the 21st September 2023, the ICB made a formal application to NHSE for their review and approval.

Following NHSE's review, they agreed that the proposed changes to the Constitution of NHS Derby and Derbyshire ICB comply with the particular requirements of the National Health Service Act 2006 as amended by the Health and Social Care Act 2022 and is otherwise appropriate.

The proposed changes to NHS Derby and Derbyshire ICB constitution were approved on the 22nd December 2023. The NHSE letter of approval can be found at Appendix 1.

NHSE approved that the Chair of the Integrated Pace Executive is included as a regular participant of the ICB Board as detailed in section 2.3, page 14 and section 3.12.4, page 25 of the ICB Constitution.

2.3. Regular Participants and Observers at Board Meetings

2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit. Participants will be affiliated to the ICB Executive Team but will not be a member of the ICB.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote. Regular participants will include the following:

(a) Chief of Staff (Board Secretary);

(b) Chair of the Clinical and Professional Advisory Committee;

(c) Chief Digital and Technology Officer; and

(d) Chair of the Integrated Place Executive.

NHSE also approved the following:

- the inclusion of the Chief Strategy and Delivery Officer (Deputy Chief Executive) as a formal Board Member;
- the change in the names of the Executive Titles; and
- a change in ICB Board quoracy to include the Chief Strategy and Delivery Officer (Deputy Chief Executive).

The NHSE approved version 1.5 of the ICB Constitution can be found on the ICB website. Integrated Care Board » Joined Up Care Derbyshire

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**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒

SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	SR10	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

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 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.

Chris Clayton
Chief Executive
Derby and Derbyshire ICB

Sent via e-mail:

NHS England Midlands

Julie Grant
Director of Strategic Transformation, East Midlands

23 St Stephenson Street
Birmingham
B2 4JB

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

22 December 2023

Dear Chris

Amendments to Integrated Care Board Constitution

Thank you for your application to amend your constitution, 24 Nov 2023.

I am writing to notify you of NHS England's decision in relation to the application for proposed changes to the Constitution of NHS Derby and Derbyshire ICB.

Decision

Following our review, NHS England has agreed that the proposed changes to the Constitution of NHS Derby and Derbyshire ICB complies with the particular requirements of the National Health Service Act 2006 as amended by the Health and Social Care Act 2022 and is otherwise appropriate.

Accordingly, the proposed changes to NHS Derby and Derbyshire ICB constitution have been approved.

What do you need to do next?

According to section 14Z29 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2022), you will be required to publish the revised constitution. This should be done as soon as reasonably practical after the receipt of this decision letter.

Conclusion

Should you require any assistance following this decision, please contact Helen Askarian, h.askarian@nhs.net.

Yours sincerely

Julie Grant
Director of Strategic Transformation, East Midlands
NHS England

Copy to:
Kay Fradley, NHS England
Helen Askarian, NHS England
Diane Gamble, NHS England

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th January 2024

Item: 135

Report Title	Emergency Preparedness, Resilience and Response Annual Report 2022/23
Author	Chris Leach, Head of Emergency Preparedness Resilience and Response
Sponsor (Executive Director)	Chris Weiner, ICB Accountable Emergency Officer
Presenter	Chris Weiner, ICB Accountable Emergency Officer
Paper purpose	Decision ☐ Discussion ☐ Assurance ☐ Information ☒
Appendices	Appendix 1 – Emergency Preparedness, Resilience and Response Annual Report 2022/23
Assurance Report Signed off by Chair	N/A
Which committee has the subject matter been through?	Audit and Governance Committee – 11th December 2023

Recommendations

The ICB Board are recommended to **NOTE** the Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2022/23.

Purpose

The EPRR Annual Report highlights the work completed by the ICB during the 2022/23 reporting period as well as the detail behind the ICBs attainment of the Partial Compliance status against the EPRR Core Standards.

Background

The ICB has the responsibility to ensure it is properly prepared to respond to, and recover from emergencies, as defined by the Civil Contingencies Act 2004, Health and Social Care Act 2022 and associated guidance and frameworks.

Report Summary

This report ensures compliance against a number of EPRR Core Standards in ensuring the ICB Board are sighted and assured of EPRR arrangements within the ICB and ICS of Derby and Derbyshire, and its preparedness status for 2023.

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.	☐

Derby and Derbyshire Integrated Care Board

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	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
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.	☒	SR10	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

Yes ☒	No☐	N/A☒

Details/Findings Response to EPRR and Business Continuity incidents can often be met within existing resources. None of the above initiatives have required any additional funding.	**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 measures taken as part of an EPRR response are intended to ensure continuity of service provision for all groups in the society we service.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable.

Appendix 1

Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire ICB

Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2022-23

1. EXECUTIVE SUMMARY

Derby and Derbyshire ICB has the responsibility to ensure it is properly prepared to respond to, and recover from emergencies, as defined by the Civil Contingencies Act 2004, Health and Social Care Act 2022 and associated guidance and frameworks.

This annual report is to assure the ICB Public Board on system and organisational Emergency Preparedness, Resilience, and Response (EPRR) activities during the period 31st August 2022 to 31st August 2023 (this is classed as the reporting `year` for EPRR).

This will include detail on:

- Delivery of the EPRR Work Programme 2023.
- Emergency Plans compliance.
- Training compliance
- Exercising compliance.
- Incidents experienced.
- Lessons and learning from Incidents and Exercises.
- Compliance with the Core Standards assurance process.
- EPRR resource commitment for 2023-24.
- EPRR work plan for the ICB and the system of Derby and Derbyshire for 2023-24.

2. BACKGROUND

The ICB, is categorised as a Category 1 responder under the Civil Contingencies Act 2004 this entails the delivery of 8 key resilience objectives:

- Assessing the risk of emergencies occurring and use this to inform contingency planning.
- Put in place emergency plans.
- Create business continuity plans to ensure that they can continue to exercise critical functions in the event of an emergency.
- Make information available to the public about civil protection matters, and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- Share information with other local responders to enhance co-ordination.
- Co-operate with other local responders to enhance coordination and efficiency.

In the NHS this programme of work is collectively referred to as Emergency Preparedness, Resilience and Response (EPRR). NHS organisations are also

expected to comply to associated legislation and guidance in addition to the Civil Contingencies Act 2004 this includes:

- Health and Social Care Act 2022
- NHS EPRR Core Standards (annual assurance process)
- EPRR Framework 2022
- ISO 22301 (Business Continuity), the ICB remains committed to ensuring alignment with ISO 22301 as directed by NHS England Business Continuity Toolkit and EPRR Core Standards.
- Associated EPRR Guidance (i.e., Mass Casualty CONOPS)

The ICB has a legal and regulatory responsibility to ensure EPRR is in place for both the ICB and to support the development of system EPRR processes to ensure the NHS can respond effectively to a range of incident types.

The ICB has an EPRR Team in place to deliver this programme, this report indicates the updated EPRR activities for the year of 2022-23 reporting (31st August to 31st August to align to the EPRR Core Standards reporting processes)

This report will demonstrate compliance specifically against core standard 3 (EPRR Trust Board Reports) and 5 (EPRR Resource) for the 2023-24 iteration of the Core Standards process.

3. DELIVERY OF THE EPRR WORK PROGRAMME 2023

As part of the EPRR Policy for the ICB a high level workplan/objectives were set for delivery in 2023, these are outlined below along with detail on the progress made for these high-level objectives:

Objective	Detail	Status (31st August 2023)
Governance	Ensure the development and embedding of effective governance processes for EPRR	Processes have been developed and embedded within the ICB to ensure effective governance. **COMPLETED**
Duty to Risk Assess	Ensure that effective risk management processes are in place for EPRR	Risk Management processes are in place in alignment with ICB procedure and requirements under the EPRR Framework 2022 **COMPLETED**
Duty to Maintain Plans	Ensure all EPRR plans are updated to reflect Cat 1 status	All plans updated as per section of this report. **COMPLETED**
Command and Control	Ensure effective ICB and System command and control processes are defined and embedded	This has been developed and embedded as part of the ICB IRP **COMPLETED**
Training and exercising	Ensure effective training and exercising is delivered in line with EPRR Framework 2022	Processes were developed and delivered in 2023, gap in relation to Loggists that is tabled for completion in 2024. **Partially Completed**
Response	Ensure that the ICB responds effectively to any incidents that affect it directly or indirectly	The ICB has successfully and robustly responded to a number of incidents during 2023. **COMPLETED**
Warning and informing	Ensure effective processes for warn and inform are developed with the ICB Communications Team	Communications team have designed and delivered an effective warning and informing plan for the system and ICB. **COMPLETED**
Cooperation	Ensure embedded system processes for working with providers are developed	Processes are now embedded across the ICB and ICS for EPRR arrangements and delivery (Local Health Resilience Partnership and

		Health Emergency Planning Officers Group) COMPLETED
Business Continuity	Ensure effective processes are developed in alignment with ISO 22301	Processes are in place however identified gaps in relation to audit and 3rd party Business Continuity Partially Completed
Chemical Biological Radiological Nuclear (CBRN)	Ensure the ICB is prepared to advise and respond to CBRN incidents	Developed and embedded as part of the ICB Incident Response plan. COMPLETED

4. EMERGENCY PLANS COMPLIANCE

During 2022-23 the EPRR team undertook an overhaul of all EPRR documentation, these were consulted with all partners within the system and wider afield i.e., NHS England, the ICB currently has the below documentation that is in date:

Plan	Purpose
EPRR Policy	The strategic oversight document for EPRR delivery within the ICB, setting out how EPRR is conducted and how the ICB will ensure compliance to legal frameworks.
Incident Response Plan	The regulatory required plan to respond to Major and Critical Incidents affecting the ICB, this also details how the ICB will coordinate the system in the event of an incident of this type.
Adverse Weather Plan	This plan details how the ICB will ensure compliance to requirements set on the NHS in relation to adverse weather events, it also encompasses the EPRR commitment to adaptation planning.
New and emerging infectious diseases and pandemics plan	This plan details how the ICB will respond and coordinate the system for new and emerging infectious diseases, local outbreaks and how it will contribute and partake in the response a pandemic.
Emergency Communications Plan	This plan details how the ICB will ensure delivery of its legal responsibility to warn and inform the system of Derbyshire and partner responders during an emergency, as well as how the ICB will alert the public to emergency incidents affecting the NHS.
Business Continuity Management System	This details how the ICB will ensure the delivery of Business Continuity processes for itself as an organisation in alignment with ISO 22301.
Business Continuity Plan	This plan details how the ICB will respond to Business Continuity Incidents that impact either directly or indirectly on it.
Service level Business Continuity Plans	These plans detail the local arrangements for each service area within the ICB and how each department will respond to any Business Continuity Incidents.

<u>Business Continuity Compliance 2022-23</u>

The ICB has conducted a full review of Business Continuity arrangements during 2022/23 this has led to a suite of plans for all service areas of the ICB, as well as

a new Business Continuity Plan and Business Continuity Management System. The process has also been exercised providing further assurance that processes are in place. Utilising the new EPRR KPIs it is possible to demonstrate the compliance for ICB Business Continuity as below:

KPI 1 - There is an overall framework in place to ensure that appropriate Business Continuity arrangements are developed and maintained. (Min 80% achievement)	**80%**
In date plans (% of total)	100%
In date BIAs (% of total)	100%
Tested in the last 3 years (% of total)	17%
Accessible to all members of staff? (Yes/No)	Yes
Number of depts internally audited (% of total)	0%

During 2023-24 team is committed to reviewing all plans and arrangements in line with the annual review requirement, ensuring that key learning from incidents and exercises is embedded as well as ensuring the inclusion of updated national guidance as released.

5. TRAINING COMPLIANCE

During 2022/23 several training courses have been run to ensure acquisition of knowledge within the ICB EPRR staff, this training is aligned to the ICB Training Needs Analysis with training aligned to the National Occupational Standards (NOS) for EPRR, these training course have included:

- ICB Incident Response Training (2nd on call, 1st on call, CEO and AEO)
- Loggist Training
- Principles of Health Command (NHSE Training for on call teams)
- Business Continuity Awareness training
- EPRR Awareness training

The % compliance for training is now graded against new KPIs for EPRR Training, using these and assessing last year's delivery and attendance we can confirm the below % compliance:

KPI 3 - Ensure effective training is in place across the ICB for roles identified within TNA. (Min 80% achievement)	**80%**
ICB Incident Response Training	98%
Loggists	50%
Principles of Health Command	82%
Business Continuity Awareness Training	92%
EPRR Awareness Training	100%

In addition, the EPRR Team has trained the below in EPRR Principles in recognition of their identified role within EPRR Response:

- Communications Team
- OCC Commanders

This has equated to 77 staff been trained across the ICB during the past 12 months, the plan for the next 12 months of training is covered within EPRR workplan 2024 section of this report.

Loggists are a key project for the ICB over the next 12 months to ensure meeting of the KPI set of 80%. This is to be achieved via an on call Loggist function that is due for deployment once approved in early 2024.

6. EXERCISING COMPLIANCE

During 2022-23 the ICB partook in several exercises to test arrangements and compliance of the ICB in relation to emergencies, these are indicated below. The ICB Command and Control team were in attendance at all exercises and associated plans were tested in line with the scenario being faced:

- Silver Siren- LRF exercise to respond to a RAF plane crash, ICB supported at Tactical/Strategic Coordination Group (TCG/SCG)
- Poseidon- System and ICB level Business Continuity testing exercise
- Kempton- COMAH exercise
- Priestly- COMAH exercise
- Poppins- System and ICB level exercise to test arrangements for Adverse Weather response.
- Hermes I and II (In hours and out of hours (OOHs) across the last 12 months in line with the 6 monthly requirements set by the EPRR Framework 2022)

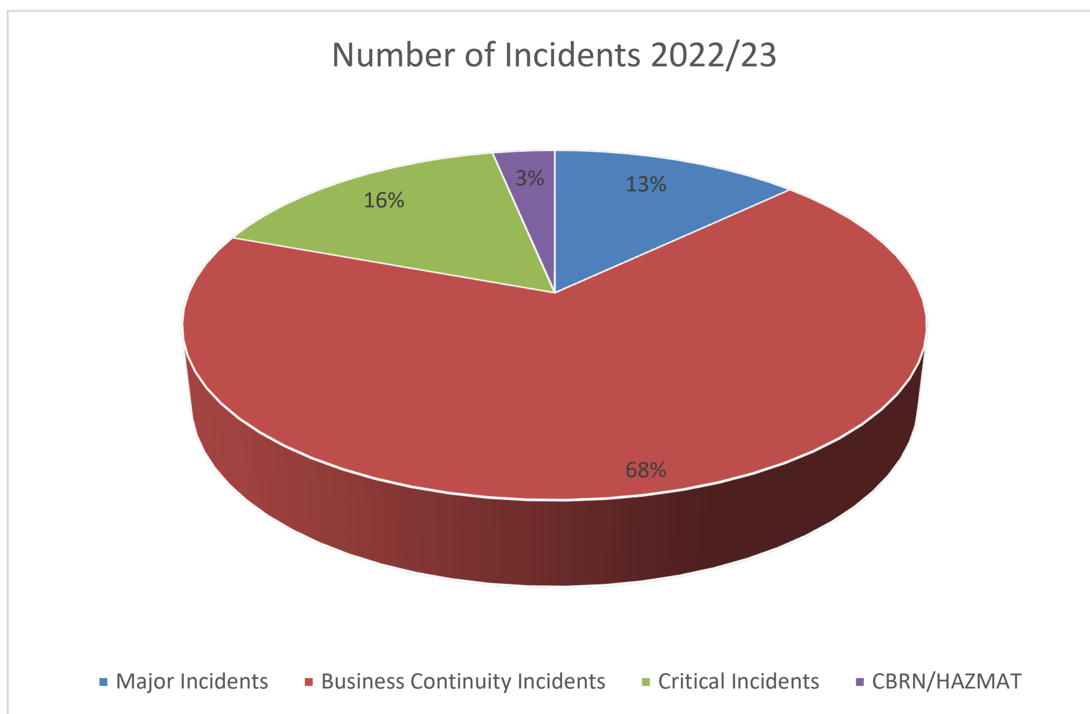
13 staff attended from a range of roles across the ICB EPRR Command and Control teams.

7. INCIDENTS EXPERIENCED

There have been a number of incidents that the ICB has been alerted to or responded to during the past 12 months, there was limited tracking of incident data from previous years so it is difficult to draw a comparison from previous years in relation to trends, however to date during 2023/24 there have been 8 incidents reported which is an increase on the same reporting period from 2022/23, these incidents have included:

- Adverse Weather responses
- Utility Failures
- Road Traffic Collisions
- Industrial Action

Major Incidents	Business Continuity Incident	Critical Incident	CBRN/HAZMAT
4	21	5	1



CBRN/HAZMAT= Chemical, Biological, Radiological and Nuclear Incidents and Hazardous Materials Incident

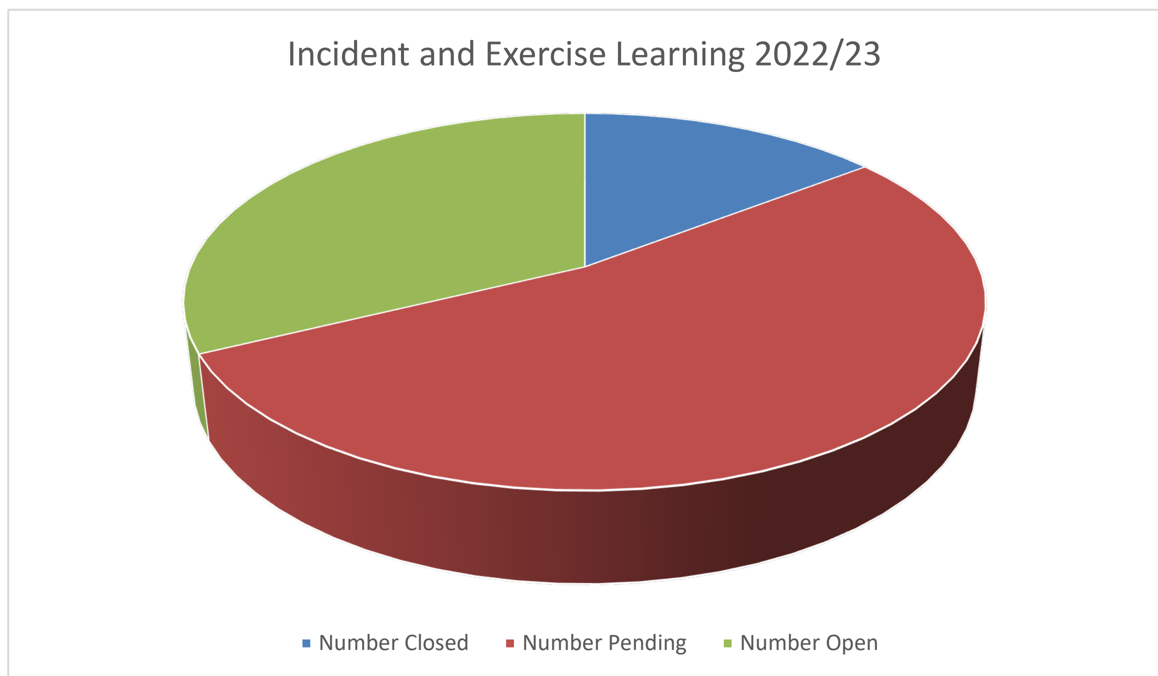
For each incident learning is compiled and then managed by either the Health Emergency Planning Officers Group (HEPOG) or the ICB EPRR assurance group.

8. LESSONS AND LEARNING FROM INCIDENTS AND EXERCISES

During the 2022-23 reporting period the ICB embedded a robust incident and exercise learning process, this ensures that learning from incident and exercises is embedded within ICB and system processes ensuring improvement of processes, plans and procedures for any future incident response.

This is in alignment with the continuous improvement process embedded within the ICB in relation to EPRR, during 2022-23 the ICB had the below number of learning points, as of the 31st of August 2023 this is the number that had been `resolved` and embedded within local arrangements for EPRR:

Total number learning points	Number Closed	Number pending closure (6-month review*)	Number open
124	18	66	40



The ICB will review any actions that a closed after 6 months to ensure ongoing embedding of learning processes, this reduces the risk of actions being opened multiple times whereby learning hasn't been fully embedded.

9. COMPLIANCE WITH THE EPRR CORE STANDARDS PROCESS

Core Standards have been approved by NHS England and DDICB has attained a status of **Partially Compliant**, this is achieved by an 81% compliance against the Core Standards (previous years was 66%), (submission is attached to this annual report)

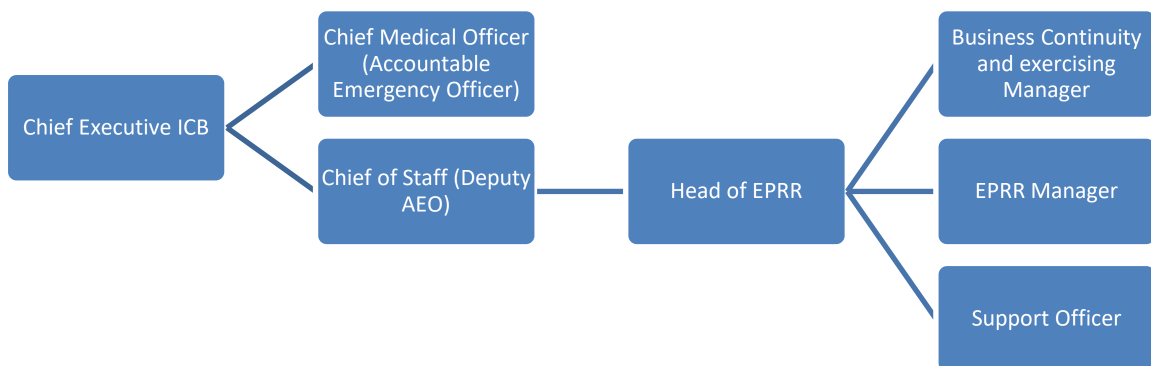
Whilst this is a good achievement for the ICB there are several sections that still require further work to ensure further increases in compliance rating for the 2023/24 reporting period, these were identified as:

Title	Gaps	Action Plan	Due Date
Infectious disease	Vaccination Planning HCID process for ICB escalation	• Action Card for HCID drafted in Incident Response Plan • Vaccination Planning as part of system Infectious Disease group	• Dec 2023 • July 2024
Countermeasures	Vaccination Planning HCID processes System Planning requires finalisation	• Action Card for HCID drafted in Incident Response Plan • Vaccination Planning as part of system Infectious Disease group	• Dec 2023 • July 2024
Evacuation and shelter	Internal ICB documents in order System Planning requires further completion	• System Evacuation and Shelter plan to be completed	• January 2024
Staff Awareness & Training	Whilst delivered not able to demonstrate completion	• KPI now set. • Online training package being developed for all staff	• Complete • January 2024
BCMS monitoring and evaluation	No Business Continuity KPI in place	• KPI now set.	• Complete
BC audit	More detail on auditing both internal and external required	• To be included in this year's EPRR Policy rewrite	• 8th February 2024
BCMS continuous improvement process	Detail on Business Continuity improvement required	• To be included in this year's EPRR Policy rewrite	• 8th February 2024
Assurance of commissioned providers / suppliers BCPs	Further detail on how providers are assessed required in BCMS	• To be included in this year's EPRR Policy rewrite	• 8th February 2024

10. EPRR RESOURCE COMMITTEMENT FOR 2023-24

Derby and Derbyshire ICB Executive Team and Board are committed to ensuring sufficient, responsible EPRR arrangements are in place in alignment with its legal responsibilities and duty of care to patients and the community it serves and supports.

In order to do this the ICB has risk assessed the local, regional, and national risks in relation to EPRR and has determined a suitable structure (inc. costs and financial implications) to deliver a safe and sufficient EPRR service. This is detailed below:



Whilst the Accountable Emergency Officer (AEO) is the designated responsible person for EPRR at the ICB, they will be supported by a Head of EPRR who is responsible for the operational delivery of EPRR as the recognised practitioner of EPRR within the organisation.

A Business Continuity Manager and EPRR Manager support the Head of EPRR in ensuring EPRR and Business Continuity are planned for and mitigated. The Governance Officer supports in providing secretariat functionality to the team as well as management of the ICB on call rota.

EPRR is funded as part of the Corporate Delivery budget, larger projects are identified, and costs allocated to the relevant department, and/or business cases provided via the identified ICB channels to ensure appropriate funding to the EPRR services provided by the ICB.

Costs are captured and reflected by finance and meet the requirements to ensure the EPRR is appropriately funded by the ICB. EPRR work plan for the ICB and the system of Derby and Derbyshire for 2023-24.

This section requests members acknowledgment to this commitment to EPRR resourcing for 2023-24.

11. EPRR WORK PLAN FOR THE ICB AND THE SYSTEM OF DERBY AND DERBYSHIRE FOR 2023-24.

A work programme has been developed encompassing learning from the previous 12 months and feedback from the EPRR Core Standards Process 2022-23, this is holistic ensuring improvement and embedding of the annual integrated emergency management (IEM) cycle.

The work plan identifies key `themes` related to effective EPRR delivery, within these themes will be key tasks assigned to the EPRR Team to deliver the work programme, the identified lead will ensure management and oversight of the key theme with the Head of EPRR maintaining overall oversight of the successful delivery of the programme.

Theme	Detail	Lead
Governance and Risk	To ensure effective governance and risk management processes are in place for the ICB/ICS	Head of EPRR
Policies and Procedures	To ensure all plans and policies and updated annually and in alignment with guidance and learning	EPRR Manager
Assurance/Core Standards/Audit	To ensure effective oversight and management of the ICS in relation to EPRR as well as internal audit processes	Head of EPRR
Training and exercising	To ensure effective training and exercising processes are embedded within the ICB/ICS	Business Continuity and Exercising Manager
Command and Control	To ensure effective command and control processes are embedded within the ICS/ICB	EPRR Manager
Cooperation	To ensure the ICB cooperates with partner agencies and where required has processes to ensure mutual working during emergencies/incidents	Head of EPRR
Business Continuity	To ensure effective business continuity processes are embedded in alignment with ISO 22301	Business Continuity and Exercising Manager

The full work programme can be seen on request via email to ddicb.eprrinbox@nhs.net.

MINUTES OF THE AUDIT AND GOVERNANCE COMMITTEE

HELD ON 12 OCTOBER 2023 VIA MS TEAMS AT 2.00PM

Present:		
Sue Sunderland	SS	Non-Executive Director/Audit Chair
Jill Dentith	JD	Non-Executive Director
Margaret Gildea	MG	Non-Executive Director
In Attendance:		
Andrew Cardoza	AC	Audit Director, KPMG
Ged Connolly-Thompson	GCT	Head of Digital Development & Digital Health Skills Development Network Lead
Joanna Clarke	JC	Principal Counter Fraud Specialist, 360 Assurance
Helen Dillistone	HD	Chief of Staff
Debbie Donaldson	DD	EA to Chief Finance Officer (note taker)
Darran Green	DG	Acting Operational Director of Finance
Keith Griffiths	KG	Chief Finance Officer
Lisa Innes	LI	Associate Director of Procurement – East (part)
Andy Kemp	AK	Head of Communications (part)
Sylvia MacArthur	SM	Head of Contract Management (Non-Acute)
Usman Niazi	UN	Client Manager, 360 Assurance
Glynis Onley	GO	Assistant Director, 360 Assurance
Suzanne Pickering	SP	Head of Governance
Chrissy Tucker	CT	Director of Corporate Delivery
Timothy Wakefield	TW	Audit Manager, KPMG
Apologies:		
Craig Cook	CC	Director of Acute Commissioning Contracting and Performance/JUCD Chief Data Analyst

Item No.	Item	Action
AG/2324/242	**Welcome, introductions and apologies.** Sue Sunderland as Chair welcomed all members to the meeting. Apologies were received from Craig Cook.	
AG/2324/243	**Confirmation of Quoracy** The Chair declared the meeting quorate.	
AG/2324/244	**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 No declarations of interest were made at today's meeting.	

EXTERNAL AUDIT		
AG/2324/245	**External Audit** Andrew Cardoza introduced Timothy Wakefield, who had taken over from Martin Ndoro as KPMG Audit Manager for Derby and Derbyshire ICB. Andrew Cardoza reported that initial conversations had been undertaken between Keith Griffiths, Darran Green and Donna Johnson and KPMG regarding planning; it was hoped that an Audit Plan would be presented to the next meeting of this Committee in December. Keith Griffiths thanked KPMG for all their work in handling the complexities of closing the accounts for last year and at the eleventh hour. He added that he felt the relationship between KPMG and the ICB, although challenging, had a single common goal, which was to ensure that our accounts and how the ICB managed its funds was always in the best interests for Derbyshire citizens.	
AUDIT		
AG/2324/246	**Internal Audit** **Progress Report:** Usman Niazi reported that since the last Audit and Governance Committee 360 Assurance had: Issued the final report resulting from the 2022/23 Committee Effectiveness review (Advisory). • Within this report there had been 6 medium risks, 5 low risks and 2 advisory recommendations. • The first medium risk related to reflecting on the defined responsibilities of each Committee and whether any adjustments were required to the responsibilities outlined within the TORs. • The second medium risk related to the frequency of the People and Culture Committee meetings, to bring it in line with other ICB Committees. • The third medium risk was about ensuring that all the Committees had forward plans in place that were based on the responsibilities outlined within their TOR. • The fourth medium risk was regarding reviewing the membership of all the Committees and making any adjustments necessary. Linked to this was monitoring attendance of the revised membership of each committee on an ongoing basis. • The fifth medium risk was about ensuring that the future presentations of the BAF to each of the Committees included a formal update on all the actions that were due for implementation since the last meeting of each Committee. Also ensuring that details on how the implementation of those actions had impacted on the profile of each risk.	

	• An advisory assurance opinion had been provided on this report due to the developing nature of the governance arrangements both within the ICB and the ICS. • It was noted that 360 Assurance would take the findings and the implementation of the recommendations outlined in this report into account when forming the overall opinion at the end of this year. Issued the final memo resulting from Stage 1 of 2023/24 Head of Internal Audit Work Programme: • 360 Assurance had completed Stage 1 Head of Internal Audit opinion. This piece of work was on the opening BAF position and the plan for reporting the BAF throughout the year. • The full memo had been included at Appendix B of the progress report (P19 of the pack). • It was noted that no formal recommendations had been made at this stage of the work programme. This was due to the ICB's intention to further develop the BAF for Q2, which would be reported to the November Board meeting, and be reviewed as part of Stage 2 of the work programme. Developed and agreed the Terms of Reference for the following reviews: • Financial Ledger and Reporting • Operational Planning • Data Quality & Performance Management Framework • System Wide Discharge Management Length of Stay • Mental Health Act (MHA) assessment claims • Post Payment Verification (PPV), with fieldwork due to commence in January 2024 • Key Financial Systems Review Status of Agreed Actions: • The current first follow up rate stood at 64% which puts the ICB in the moderate assurance category in terms of the HOIAO for the follow up of actions. • The overall implementation rate stands at 100% • It was noted that in the period 1 April to 30 September, 8 actions were due during that 6-month period, 4 had been implemented within the original due date, with 3 further actions being implemented ahead of their due date of 31 October. Jill Dentith reported that regarding Committee governance and attendance, we were working on the actions around that, but because we had amended TORs we might have two parts to the report, one in terms of former TORs and a second one in terms of the new TORs. Jill Dentith then referred to the BAF arrangements and asked how these were going to be reported to Committees, and whether we were on track with that as she believed the due date was end of November?	

	Jill Dentith reported that the follow up rate on actions was good; but did not necessarily look good due to the small numbers involved. Suzanne Pickering reported that we were on track with the developments in terms of the BAF. The Q2 BAF would be going to the ICB Board on 16th of November. It was noted that the BAF was reviewed by Committees monthly; Committees would sign off the Q2 before it went to ICB Board. In terms of the recommendations which Usman Niazi had gone through for the Committee Effectiveness review and for the Stage 1 for HOIAO, the Governance Team would make sure all actions were enacted upon. The Chair reported that in relation to the follow up of internal audit recommendations, she took comfort from the fact that the ones that were slightly delayed were low priority and that they had all been implemented. She agreed that when we had such low numbers of follow up rates on actions, it distorted the percentages. Margaret Gildea referred to the People and Culture Committee and the frequency of meetings. The Committee accepted the recommendations, but reported on the push back from System partners, on how we were going to address this. There was to be a development day where the purpose of the Committee was going to be reviewed. It was noted that it was not a statutory Committee, and members wanted to ensure that they were getting value from it and understand the need for bi-monthly rather than quarterly meetings. Suzanne Pickering reported that in terms of the Internal Audit recommendations, Frances Palmer and herself had a robust mechanism in place in terms of checking and monitoring to ensure that work would meet 100% completion rate. **Counter Fraud Progress Report** Joanna Clarke reported that the progress report covered the work carried out since the last Committee meeting. It detailed proactive work and how this related to the ICB's past and projected future CFFSR scores, as well as giving summary information about allegations and investigations. Appendix A provided details of briefings, fraud prevention notices and warnings that had been shared with appropriate officers. Joanna Clarke highlighted the table on page 3 of her report which showed a couple of ambers and explained that they were to indicate work in progress. It was noted that the amendments to the Fraud and Corruption Policy had been done but needed ratification by the ICB. The Chair queried the consistency on the use of ambers; on P27 it was showing 2 ambers for components 3 and 4 and then the detailed table showed 3 ambers for 4, 10 and 11 and not 3 and then the following report (the plan), did not show any ambers.	

	Joanna Clarke apologised stating it was an error on her part; there should only be the two ambers as per the first table. She agreed to correct this. Joanna Clarke reported that the NHSCFA would soon release new data to the Counter Fraud community which would be used to review the ICB's fraud risk assessment in Q3. **Audit and Governance Committee NOTED the Internal Audit and Counter Fraud Progress Reports.**	
AG/2324/247	**Internal Audit Recommendations Report** Chrissy Tucker presented the Internal Audit Recommendations report. It outlined the actions undertaken following the three 360 Assurance Audits which had already been discussed earlier in the meeting; these had been updated in the Plan. It was noted that there were no outstanding actions to take. **The Audit and Governance Committee NOTED the Internal Audit Recommendations Tracker.**	
FOR DECISION		
AG/2324/248	**Audit and Governance Committee Annual Report 1st July 2022 to 31st March 2023** It was a requirement for Committees of the ICB to produce an Annual Report each financial year, as set out in the terms of reference. The Chair reported that this Annual Report covered the period 1 July to 31 March 2023. Members agreed that there was nothing that they wanted to add or amend. It was noted that the Audit and Governance Committee Annual Report would now be presented to ICB Board. **The Audit & Governance Committee APPROVED the Audit & Governance Committee Annual Report for the 1st July 2022 to 31st March 2023.**	

AG/2324/249	**ICB Governance Handbook** Suzanne Pickering reported that in line with previous discussions, the TORs for all Committees had been reviewed as part of the ICB Annual Review, and as part of the actions required for the Committee Effectiveness Review. The TOR had been reviewed, updated, and agreed at each of the ICB Committees. It was noted that final approval of those were given by the ICB Board at its meeting on 21st of September. Clean copies of the TORs were included within the Agenda and Papers. Suzanne Pickering reported that when the ICB was first established, the System Quality Group (SQG) had been included in the Governance Handbook as a statutory Committee. However, when we received the published guidance, it was reported that this Committee should not form part of the statutory accountability of the ICB. Therefore, in this revised ICB Governance Handbook we had removed the SQG, which would now be a subgroup of the Quality and Performance Committee. The Functions and Decisions Map and Governance Structure had also been updated to remove the SQG. This was the only change made to the ICB Governance Handbook. The Chair reported that there was a need to keep under review, the change to quoracy of Committees, which included Non-Executives from Provider Trusts. It was noted that there had already been an issue at the last System Finance, Estates and Digital Committee where it had not been quorate due to non-attendance by Non-Executives from Provider Trusts. The ICB Chair had written out to all partner members to explain that we valued their inputs and explaining the requirement for quoracy at Committees. **The Audit and Governance Committee APPROVED the ICB Governance Handbook.**	
AG/2324/250	**Estates Update - ICB Headquarters** Helen Dillistone reported that as part of the requirement to reduce the ICB's running costs, an efficiency target had been set for corporate estate of £381k to March, producing a new annual budget for the whole of corporate estate of £558k. To support this, a review of corporate estate had continued to consider any further options open to us, including reducing our footprint at each of our corporate premises, namely Cardinal Square in Derby and Scarsdale in Chesterfield. It was noted that the purpose of this paper was to update the Committee on discussions and options pertaining to corporate estate, following a review in light of the reduced requirement for accommodation with the introduction of hybrid working and the reduced running cost allocation expected in the next few financial years. The following proposals were highlighted:	

	• To further reduce the space at Cardinal Square (Head Quarters), Derby, by removing the ground floor and keeping first floor north. • The other option, and the recommended option in the paper, was to take a smaller amount of space at the City Council offices in Derby. This would allow closer working with one of our key partners in the System and would give better access to higher quality estate. • It was noted that the City Council had indicated that they could accommodate for 70 desks, which effectively matches the accommodation at Cardinal Sq north. This would also include a more enhanced offer around meeting room availability. • There were guarantees from the City Council regarding the licence arrangement/management costs and not being subjected to escalating costs year on year. • The landlord at Cardinal Sq was keen to know our decision so that they could make appropriate arrangements, and once a decision had been agreed, we could therefore serve appropriate notice. • It was noted that if the ICB served notice in October, we would be looking to move in Spring next year; we could then get the realisation of savings as close into the new financial year as possible. • It was noted that the CEOs of both the ICB and DCC have had a number of discussions regarding co-location, and it was felt on balance that DCC would be a better option for the future location of ICB HQ given the high quality of accommodation, and the immediate availability. • A detailed options analysis around the Scarsdale premises at Chesterfield was currently being undertaken. • Margaret Gildea supported the DCC co-location proposal. The Council offices felt occupied, and the ICB would not have to worry about being accountable for the building. • It was noted that ICB staff would not use the Assembly Rooms car park and would continue to use the Exeter Street car park, which was equidistant between Cardinal Sq and DCC premises. It was noted that the distance from Exeter Street car park and the Council offices was about 5 minutes. As this was not a material change, we would not have to formally consult in terms of that change. • It was noted that if we were to make more significant changes, related to the Scarsdale accommodation, which were at an exploratory stage currently, this may raise the need to consult depending on what those options were, and what the preferred option might be. • Helen Dillistone reported that reference to the above would be made in the structures conversation/consultation that was being launched in the middle of November. The consultation period was likely to be 45 days to give people plenty of time to have a look at it, and reference would be made to the estate proposals. • Jill Dentith referred to the fact that the Council would be maintaining the property and asked whether this would impact staff currently employed by the ICB who were currently maintaining Cardinal Sq?	

	• Helen Dillistone reported that we would be able to make some small savings from some of the ancillary support that we had in terms of health and safety. It was noted that ICB staff who worked on HQ estate was quite small in terms of resource and it was hoped to redeploy them into other areas of the structure; estate was not their full-time role. • It was noted that the license with DCC regarding rent would be fixed for 5 years and we would avoid ongoing inflation, which could have been quite significant otherwise. Regarding the utility's element of the licence, this would not be fixed, unsurprisingly, and would be passed on; it was likely to be minimal and we may see some small increases year on year for that element of the licence. • Jill Dentith referred to the Scarsdale premises. She reminded members that she had raised this at the last ICB Board meeting, that she felt it important that as an organisation we had some presence in the north of the county. However, she wanted it to be a cost-effective presence as well as a physical one. She added that there may be opportunities for co-location with other partners at different premises or co-location with partners at Scarsdale. It was important to keep our partners abreast of these developments in case other partners were interested in these proposals. • The Chair referred to the reduced capacity for staff in these proposals. The Executive Team would need to manage expectations as to when staff could come into the office. It was noted that Cardinal Sq was deserted on some days and packed on others; this needed to be more actively managed. **Recommendations:** Whilst the facilities available and overall costs at Cardinal Square and DCC were similar, it was felt that on balance DCC was the better option for future location of ICB headquarters, given the higher quality accommodation, the immediate availability of suitable meeting rooms, the reduced need to use ICB resource on managing the accommodation and importantly the partnership signal that was given through co-location with a system partner in a publicly-funded building rather than with a private landlord. An implementation plan would then be created dependent upon the landlord's view and whether he would permit us to remain on site at First Floor North until end March 2024 (agreement with DCC potentially to commence 1st April 2024). If that could not be agreed, we could decant to the ground floor temporarily. In terms of Scarsdale, it was recommended to further explore savings available, options being: • Close Scarsdale completely and transfer staff bases to Derby or to home – the ICB would be liable for void costs of around £360,000 ongoing unless the space could be let to other tenants. • Close Scarsdale and search for smaller accommodation in Chesterfield. This would potentially incur double running	

	costs unless tenants could be found to take over the Scarsdale property. • Maintain Scarsdale but reduce our footprint and financial liability through encouraging other System partners to take more of our space directly with NHSPS. Work could be undertaken to review how much space the ICB would wish to release in order to realise the required savings. **The Audit and Governance Committee APPROVED the recommendations set out in this report.**	
AG/2324/251	**Audit & Governance Policies:** The Chair apologised for the fact that the Media and Social Media Policy was not sent out until earlier this morning and she hoped that members had been able to review it. She added that if any member felt that they had not had enough time to review the policy to declare it. Members were happy to proceed. **Photography Consent and Image Storage Policy** Andy Kemp reported that this policy report outlined the following in the context of actions that staff members must take to ensure compliance: • Legal basis of photography consent. • GDPR requirements. • Consent definitions and how these inform approaches to consent. • Records storage including security requirements, timescales for consent and deletion processes. The report provided examples of documentation which staff could use and points of contact for advice. It was noted that "photo consent" also included consent to publish film, or sound. **Media & Social Media Policy (revised)** Andy Kemp reported this policy was a refresh of an existing policy. It was noted that we were looking to reach a much younger audience through our recruitment. We are aware that TikTok carried an element of risk from reputational and IT security perspectives. This policy sought to mitigate those risks and provide assurance that any use of this channel would be delivered on equipment which was separate to the ICB's digital platforms and therefore does not represent a risk to the IT infrastructure. TikTok opened a significant opportunity to access audiences where we traditionally had less reach than others and these audiences were important to the achievement of the objectives of some of our programmes. From a reputational perspective, TikTok was generally perceived as being more controversial than traditional social media so this policy described the extra layers of control in place to ensure that objectives were delivered alongside ensuring that the ICB reputation was protected.	

	Jill Dentith asked whether we used commercially provided images, and if so, did we know the policies that those organisations had in place regarding consent around those images? Andy Kemp reported that all our images came from NHSE and were nationally sourced; we did not buy commercially provided images. As for our System partners, we had asked for assurance that they had consent, as we needed to make sure we had absolute compliance. **The Audit and Governance Committee APPROVED the following policies:** • **Photography Consent and Image Storage Policy** • **Media and Social Media Policy (revised)**	
ITEMS FOR DISCUSSION		
AG/2324/252	**Risk Management Deep Dive – Finance** Darran Green presented a Deep Dive on Finance, a copy of the slides were available on request from Debbie Donaldson. The following was highlighted: • The Deep Dive on Finance gave the opportunity to help Committee understand the environment that the ICB was working within to deliver in-year and recurrent financial balance, and to get an understanding of the wide range of issues that were impacting its ability to do that, many of which were outside the ICB's control, and in some instances were driven by NHSE decisions. • This Committee was the only space where there could be a conversation about the ICB's finances; the System Finance, Estates and Digital Committee reviewed the System's finance position. • This Committee was the only place where colleagues from the finance directorate could bring to life some of the challenges that we were dealing with in the ICB as a statutory body. • The presentation had been stylised to bring to life some of the day-to-day reality that we were living with, and the nature of the conversations and uncertainty that sits behind the numbers that Committee would see later in the M5 Finance Report. Understanding the Impact of NHS National Team Decisions and Guidance and how that affects us on a day-to-day basis: • We were constantly viewed as a £2.2bn system (and funded that way) when we were a £3.2bn system. • There were unique characteristics in our System, we hosted an ambulance service that delivered across the East Midlands. • One of our System partners (UHDB) as well as having a hospital in Derby also had a considerable footprint in Staffordshire, which was Burton acute hospital and two community hospitals.	

	• Any additional allocations would probably be distributed to us on what our current allocations were. This was flagged to NHSE constantly and the ICB was looking to the regional team to support us in trying to repatriate money that had gone to neighbouring ICBs to help the providers in our System deliver the services that they needed to do outside of Derbyshire. • Convergence factor applied to Derbyshire NHS allocations which reduced the allocation by £14.4m in 2023/24 (£100m over 5 years). • There were a lot of care homes opening in Derbyshire and this was creating an influx of patients from out of Derbyshire with serious and long-term conditions relocating and registering with our GPs (per national who pays guidance) - cost in 2023/24 estimated to be £1m. This was not reflected in how our allocation was calculated. • Any Qualified Providers (AQPs) could enter the market and create capacity, which must be paid for by the ICB, but does not meet local priorities or need. • Delegated PCCC contracts agreed nationally but insufficient allocations. There was a meeting set with national colleagues to further understand the impact of this but was creating a cost pressure on us this year. • Inadequate pay award and the indirect impact on the market. There had been some very detailed guidance around how that could be applied. • The pay award could only be applied to people on A4C contracts who were employed by NHS organisations. A lot of providers we used in Derbyshire, for good reasons, had brought their staff onto A4C terms and conditions, but they were not NHS organisations. • It was noted that DHU provided us with our out of hours GP and 111 services and used A4C to pay their staff, and had honoured the pay award to their staff, but we as the ICB had not been funded to pass that on to them. This was creating a huge impact on DHU. • There were other small independent providers who again followed A4C and were facing a substantial cost impact. • Difficulty in re-aligning NHS contracts outside Derbyshire that were based on 2019/20 activity levels. We were potentially overpaying NHS providers over our borders. • Changes in Specialist Commissioning rules - we now have 4 complex MH patients with a cumulative FYE cost of £4.9m, which would previously been paid for by Specialised Commissioning and were now being paid for by the ICB. Again, this was not reflected in allocations received. • The scale of these things was very material for an organisation that did not have a large running cost base, did not have many staff or estate and we did not keep reserves. We were constantly juggling where we could go further and faster on efficiency to meet the needs of some of these surprises which puts added pressure on our own managerial teams. It created difficult conversations with our independent sector colleagues who wanted 10% more when we wanted to give them 5% less. • The Chair asked what sort of response we got from region when the above issues were raised with them? Did they recognise	

	the validity of these arguments, or were they not listening? It was noted that they did not appear to be listening. • Margaret Gildea felt huge sympathy to the finance team in trying to work through this and perhaps not feeling heard. She asked whether other Systems were losing money into Derbyshire? Darran Green reported that we recognised that did happen, but mostly it was patients into Derbyshire, which was unique. • It was noted that we had three different regional boundaries, West Midlands, North-West, and South Yorkshire. • Staffordshire caused the ICB the biggest problems, coming back to the population-based allocation, which did not take into account the deprivation in that part of the patch. Arguably Staffordshire ICB would get that benefit, but we had to get the money off them because we were providing care to 20% of the residents, but that was not something they were willing to give up. It was noted that there were some difficult conversations around this. • Jill Dentith referred to the regional conversations, she found this very disappointing that they were not recognising the issues raised above. She asked whether there was anything that the ICB Board or Chair to Chair meetings could do in terms of raising these issues? • Jill Dentith raised her concerns regarding the unfunded pay award to DHU and their staff and the impact of specialised commissioning mentioned earlier; she found the position very worrying. Current Economic Climate: • We had a lot of independent sector providers who provided mental health and community services. These tended to be small providers, but we were very reliant on them. • They were demanding anything upwards of a 10% uplift, particularly around CHC packages. They were in a position where they could just pull out of the NHS market. They could provide NHS services to people who pay privately, and if the NHS did not keep up with the market rate, then they would pull out of the market confident in the knowledge that they would be able to fill their capacity in other ways. • The ICB had not been funded at anything like that level. • Due to the general economic climate, we had practices in Derbyshire that were struggling to maintain a level of financial viability. They were now asking for ICB financial support. • This was something we could offer within a framework, but would come at a cost, which was not part of the allocation that we received. The danger was, if we did not offer that financial support, those GP practices could close overnight. General Practices were independent businesses and the burden for providing primary cares services to those patients would pass to the ICB overnight. • We knew from previous experience, that we would have to get a provider in there very quickly and that would come at a premium price.	

	• This was driven by the fact that we were only given 2.8% growth in 23/24 and inflation was running at a much higher cost than that. • Industrial action was having a serious impact on the NHS. There was a direct cost of having to backfill for the people who were out on industrial action. There was also the cost of catching back up on that activity. The amount of management time within providers and the ICB that was taken up by managing the impact of industrial action often meant that management time could not be directed at doing things like delivering the efficiencies that we set out to do at the start of the year. • Due to industrial action, there was more pressure nationally to use more of the independent sector to help with the extended waiting lists. This meant a bigger bills for the ICB as we were the ones who would have to pay for it. There would be no extra funding to cover it. Impact of JUCD Provider actions: • Decisions being made by DHcFT Clinicians on treatment and where it takes place that did not affect the Trust but did have an impact on the ICB. • Providers focussing solely on discharging from their hospital may mean people going out on expensive and inappropriate care packages which was still a cost to the ICB (this was a cost shift at a higher cost). Impact on the JUCD: • Cash impact of using non-recurrent balance sheet solutions on in-year position. • There was not a limitless supply of goodwill from NHS staff in the System. • The ICB currently had a 30% running cost reduction but as a finance team we must meet all financial statutory obligations, to the highest professional standards, with a reducing workforce. • The ICB had a statutory responsibility to ensure the System breaks-even. We could not under-estimate the amount of time and effort it took to supporting and leading the System into that. The Chair felt that the Deep Dive had been helpful to summarise the issues. The challenge was whether we felt that all the risks were adequately recognised within both the ICB and the wider System organisations. It was noted that this was not something that could just be managed by finance and through the various risk registers. Did we feel that System partners were sighted on these elements, whilst quite a lot of them were organisational, it would have a System impact. Did we feel that the actions that we were developing to try and mitigate the issues and challenges were going to be sufficient, and if not, what more did we need to do? The Chair felt that Darran Green had very eloquently explained the scale of the problems and challenges that we faced, she felt the bit that was missing for her was how comfortable both Darran Green	

	and Keith Griffiths were with the actions being taken to try and mitigate these challenges. Keith Griffiths reported that as the financial squeeze had got stronger this year, the nature of the conversations that we were having within the ICB about what it was like at ground level had become more obvious. To understand what was driving the spend on CHC or the Independent Sector for example, we needed to understand where the decisions were made, what influence we had and what could we do. He felt the moving parts described here in this Deep Dive were not visible to all parts of the Executive. He felt that we had not airlifted the scale of the issues, politics, and dynamics into the Executive level often enough and then up to ICB Board; we needed collective awareness. It was noted that when things shift for us as an ICB, they shifted in millions not hundreds of thousands and that was what we were seeing in 23/24. An appreciation of what the ICB was doing needed to grow in other parts of the System and with Local Authority colleagues. Keith Griffiths referred to the high-cost packages for mental health patients and the disconnect between clinical decisions in one organisation and the cost being picked up somewhere else. It was noted that there was an appetite to align those two things, which would mean the ICB giving up its financial resources to the Mental Health Trust, so that clinical decision makers had the financial stewardship responsibility as well. Clinicians may then question whether some of the expensive cases that we were seeing coming through may get reassessed a bit more frequently rather than running in perpetuity as they did now. We needed to work collectively as a System to put different clinical protocols together that applied for physical health patients as well, so that patients got the right level of care that they need. Keith Griffiths reported that these conversations were not necessarily in the best interests of those independent partner organisations that provided the care. There was anecdotal evidence that 7:1 care in a private setting was obviously very lucrative, so why would the organisation that provided this care want to recommend that package be reduced, or the patient moved into a different setting. Financial stewardship and accountability were an option for us and something that people were hesitant for but could see the benefit in doing it. The Chair thanked Darren Green and Keith Griffiths for their presentation. It was recognised that there were no easy answers, but it was something that we needed to make sure we continued to work on collectively. There may be a need to raise awareness more widely across both the ICB Board and the organisations about the issues that had been outlined today. **Audit and Governance Committee NOTED the issues raised from the Deep Dive on Finance.**	
CORPORATE ASSURANCE		
GOVERNANCE		

AG/2324/253	**ICB Corporate Risk Register Report** Chrissy Tucker reported that as at 30th September 2023, the Audit and Governance Committee were responsible for five ICB Corporate risks, two of which were scored high; Risk 11 regarding climate change and Risk 16 regarding staff wellbeing as a result of the restructure. It was noted that Risk 16 description had been amended following comments at last month's meeting. The three remaining risks were scored low, and there had been no movement in scores for this month. The Chair expressed concern that Risk 07 seemed to have made absolutely no progress at all: *"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".* Chrissy Tucker reported that HR had struggled with resource to get this work done and had previously indicated that they would get some temporary admin support to carry out the task. Chrissy Tucker agreed to give an update to Committee in December. Chrissy Tucker clarified that the ICB did not have issues around staff resources within the HR department; it was admin support to the HR team to deliver this work. The Chair highlighted Risk 03: "*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".* It was felt this Committee needed further assurance that the Committee responsible for this risk, namely, Strategic Commissioning Committee (SCC), was sighted on these issues and that the Primary Care Subgroup was updating SCC on the risks around the potentially failing practices. Chrissy Tucker agreed to take this action and report back. **The Audit and Governance Committee:** • **RECEIVED the risks which were the responsibility of the Committee as detailed in Appendix 1.** • **NOTED Appendix 2 which detailed the full ICB Corporate Risk Register.**	 **CT** **CT**
AG/2324/254	**Integrated Assurance Mapping** Helen Dillistone presented the Integrated Assurance Mapping report. The purpose of this paper was to update the Committee on	

	the work undertaken by Deloitte in respect of reviewing assurance processes across the Derbyshire system. It was noted that as part of the ongoing development of the ICB and its governance and assurance processes, it had been recognised that across the Derbyshire System there may be duplication in our processes with System partners, and equally there may be gaps. Assurance processes within Provider organisations had rightly been established to serve their particular purposes and, as the ICS matured, we had an opportunity to map how these processes worked together currently and how we might make enhancements to support the System and to plug any gaps. This exercise was not intended to replace processes organisations already had in place that worked for them. Deloitte were commissioned to undertake the review, attached at Appendix 1. It was noted that the document was in draft currently, but only minor amendments were expected in the final version. It was felt that this report needed to be read in conjunction with the Committee Effectiveness Report. Helen Dillistone reported that the aim of the exercise was to map what we currently had in the System and to look at areas for further development and improvement. There had been a brief discussion with the Chief Executive Group (CEO Group) last Friday, and they had requested that it be revisited at their November meeting. The CEO Group were very interested in seeing how it could help with some of their work and how it could be linked in across the System to help support conversations and engagement. The map of meetings/Committees (P226) was highlighted as being an up-to-date organogram of the System architecture. Jill Dentith referred to the organogram and reported that Derby City Council were down twice, she felt one of them should be Derbyshire Health & Wellbeing Board. Helen Dillistone agreed to amend this after today's meeting. Jill Dentith then referred section about System Finance and Estates Committee (SFEC) and how it did not get the opportunity to talk about the ICB's financial position; this was not the role of SFEC, ICB conversations about finance come through the Audit and Governance Committee. We needed to ensure that was made clear. Jill Dentith found the section around Delivery Boards and PLACE fascinating, as one of the main conversations at SFEC was around our reliance on Delivery Boards, PLACE and PCNs in terms of the targets that we had to achieve and the cost efficiencies. If that mechanism was not there to support them, or it hindered them, then that would be a barrier we needed to release or free up. The mechanism and governance needed to be right, which was a difficult balance. We would not want it to be too tight that they were constrained by it, but equally we would want it so that they could raise issues and escalate promptly.	 HD HD

	Margaret Gildea felt this had been a good report, and asked how we were going to drive forward the next steps? Helen Dillistone reported that how we use this and take forward the conversation would not be in isolation, it was a starting place and would be used in other work that we were doing across the System. It was noted that we were currently working on how we would govern and seek assurance across the System going forwards. **The Audit and Governance Committee NOTED the contents of this report and Appendix 1.**	
AG/2324/255	**Conflicts of Interest Report** Chrissy Tucker presented the Conflicts of Interest Report, and apologised for an appendix which was missing from the papers, namely, the Conflicts of Interest that had been recorded so far this year. This would be emailed out separately to members for completeness. It was noted that the purpose of this paper was to assure Committee of the activity that the ICB had undertaken since the last report in June 2023, regarding managing its conflicts of interest. The Chair felt that it would be helpful to get a sense of the level of compliance with the annual updates. Did we get 100% compliance, were there any sticking points that we had to chase up on? Chrissy Tucker agreed to provide this information at the next Committee meeting in December. **The Audit and Governance Committee NOTED and RECEIVED assurance from the Conflicts of Interest Report.**	CT CT
AG/2324/256	**Freedom of Information Quarter 2 Report** Andy Kemp explained this report provided details of Derby and Derbyshire ICB's compliance under the Freedom of Information Act (2000) in Q2 of 2023/24. During July – September 2023: • FOI numbers had increased, with 126 FOI requests received in Q2 2023/24 compared to 64 in Q2 of 2022/23. • No requests were responded to during this quarter outside the statutory timescale of within 20 working days of receipt. • 115 responses were sent. • 8 responses included exemptions under the Freedom of Information Act. No requests were refused in entirety, segments or single questions came under exemption, these were Section 12 = 4 Section 40 = 2 and section 43 = 2, commercial sensitivity. Andy Kemp had reported at the last Committee meeting, a significant increase in volumes, and to the point where we were seeing crossover with, or triangulation with, enquiries and	

	complaints showing similar themes and trends, and this had been impacting on the wider business in terms of people being involved in generating responses. He reported that he was pleased to say that through some of the additional resource diverted into the FOI function, they were able to address this. He went on to add that in recent weeks we had seen numbers of FOI revert to a lower trend for October. It was noted that to support with mitigation of the increase in FOI requests, the FOI Officer's core hours had been temporarily increased from 30 to 37 hours per week. The FOI Officer also attended some online training to help improve confidence in the processing of requests, especially when applying exemptions. This had helped with managing the case load. Jill Dentith reported that it was positive that we were hitting the targets for FOI, with the help of temporary support, but that there was a need to assess the cost effectiveness of these fixed term measures in terms of value for money. Andy Kemp agreed to take this away and provide and update to the next Committee meeting in December. Keith Griffiths reported that there was a REMCOM next week to discuss the running cost allowance impact. It had been noted in the meeting earlier that we had Risks on the risk register that were not getting closed off due to pressures on FOI; this was part of the reality being discussed next week on how we could not do everything with a 30% reduction. The Chair reported that if we could not do everything, then we needed to revisit those risks to see if there were other ways of dealing with them, or whether we needed to accept that there were risks we could not mitigate. **The Audit and Governance Committee RECEIVED the Freedom of Information Q2 Report describing the performance of the ICB against our statutory duties regarding responses sent to requests made under the Freedom of Information Act.**	AK
AG/2324/257	**Digital and Cyber Security Assurance Report** Ged Connolly-Thompson presented the Digital and Cyber Security Assurance Report and highlighted the following: • The purpose of the paper was to give assurance to the Committee that the ICB was actively managing the contracts with Tameside and Glossop Integrated FT. • There were no KPIs for this meeting; but these would be chased up and the information sent out to members as soon as possible. • The service with NECs remained relatively stable. • KPIs were predominantly green. • There was an active discussion regarding depreciation of service resulting from the running cost reduction. It was noted that this would be a difficult conversation with colleagues, to	

	help them understand the reasons why. It was noted that there would be services which they had access to before which would no longer be available. There would also be access to services confined to core hours. • Currently we are engaging with GP providers on NBC regarding GPIT which would take the brunt of the cuts and the changes. • We were looking at what the frontline issues were going to be, and make sure those changes were communicated prior to the changes to ensure as smooth a process as possible. • The Chair agreed that it was important that we were involving people in discussions regarding the need to reduce services and that they were involved in prioritising what they needed going forwards. **The Audit and Governance Committee NOTED the Digital and Cyber Security Assurance Report.**	
AG/2324/258	**Information Governance Report** Ged Connolly-Thomson presented the Information Governance Report. The report provided an overview of the activity of the IG team including: • Decision items for IG Assurance Forum approval • Data Security and Protection Toolkit workplan • DPIAs • Procurement activity • DPIA Log. The following was highlighted: • The lessons learnt from Data Security Protection Toolkit submission 23/24: 4 key themes were identified in the review undertaken by IG following the DSPT submission for 2022/23. An action plan was formed which went through IGAF. • We now had a DSBT work plan, so the team knows what needs to be done by when. • Conversations would take place about training and adherence to processes much earlier, and that information was collated and ready in time. • Work would be undertaken with 360 Assurance to make sure the audit was undertaken appropriately. • Quoracy would be reviewed, and members of IGAF would be identified. Guest members would be invited into the conversation. Business Intelligence and data use was something which should be brought into IGAF. • We had data sharing agreements with NHSE and other organisations – we needed to ensure that any information requests coming through were looked at in line with our existing contracts and our data sharing agreements so that we remained compliant. • NHSE had previously held the material risk re Section 251's and now they had divested that into the ICBs. We needed to ensure that we recognised that; this created an additional risk to the organisation, and we needed to start to mitigate that risk.	

	• Accountability and Governance – there was a need to require officers to attend to answer a query or help the group make decisions. Audit and Governance Committee were asked permission to request an officer to attend in this instance. The Chair felt that this was a reasonable request. **The Audit and Governance Committee NOTED the Information Governance update for October 2023.**	
AG/2324/259	**Procurement Highlight Report** Lisa Inness presented the Procurement Highlight Report (August) and explained that the paper 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 (a long-standing pilot): was currently on amber due to it being a compliance risk in terms of the regulations due to the value of the contract £736k. Procurement was making sure it could get a compliant process undertaken in the time frame allocated. • Audiology: was currently red, this was a compliance risk, and the contract was due to end on 31 March 2024. An extension had been put in place for 6-9 months to facilitate that, and this had now moved to amber with the extension option. • 111 re-procurement including Integrated Urgent care services CAS (Clinical Assessment Service): both were at green currently. There had been threat of a legal challenge from the market from new entrants based on lack of opportunity. This had been reissued and concluded with no challenges as of midnight on Monday. This would now progress through to contract award. • NEPTs: currently on green in August report, however, it had been pulled from the market for the second time due to issues with activity data and this had been moved to amber whilst awaiting commissioning feedback. This would need to go back out to market for a third time. • Wheelchairs Services: currently red; we were out of time to re-procure and the existing contract had now been moved to amber in September as an extension to contract had been awarded of 7.5 months. • Advice and Guidance Platform: currently on green in the August report, unfortunately this had had to be pulled as a non-award of contract due to legal papers being served on the process. The ICB was currently working through the legal issues with the intention of going back out to market w/c 16 October. **Future Projects (Contracts coming up for expiry in the next 18-months):**	

	• Impact+ Respiratory Services (Clinical) • Community Action Derby (Clinical) • MSK & Triage Service (Clinical) • Community Physio for Non-Complex Service (Clinical) • Occupational Therapies (Clinical) The Chair reported that looking through this paper, there were a few contracts where we were showing amber on compliance, where it looked like we were not complying with legislation particularly around value, but that the ICB was saying it would take that risk. This combined with the issues with the Impact+ contract, which was not well managed through procurement, and the 111 issues around specification and affordability queried by ICB Board, made her feel that this Committee needed a Deep Dive on procurement that looked at a number of things. Particularly around how well we work between ICB staff, Procurement, and CSU in terms of compliance with legislation, timeliness and setting up of initial specifications and affordability. A deep dive would flag up lessons we needed to learn, and how we approached some of these high-profile contracts. Jill Dentith thanked Lisa Innes for the update today but reported that we seemed to be in a semi-perpetual cycle of rolling contracts forward, when we should be looking at the contract in advance, in good time and looking at value for money that we get from a service provided to patients, not just rolling a contract forward. She agreed that a deep dive would be useful and should include contributions from a CSU perspective and from the ICB regarding reviewing forward planning. We needed to proactively manage these contracts. Margaret Gildea agreed with the comments from both the Chair and Jill Dentith above. She reported that we often had to agree decisions because there was no other option due to time constraints and she too welcomed the suggestion of a deep dive. Lisa Innes reported on issues regarding having the right commissioning resources available at the right time which often caused constraints. It was noted that Lisa Innes was working with Chrissy Tucker and Craig Cook looking at SLA efficiencies, and regular meetings were taking place regarding work plans in terms of prioritising high-profile projects and services required. The ICB had requested 20% efficiency in the next 12 months and as a result procurement needed to streamline their service. Chrissy Tucker reported that we had a contracts database in place that listed everything about contracts and when they expired. We also had a contract's expiry tracker that went to SLT every month, which should generate a time by which we do things. She felt we needed a deep dive to find out why that was not working and that would need to take place with the commissioning team. Chrissy Tucker reported that we had a meeting with Arden and Gem CSU regarding the requirement to take some money out of	

	the contract and how we would do that. One of the things that was talked about was having some kind of gateway in the ICB, rather than ICB staff approaching the CSU directly with procurement requests that we have somebody in the ICB that helped to prioritise that work as we would have less resource from CSU. We needed to work differently to make the best use of the CSU's expertise, whilst at the same time reviewing what we were doing in the organisation. She felt a deep dive could pick up all the things raised today and how we could work in the future; it was noted that the ICB had a new Executive for Strategy and Planning, and she was keen to discuss new ideas. Keith Griffiths supported a deep dive, which would need to look at the market that we were operating in, not just the process; we were working in a more litigious environment and a reduction of players in the market. These two things together meant we were weakened in our ability to exert our buyers influence. He felt the learning from the 111 service was fundamental and he would be looking for what Arden and Gem CSU give us around the question of affordability. He appreciated that we needed to be navigated through a legal process to make sure we were compliant but there was a real risk that slavishly following that gives us a bigger cost at the end of it. He too welcomed a deep dive on procurement, which should include the role of Arden and Gem CSU or any other external partners that the ICB may wish to use, and our commissioning frameworks. The Chair requested that at the next agenda setting meeting for the Committee, an agreement of a realistic timeframe for the deep dive could be set. **The Audit and Governance Committee:** • **REVIEWED the Highlight report for Derby and Derbyshire ICB.** • **NOTED status of projects – future project, in-progress and completed.** • **REVIEWED key issues and activities over the current period.**	CT/SS
FINANCE		
AG/2324/260	**Month 5 ICB Financial Position Review** Keith Griffiths reported that this paper presented the financial position of NHS Derby and Derbyshire ICB for the period ending 31st August 2023. It highlighted the key areas where we had particular I&E challenges, as well as summarising the efficiencies position for the ICB. As of 31st August 2023, the ICB financial position was £2.6m overspent year-to-date and has a forecast breakeven position. However, this had been achieved by recognising £5.0m Dental underspend and there was now a requirement to deliver an additional £5.6m of savings due to the pressures we were currently experiencing.	

	The ICB efficiency delivery at the end of August 2023 was £0.4m over the YTD target. Whilst the M5 reported position reflects full delivery of the efficiency plan, it was likely that delivery would fall short of the current recorded plan by £4.9m. The ICB was still committed to achieving the full savings of £44.2m however, new efficiency programmes of £5.1m would be required to achieve this and the additional £5.6m to break even as identified above. Plans with a red or amber RAG rating had a medium to high delivery risk and account for £15.0m (38.0%) of the expected delivery of £39.1m in addition to the £5.1m shortfall. Only £20.0m of efficiencies were expected to deliver recurrently; this had been planned to be £33.2m. This created a recurrent pressure as we moved into 2024/25. To reach a breakeven position and improve the recurrent position, more work must be done to create new schemes. Within the forecast outturn breakeven position were collective pressures from Prescribing £6.5m, Better Care Fund contract £5.7m, Mental Health expenditure of £2.0m and Primary Care Co-Commissioning of £1.1m offset by the dental underspend and increase in required savings. The unmitigated likely case prediction was a deficit of £28.4m driven by excess inflation, and the under achievement of efficiencies. The worst case had moved to a £50.4m deficit, within that position there was risk associated with delivering efficiencies of £10.2m and on the £5m benefit from the Dental underspend not being available to the ICB. Executive Directors needed to address the operational risks immediately and teams were expected to make sure efficiency opportunities progress through the appropriate gateways to start to deliver the planned savings. **The Audit and Governance Committee NOTED the M5 ICB Financial Position.**	
FOR INFORMATION		
AG/2324/261	**Non-Clinical Adverse Incidents** Chrissy Tucker reported that there had been no non-clinical adverse incidents. **Audit and Governance Committee NOTED this verbal update.**	
AG/2324/262	**Specialised Commissioning Services – Pre- Delegation Assessment Framework** Chrissy Tucker reported that the pre-delegation assessment had been co-produced by ICB and NHS teams for the East and West Midlands, though joint working groups and workshops led by the ICB Executive leads for specialised services. This collaboration ensured equitable assessment of the work all parties needed to undertake in their readiness for the delegation of these services. The Midlands model of Joint Commissioning, enabled each partner to jointly exercise their statutory functions, making equitable	

	decisions through Joint Committee arrangements. Joint Committees would need to update their terms of reference to reflect delegation. ICBs were asked to review the Pre-Delegation Assessment Framework (PDAF) and approve its submission to the National Moderation Panel. The PDAF was presented and reviewed at the Delegated Services Programme Board on the 8th September 2023 before being signed by the Chief Executive and returned to the regional team at NHS England by the 25th September 2023 for collation and submission. The Chair reported it was a nationally driven approach, and it was how we protected ourselves from the financial consequences of the budgets not following the activity, which was a genuine risk. Chrissy Tucker reported that a risk share had been mentioned and there was a meeting being held in the next month or so to look at that in more detail about what that would look like and how it would work. She agreed to keep Committee informed of any progress made. **The Audit and Governance Committee NOTED the submission of the East Midlands multi-ICB Pre-Delegation Assessment Framework for specialised services to the national moderation panel.**	
AG/2324/263	**Verdict of Lucy Letby – Freedom to Speak up Plan** Helen Dillistone reported that on 18 August 2023, the ICB's Chief Executive Officer 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 had 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 reminded 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 would be followed by a prompt response. It also confirmed the expectation of all NHS organisations to adopt the updated national to Freedom to Speak Up (FTSU) policy by January 2024. It was noted that the letter went through the ICBs Public Board at its meeting in September. The Paper was presented to Audit and Governance Committee to ensure that members were sighted on the content, and the recommendations made which must be actioned by both the ICB	

	and provide a position of the ICB in relation to the five areas stipulated. It was noted that the ICB had adopted the national FTSU Policy, which received approval from the Audit and Governance Committee on 8 June 2023. Following the approval, 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 was progressing with the appointments to these roles. The Chair asked whether there had been a good level of interest in the roles. Helen Dillistone reported that there had been. Jill Dentith highlighted the action plan attached to the agenda papers, detailing lots of things that we were doing well which was very positive, but reported that there appeared to be several gaps. She felt it would be useful to have a timescale for those and a lead name; she hoped to see a more complete iteration in due course. **The Audit and Governance Committee NOTED the NHSE letter dated 18 August 2023 and the requirement for proper implementation and oversight of the national Freedom to Speak Up (FTSU) policy.**	HD
AG/2324/264	**Joined Up Care Derbyshire National Oversight Framework** Chrissy Tucker reported that on the 8th August 2023, the ICB's Chief Executive Officer received a letter from Julie Grant, Director of Transformation (East Midlands), NHS England (Appendix 1), in regards to the ICB's Quarter 1 segmentation review and approval by the Midlands Regional Support Group on the 27th July 2023. The paper was presented to Audit and Governance Committee to ensure that members were sighted on the ICB's outcome of the Q1 segmentation for the National Oversight Framework, and timescales for the 2023/24 Quarter 2 segmentation review. The paper also formally noted the Committee's virtual approval of the National Oversight Framework Quarter 2 templates on the 5th October 2023. The following was highlighted: • There was a very short timescale to respond; the data release was late, and it had been difficult to pull the information together in a timely fashion. • As a result, it had not gone as outlined in the process that had been presented at the previous Committee. • The updated version was included within the agenda pack, and it had been submitted on the Friday of that week.	

	• We now awaited feedback from NHSE on whether they accept our recommendation and after that we need to write out to providers to confirm what the segmentation level was. • Contained within the pack was a letter from NHSE confirming Q1 position. • The Chair asked whether we got a quorate response from each of the Committees? Chrissy Tucker reported that it was not quorate, but that had received a lot of responses back. • The Chair hoped that we could review it after the next round and that we would be given more time to do it. **The Audit and Governance Committee NOTED the Joined-Up Care Derbyshire National Oversight Framework Letter 2023/24 and formally NOTED the committee's virtual approval of the National Oversight Framework Quarter 2 templates on the 5th October 2023, subject to the amendments provided.**	
AG/2324/265	**Bi-Annual Committee Attendance Report** The Chair reported that all Committee Terms of Reference stated that the level of attendance expected of members, or a nominated deputy should be at least 75% of meetings. The Committee Effectiveness Review identified that none of the Committees had received a report advising them of actual attendance rates by their members. Review of minutes of the Committees' meetings held between July 2022 and March 2023 had revealed that some members were not attending sufficient meetings and, in some cases, never in attendance. As the Committees entered their second year, it was felt that a review of membership would be appropriate to monitor the process for attendance at meetings and to ensure that there was sufficient representation by members. As a result, a bi-annual Committee attendance report had been produced. The Chair requested that the attendance report be amended as Margaret Gildea had not become a core member of this Committee until July 2023. Prior to that Margaret Gildea could have attended by invitation only. Keith Griffiths reported that he felt we needed someone senior from the contracting team to attend this Committee; he had been given assurance 48 hours ago that Craig Cook would be attending, which had not been the case. He felt this needed to be escalated. Jill Dentith reported that System Finance, Estates and Digital Committee had produced two tables, one pre and one post the recent changes to the TOR so that we could see and monitor the changes. **The Audit & Governance Committee NOTED the Bi-Annual Attendance Report to Audit & Governance Committee.**	SP KG
	MINUTES AND MATTERS ARISING	
AG/2324/266	**Minutes from the Audit and Governance Committee Meeting held on 10 August 2023**	

	The minutes from the meeting held on 10 August 2023 were agreed as a true and accurate record.	
AG/2324/267	**Action Log from the Audit Committee Meeting held on 10 August 2023** The action log was reviewed and updated during the meeting.	

CLOSING ITEMS		
AG/2324/268	**Forward Planner** **The Audit and Governance Committee NOTED the Forward Planner.**	
AG/2324/269	**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? **YES**	
	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? **YES - PROCUREMENT**	
	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? **NONE**	
AG/2324/270	**Any Other Business** There was no further business.	

DATE AND TIME OF NEXT MEETING
Date: Thursday 14 December 2023
Time: 2.00PM
Venue: MS Teams

Signed: ………………………………………………………… Dated: ……………………………..
(Chair)

Derby and Derbyshire
Integrated Care Board

MINUTES OF THE ICB PEOPLE & CULTURE COMMITTEE

06 SEPTEMBER 2023, 09:00–11:00

Via MS Teams

Present:		
Gildea, Margaret	MG	ICB Non-Executive Member and Chair of ICB PCC **(Chair)**
Bayley, Susie	SB	General Practice Taskforce Derbyshire – Medical Director
Garnett, Linda	LG	JUCD Programme Director, People Services Collaborative
Knibbs, Ralph	RK	DHcFT Non-Executive Director and Chair of PCC
Moore, Liz	LM	Derby City Council, Head of HR
O'Connell, Amy	AO	DHU, Head of People and Culture
Patel, Atul	AP	CRH Non-Executive Director and Chair of People Committee
Smith, Beverley	BS	ICB Director of Human Resources.
Tidmarsh, Darren	DT	DCHS Chief People Officer / Deputy Chief Executive
Wade, Caroline	CW	CRH Director of HR & OD
In Attendance:		
Bradley, Faye	FB	UHDB, Assistant Director, People Services - on behalf of Amanda Rawlings
Frearson, Lucinda	LF	ICB, Executive Assistant **(Admin)**
Lumsdon, Paul	PL	ICB, Interim Chief Nurse
Mahil, Sukhi	SM	JUCD Assistant Director Workforce Strategy, Planning and Transformation
Pearson, Sally	SP	Derbyshire County Council, Head of Learning and Development – on behalf of Jen Skila
Pickering, Suzanne	SPK	ICB, Head of Governance
Robinson, Tracey	TR	ICB, Project Manager, People Services Team
Apologies:		
Blackwell, Penelope	PB	Place Board Chair and NHS Derby and Derbyshire CCG Governing Body GP
Clayton, Chris	CC	ICB, Chief Executive
Dawson, Janet	JD	DCHS, Non-Executive Director and Chair of PCC
Dentith, Jill	JED	ICB, Non-Executive Director
Gulliver, Kerry	KG	EMAS, Director of Human Resources & Organisational Development
Rawlings, Amanda	AR	UHDB, Chief People Officer
Skila, Jen	JS	Derbyshire County Council, Assistant Director HR

Item No.	Item	Action
PCC/2324/001	**Welcome, introductions and apologies:** Margaret Gildea (MG) as Chair welcomed all to the meeting, introductions were made around the virtual room and apologies noted as above.	
PCC/2324/002	**Confirmation of quoracy** The meeting was confirmed as quorate.	

PCC/2324/003	**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 Integrated Care Board (ICB). Declarations declared by members of the People and Culture Committee (PCC) 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.	
ITEMS FOR DECISION		
PCC/2224/004	**Terms of Reference (TORs)** The purpose of this report was for the Committee to formally review, discuss and agree the TORs for recommendation to the ICB Board for approval at their September 2023 meeting. The PCC was established by NHS Derby and Derbyshire ICB as a Committee of the ICB Board in accordance with its Constitution. A review of committees had been undertaken by 360 Assurance their report outlined a number of recommendations some of which had been updated within the TORs and appeared as track changes within the document. The Committee offered the following comments and questions: • Darran Tidmarsh (DT) queried the quoracy feeling it may be a struggle at times with the ICB Executives. Suzanne Pickering (SPK) advised that there was always an option for Chief Officer or Deputy to attend so there would cover available. **The People and Culture Committee AGREED and ACCEPTED the Terms of Reference as presented.**	
ITEMS FOR DISCUSSION		
PCC/2324/005	**Deep Dive: People Services Governance** Linda Garnett (LG) presented the report following a request at the last committee for more clarity around the People Services Delivery Board and Workforce Advisory Group, providing information for assurance regarding the supporting governance structures to the PCC and asking members to discuss the overall PCC governance in light of the recommendations in the recent audit report on Board sub committees issued by 360 Assurance. The two meetings sitting underneath the PCC are: -	

	People Services Delivery Board (PSDB): The Board reports into the Transformation Coordination Group (TCG) which is accountable to the Provider Collaborative Leadership Board (PCLB) which in turn is accountable to the ICB Board. This monthly meeting is chaired by Amanda Rawlings (AR) and attended by HRDs or Chief People Officers from partner organisations, receiving information on work programs. **Workforce Advisory Group (WAG)**: Established 12 months ago to provide more engagement with the wider partnerships and includes representation from the Local Authority (LA), voluntary sector and primary care with an agenda focused mainly on workforce plans and development. Next step is developing the role to be more explicit, working towards the Workforce Strategy along with LA colleagues. The WAG does not currently have formal accountability into anywhere but may look to feed through to the Integrated Care Partnership/ICS Executive. One of the recommendations from the audit report was that each committee would have a development session. During the session the committee needed to reflect on the overall purpose of the committee and accountability for governance required. LG had described the main purpose of the committee and its roles and responsibilities within her report identifying the type of governance required and suggesting changes which reflected the recommendations in the audit report. The Committee offered the following comments and questions: • Susie Bayley (SB) was supportive of a development session to help members add value and highlighted the need to look at how to feed in risks re primary care. • Paul Lumsdon (PL) too was really supportive on the general direction and reducing duplication, defining clear lines around who is doing which responsibilities and wished to join the development session linking in with Chief Nurses. • Caroline Wade (CW) liked the simplicity and clarity within LG's report and supported the closer integration with finance and operational colleagues emphasising that until we achieve better integration, we are not going to deliver one Workforce Strategy. • Ralph Knibbs (RK) questioned the TCG and whether this was a duplicate meeting that required reviewing in light of changes being made. **Action: LG to discuss with Tamsin Hooton, Chair of the operational delivery groups for the system.** • Atul Patel (AP) felt it important to make a statement in the TORs not to get in the way of other colleagues and structures and to note as a risk the more complicated things are the more procedures are required. **The People and Culture Committee DISCUSSED and AGREED to arrange a development session for the Committee.**	**LG**

	Action: LG and MG to draft development session agenda and circulate to colleagues for comment with a request for all to bring to the session samples of duplication. Other possible topics highlighted were sequencing/reporting and reporting routes. **Beverley Smith (BS) left the meeting.**	**LG/MG**
CORPORATE ASSURANCE		
PCC/2324/006	**Latest Workforce Report** Sukhi Mahil (SM) reported on the M4 workforce position and requested committee to note the progress being made to align workforce and finance, highlighting M4 being below plan in terms of substantive bank and agency at month compared to M3. There had been an increase and improvement in the recruitment of those substantive positions therefore the reliance on temporary staffing had reduced slightly. There had also been a lot of agency usage due to industrial action and this too had declined this month. The report had identified data quality issues this month with the University Hospitals Derby and Burton (UHDB) data, this is being worked on and rectified so the figures are likely to change for UHDB. Figures do remain above plan as a result to changes to the national and provider workforce returns submissions as East Midlands Ambulance Service (EMAS) now has to record their temporary staffing as agency. From an ICB total perspective the establishment figure is 28.8k staff but currently have just 27.1k staff in post which is under establishment, also figures compared to pay costs do not corelate and requires a more detailed review. The Committee offered the following comments and questions: • LG asked all to note the incredible amount of work being done and although PCC cannot take assurance that we are within our pay costs previously this type of granular information was not available. • DT thanked SM for the work being done and agreed with the combined approach suggesting a future agenda item in terms of signing off the plan and assuring ourselves that the figures are relatively comparable so the data can be sense checked. • RK highlighted the incredible amount of work carried out checking and double-checking information pulled from different systems from different Trusts and wondered whether a quality improvement project would assist and support the work. LG agreed but believed there was a role for the Chairs of the People Committees in the Trusts to support and discuss within their own organisations how they are contributing and how we do our reporting.	

	• MG commented on the 1000 staff not there and when we do not have the resources that is when treatment and resources for the public reduce. **The People and Culture Committee NOTED the Workforce Report.** **Assurance Report from the People Services Delivery Board** LG presented the assurance report which summarised the work being done across the different workstreams, some of the risks considered and in terms of mitigation being flagged to the collaborative delivery boards. Discussions had taken place at the last delivery board around whether this was the right work and whether resources were being spread too thinly. Each workstream has been asked to take a step back and ask themselves are any of things being done adding value and contributing to the two values set at the beginning of the year around managing pay costs to plan and improving workforce supply. Replies so far confirm that the right things are being done and would wish to continue. The Committee offered the following comments and questions: • DT supported what LG had said emphasising the huge agenda and believed the shape would change once the governance structure had been agreed as in agenda items 4 and 5. **The People and Culture Committee NOTED the Assurance Report.** **Agency Reduction Plan** LG presented to committee to provide a summary of the M4 agency usage position and to provide assurance regarding the development of the agency reduction plan. LG began by highlighting the strong focus on agency spend with NHSE who had requested regular reporting and believed it would be helpful to show what the expectations were, pointing out that we perform well in agency spend and are the lowest across the region but due to agency cap we do not get any credit or benefit for being the lowest user. The ask is to develop an agency reduction plan and assign an SRO, HRDs have agreed the system SRO to be Jennifer Smith (Deputy of Human Resources and OD at Chesterfield Royal Hospital (CRH) who is currently pulling together work being done in different providers. Trusts will be doing this anyway and there was a wish not to get in the way of those Trusts. The report describes the current position, identified needs, and sets out the work required and what areas there are to do collaborative work together. The Committee offered the following comments and questions: • Sally Pearson (SP) commented that Derbyshire County Council were also trying to reduce agency spend.	

- PL emphasised the work being done across Trusts with Chief Nurses, as nurse agency spend is a major factor.

- CW stressed this was not something just within Derbyshire and there was danger of duplication with a need for one trajectory which goes back to the previous conversation around data quality and seeing clear direction.

The People and Culture Committee NOTED the Agency Reduction Plan.

BAF (Board Assurance Framework) Risks
The purpose of the report is for Committee to discuss the BAF Strategic Risks which are the responsibility of the PCC and following the ICB Board and Internal Audit feedback, further development and strengthening of the risks has been undertaken. Two strategic risks have been identified which are the responsibility of the PCC: -

Strategic Risk 05 - *There is a risk that the system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.*
The overall risk score currently remains at a high level 20.

Tracey Robinson (TR) requested approval from members to move 2 outstanding deadlines from Q2 to Q3 as the surveys have been completed.

- It was noted that the engagement and annual staff opinion surveys information had not yet been shared with providers. Therefore, the action was to be reworded to state further actions were required but the survey had been carried out.

- CW advised that as the Senior Responsible Officer (SRO) she could inform members that the occupational health and services review had been completed but new contracts had not yet been issued and will be an ongoing activity.

Strategic Risk 06 - *There is a risk that the system does not create and enable One Workforce to facilitate integrated care.*
The overall risk score remains at a high level 12.

The Committee offered the following comments and questions:

- DT thought it would be good practice to understand what would have to be different to change the score and when do these threats no longer look like a threat.

- PL agreed adding that committees need to look at the content of their meeting and have the discussions around whether there is to be a change on the BAF.

- LG proposed holding a development session around the BAF.

	The People and Culture Committee RECEIVED Risk 05 and 06 assigned to them. **The People and Culture Committee AGREED to remain at a risk score of 20 for Risk 05.** **The People and Culture Committee AGREED to remain at a risk score of 12 for Risk 06.**	
ITEMS FOR INFORMATION		
The following items are for information and will not be individually presented		
PCC/2324/07	**No Ratified Minutes** There were no ratified minutes presented to the Committee.	
PCC/2324/08	**People & Culture Committee Annual Report 2022/23** The annual reports for the committees will be going to the November ICB Public Board but the report will also be used as a guiding document for the development session. MG added as a conclusion to the report that the engagement with committee had been fantastic with all HRDs, representatives and Chairs attending committees. A big agenda had been tackled along with some difficult issues, and a lot has been covered in today's meeting, and we shall review work of the committee at a development session. **The People and Culture Committee NOTED and APPROVED the Annual Report.**	
MINUTES and MATTERS ARISING		
PCC/2324/009	**Minutes from the meeting held: 23 June 2023.** The minutes of the meeting held on 23 June 2023 were accepted as a true and accurate record of the meeting. **The People and Culture Committee ACCEPTED the Minutes.**	
PCC/2324/010	**Action Log from the meeting held: 23 June 2023** The action log was reviewed and will be updated for the next meeting. **The People and Culture Committee NOTED the action log.**	
CLOSING ITEMS		
PCC/2324/011	**Forward Planner** The forward planner was presented as a recommendation from the 360 Assurance Audit Report with a wish to review after the development session that is to be arranged to look at sequencing and to set around the 10 functions.	

	The People and Culture Committee ACCEPTED the Forward Planner NOTING possible changes following the development session.		
	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? • **BAF deep dive or development Session to be arranged.**	
	8.	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? • **Highlighting the recruitment of people as a substantial risk** • **The inability to have absolute quality data remains a risk.** • **The alignment between the approaches that other committees are taking.**	
PCC/2324/012	**Any Other Business** No further items of business were raised.		
DATE AND TIME OF NEXT MEETING			
	Date: Wednesday 06 December 2023 **Time:** 09:00 – 11:00 **Venue:** via Microsoft Teams **Development Session:** Thursday 23 November **Time:** 13:00 – 15:00 **Venue:** Via Microsoft Teams		

Derby and Derbyshire
Integrated Care Board

MINUTES OF THE PUBLIC PARTNERSHIPS COMMITTEE

HELD ON: 31 October 2023, 10:00 – 12:00

VIA MS TEAMS

Present:		
Julian Corner	JC	Non-Executive Member DDICB **(Chair)**
Jill Badger	JB	Deputy Lead Governor, Derbyshire Community Health Services NHS Foundation Trust - Deputising for Lynn Walshaw
Steven Bramley	SB	Lay Representative
Val Haylett	VH	Governor, University Hospitals of Derby and Burton NHS Foundation Trust - Deputising for Maura Teager
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
Jocelyn Street	JS	Lay Representative
Sue Sunderland	SS	Non-Executive Member, DDICB
Sean Thornton	ST	Deputy Director Communications and Engagement, DDICB – Deputising for Helen Dillistone
Carol Warren	CW	Lead Governor, Chesterfield Royal Hospital
In Attendance:		
Lucinda Frearson	LF	Executive Assistant, DDICB (**Admin)**
Hannah Morton	HM	Public Involvement Manager, ICB
Ellen Parr	EP	Mental Health Commissioning Manager, ICB
Apologies:		
Sam Dennis	SD	Director of Communities, Derby City Council
Helen Dillistone	HD	Executive Director of Corporate Affairs, DDICB
Maura Teager	MT	Lead Governor, University Hospitals of Derby and Burton NHS Foundation Trust
Lynn Walshaw	LW	Deputy Lead Governor, Derbyshire Community Health Services NHS Foundation Trust

Item No.	Item	Action
PPC/2324/061	**Welcome, Introductions and Apologies** Julian Corner (JC) as Chair welcomed all to the meeting and introductions were made around the virtual room. Apologies were received from: Helen Dillistone, Sam Dennis, Maura Teager and Lynn Walshaw	
PPC/2324/062	**Confirmation of Quoracy** The meeting was confirmed as quorate.	

PPC/2324/063	**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: Sean Thornton (ST) brought to PPC's attention the living well paper on today's agenda and the option to bring the living well engagement approach into the ICB meaning it would come under the managerial stewardship of ST and Karen Lloyd (KL). Amy Salt (AS) as a member of Healthwatch Derbyshire advised that Healthwatch currently as part of their engagement had the contract pending decisions being made. JC stated the committee would not be making contract or financial decisions but advising and informing on the paper.	
	ITEMS FOR DECISION	
PPC/2324/064	**Evaluation Framework – Theory of Change** Hannah Morton (HM) presented the paper for discussion which detailed the development process of a JUCD Evaluation Framework. PPC was being informed and sighted on the approach from the start to provide an opportunity to influence the model and to consider if assurance was being gained. A draft theory of change model had now been written and was also being presented today. A further event to discuss the framework was being held in December with PPC members invited to join. **Action: HM to forward invite and event information to members.** The Committee offered the following comments and questions: - • JC asked what the relationship was between the evaluation framework and the reference group. HM advised part of the core and remit of the reference group would be to oversee the design and monitoring of the framework. • Sue Sunderland (SS) could see a lot of ambition but questioned how it was going to work and fit in. • Jocelyn Street (JS) felt confusion due to the plethora of reference groups and asked regarding the PPC sub reference group. HM advised that this would be that reference group.	**HM**

	• Steven Bramley (SB) questioned were the members of the reference group would be recruited from as there was a need to engage with the people to gain feedback. • JC highlighted that the ICB board and some of its sub committees have social authority remit and those colleagues provide a bridge to social care responsibilities and can bridge when needed and may be worth exploring. • SS pointed out that the framework was badged as JUCD but totally excluding the Local Authority would not be right as getting better linked up care does need to be system wide and involve the Local Authority if possible. • Tim Peacock (TP) commented that measures were critical and evidence was required that the engagement was achieving the objective of the plan. • JS agreed with TP that PPC should be involved in all steps and would like to see representation from PPC on the group and for PPC to receive oversight on how it is working and should not devolve that responsibility to a subgroup. • Hazel Parkyn (HP) liked the idea that lay reps would have a say as the most important part was the people using that service and the people you are putting into that group need to be a mixture of experts and had personal experience. **The Public Partnerships Committee DISCUSSED and proposed a face-to-face meeting be arrange around the evaluation tool.**	**ST**
ITEMS FOR DISCUSSION		
PPC/2324/065	**PPC Role in Provider Engagement Assurance Update** The paper outlines the role of the ICB in assuring patient and public involvement is taking place in NHS Trusts/Foundation Trusts in Derby and Derbyshire. Following the last presentation of the paper legal advice had been sought and KL wished to update members that following investigation into whether the NHS Trusts had in place no evidence could be found therefore legal advice was sought. The Committee offered the following comments and questions: - • SS asked why the item had been brought back as committee did not think it was part of their role and had shut down the item. • SB believed the providers had their own strategy responsibilities and should comply with them, if the ICB was looking at this as a whole it should be at a more senior level. • JS highlighted that the ICB did not have the authority or remit to supervise partner organisations and Trusts. **The Public Partnerships Committee NOTED the report.**	

	Action: ST to raise with the Executive to establish what process they wished the PPC to assure against.	**ST**
PPC/2324/066	**Living Well** The ICB Public Partnership Committee are recommended to note the proposed approach and delivery model for the Living Well Community Engagement preferred option due to the recent notification (29th August 2023) from Healthwatch Derbyshire that they will cease to provide the Living Well Community Engagement Service at the end of the current contract (31st March 2024), an options appraisal exercise had been conducted to secure the best option for the continuation of the service, in alignment with the Living Well Programme to 31st March 2025. **JC asked AS due to her interest in the item to step back from the discussion.** The Committee offered the following comments and questions: - • SS felt that there was not enough information to make a reasonable comment and would have preferred information on all options suggesting deferring until all options were provided. • HP commented that we had not learnt from what happened with mental health and those in charge are stating they cannot work the two together. We require trust, stability, and security, one-year contracts are not good at maintaining good staffing. **The Public Partnerships Committee NOTED the paper but felt committee needed sight of wider option appraisal and requested a return to a future committee.** **VH left the meeting.**	
	COMFORT BREAK	
PPC/2324/067	**Fertility Update** The paper presented by KL was to inform committee of the process for aligning fertility policy around Fertility Treatment in the East Midlands. **The Public Partnerships Committee NOTED the update.**	
PPC/2324/068	**PPC Membership Update** ST provided a verbal update, explaining that when the TORs had been reviewed previously it had been decided to strengthen the lay representation on the committee and invite Local Authority members to attend. The current terms of office for existing lay members TP, SB and JS had now been confirmed in letters and Governor colleagues were in line with terms of office with Trusts. There was still a requirement to find lay reference group representatives as this work had not yet started. The Committee offered the following comments and questions: -	

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JC highlighted the commitment of attendees but pointed out that the Committee did not have the diversity which it should and urged this to be a priority moving forward.
The Public Partnerships Committee NOTED the verbal update.
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<tr><td>PPC/2324/069</td><td>
Insight Group Report & Insight Framework

The ICB Public Partnership Committee are recommended to note the Insight Framework Update reporting on progress relating to the development of community led insight and sustained engagement to address health inequalities and promote agency across Derbyshire and Derby.

KL advised that the System Insight Group (SIG) had not yet met but the role and remit of the group had been reviewed and it was thought this could be done on a topic basis making suggestions and recommendations based on information and experiences.

The Committee offered the following comments and questions: -
JS thought the tool was terrific, not wishing the committee to get into the minutia but would like updates on reports and any major trends identified, etc.
TP felt it sounded like there was an indicator or some type of measure and asked if the group was reporting in a structured way what was being reported.
SB fully supported the tool, feeling the committee did not need to know the granular details of all but have sight of what and how much was being gathered, how it is being used and what difference it is making to services being provided.
The Public Partnerships Committee NOTED the Insight Group Report & Insight Framework.
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<tr><td colspan="3" align="center">CORPORATE ASSURANCE</td></tr>
<tr><td>PPC/2324/070</td><td>
PPI Assessment Log

The ICB Public Partnership Committee are recommended to note the PPI Forms and take Assurance that forms are being completed and actioned appropriately. The report is an update on PPI forms received by the Engagement Team during August and September of this year. It outlines a brief description of the service change, the advice and assessment that has been made in terms of whether the legal duty to inform, involve or consult applies to the change proposed, and the rationale for the decision.

The Committee offered the following comments and questions: -
SS highlighted Talking Therapies and asked why 'formal duty did not apply' which was noted in the paper.
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	The Public Partnerships Committee NOTED the log and felt assured that forms were being completed and actioned appropriately. ***Post Meeting Note from KL****: The reason for assessing as 'no legal duty' currently, is because it's currently sitting with the patient experience team to gather insight around the current experience of the service to feed into the service specification, but no changes have been identified at this moment in time. Should they decide they need to make some changes as a result of the experience data they receive then they should come back to us, so we can reassess what level of involvement is needed.*	
PPC/2324/071	**Board Assurance Framework (BAF) Strategic Risk Report** The purpose of this paper is to set out the detailed actions taken so far in support of mitigation of ICB Board Assurance Framework (BAF) Strategic Risk 3. • The Strategic Aim is: To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire. • The Strategic Risk is: There is a risk that the population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes. The Public Partnerships Committee are recommended to discuss and agree the Board Assurance Framework Strategic Risk 3 which is the responsibility of the Public Partnerships Committee. **Strategic Risk 3:** *There is a risk that the population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.* *The risk score remains high at level 12 but would like by the end of the year to be at a target score of 9.* The Committee offered the following comments and questions: - • SS believed that is was correct that the committee did need to give assurance level. • JS asked when might we expect to see the risk coming down. ST advised that a lot of work was underway, but some was not going to deliver for a long time but would take advice from the committee on the risk level. **The Public Partnerships Committee DISCUSSED the Strategic Risk, it was agreed to continue discussions at the next meeting.**	**ST**
PPC/2324/072	**Risk Report – October 2023** The purpose of the paper was to present the operational risk owned by the committee held on the ICB's Corporate Risk Register for review and	

	to provide assurance that robust management actions were being taken to mitigate them. As of October 2023, the PPC are responsible for 2 ICB corporate risks. **RISK 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.* **It was recommended that the overall risk score remains at a level 9.** **RISK 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.* **It was recommended that the overall risk score remains at level 12.** **The Public Partnerships Committee RECEIVED Risk 13 and 17 assigned to them.**	
FOR INFORMATION		
PPC/2324/074	**Bi-Annual Committee Attendance Report** The Public Partnership Committee are recommended to note the Bi-Annual Attendance Report. Following a Committee Effectiveness Review which was undertaken by the ICB's Internal Auditor's, 360 Assurance, a recommendation was made to present a report on a bi-annual basis to each corporate committee of the ICB. All Committee TORs outlines the level of attendance expected of members, or a nominated deputy which is at least 75% of meetings. The Committee Effectiveness Review identified that none of the Committees had received a report advising them of actual attendance rates by their members. Review of minutes of the Committees' meetings held between July 2022 and March 2023 revealed that some members were not attending sufficient meetings and, in some cases, never in attendance. **The Public Partnerships Committee NOTED the Report.**	
MINUTES AND MATTERS ARISING		
PPC/2324/075	**Minutes from the meeting held on: 26 September 2023** The Public Partnerships Committee **ACCEPTED** the Minutes as a true and accurate record of the meeting.	
PPC/2324/076	**Action Log from the meeting held on: 26 September 2023** The action log was reviewed and will be updated for the next meeting.	
CLOSING ITEMS		
PPC/2324/077	**Forward Planner 2023/24** The Forward Planner was **ACCEPTED** by the Committee.	

	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? **No** 4. Were papers that have already been reported on at another committee presented to you in a summary form? **n/a** 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? **No** 8. What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? **None at this time.**	
PPC/2324/078	**Any Other Business** No further items of business were raised.	

DATE AND TIME OF NEXT MEETING
Date: Tuesday 28 November 2023
Time: 10:00 – 12:00
Venue: MS Teams

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								
Operational Plan 2024/25								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 Plan and Progress										X
One Public Estate Strategy										X

ICB Key Areas	20 Apr	15 Jun	20 Jul	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Memorandum of Understanding - Voluntary, Community and Social Enterprise Sector and the ICB		X								
Partnership Consultation for DCHSFT Organisational Strategy 2023-2028			X							
System Focus										
System level Primary Care Access Improvement Plan						X				
Integrated Care Strategy										X
Population Health & Inequalities										X
Place Alliance and Provider Collaborative Update										X
Derbyshire County Council Director of Public Health Annual Report 2023						X				
Derby City Council Director of Public Health Annual Report 2023										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

ICB Key Areas	20 Apr	15 Jun	20 Jul	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Finance and Estates Committee Assurance Report	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
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

NHS
Derby and Derbyshire
Integrated Care Board

ICB Key Areas	20 Apr	15 Jun	20 Jul	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
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