Joined Up Care Derbyshire

NHS Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC AGENDA

Thursday 21st March 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/2324/141	Welcome, introductions and apologies: Dr Andy Mott, Andy Smith, Michelle Arrowsmith	Richard Wright	Verbal
	ICBP/2324/142	Confirmation of quoracy	Richard Wright	Verbal
	ICBP/2324/143	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/2324/144	Minutes from the meeting held on 18 January 2024	Richard Wright	Paper
	ICBP/2324/145	Action Log – January 2024	Richard Wright	Paper
09.10	**Strategic and Leadership**			
	ICBP/2324/146	Chair's Report – March 2024	Richard Wright	Verbal
	ICBP/2324/147	Chief Executive Officer's Report – March 2024	Dr Chris Clayton	Verbal
09.20	**Risk Management**			
	ICBP/2324/148	Board Assurance Framework – Quarter 3 2023/24	Helen Dillistone	Paper
	ICBP/2324/149	ICB Risk Register – February 2024	Helen Dillistone	Paper

Time	Reference	Item	Presenter	Delivery
09:30	**For Decision**			
	ICBP/2324/150	Domestic Abuse Pledge	Helen Dillistone	Paper
	ICBP/2324/151	Delegated Specialised Commissioning Services from NHS England • Delegation Agreement, Collaboration Agreement and Operating Framework	Dr Chris Clayton	Paper
	ICBP/2324/152	Year End Closing Position 2023/24	Keith Griffiths/ Craig Cook/ Linda Garnett	Paper
10.50	**Integrated Assurance & Performance**			
	ICBP/2324/153	Integrated Assurance and Performance Report • Quality • Performance • Workforce • Finance	Dr Chris Clayton Dean Howells/ Dr Deji Okubadejo/ Craig Cook/ Richard Wright Linda Garnett/ Margaret Gildea Keith Griffiths/ Jill Dentith	Paper
10.05	**For Discussion**			
	ICBP/2324/154	Holistic Discharge Review	Sue Sunderland/ Dr Chris Weiner	Paper
10.20	**Corporate Assurance**			
	ICBP/2324/155	Audit and Governance Committee Assurance Report – February and March 2024	Sue Sunderland	Paper
	ICBP/2324/156	Finance, Estates and Digital Committee Assurance Report – January and February 2024	Jill Dentith	Paper
	ICBP/2324/157	Derbyshire Public Partnership Committee Assurance Report – February 2024	Richard Wright	Paper
	ICBP/2324/158	Population Health and Strategic Commissioning Committee Assurance Report – January and March 2024	Richard Wright	Paper
	ICBP/2324/159	Quality and Performance Committee Assurance Report – December 2023 and January 2024	Dr Deji Okubadejo	Paper

Time	Reference	Item	Presenter	Delivery
	ICBP/2324/160	People and Culture Committee Assurance Report – February 2024	Linda Garnett	Paper
10.35	**Items for Information**			
	The following items are for information and will not be individually presented			
	ICBP/2324/161	Fit and Proper Person Test Framework	Helen Dillistone	Paper
	ICBP/2324/162	Ratified minutes of Derby City Council Health and Wellbeing Board – 09.11.2023	Richard Wright	Paper
	ICBP/2324/163	Ratified minutes of ICB Committee Meetings • Audit and Governance Committee – 11.12.23 and 08.02.24 • People and Culture Committee – 06.12.23 • Public Partnership Committee – 30.01.24 • Quality and Performance Committee – 02.11.23, 30.11.23 and 21.12.23	Richard Wright	Papers
10.40	**Closing Items**			
	ICBP/2324/164	Forward Planner	Richard Wright	Paper
	ICBP/2324/165	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/2324/166	Any Other Business	Richard Wright	Verbal
	ICBP/2324/167	Questions received from members of the public	Richard Wright	Verbal
Date and time of next meeting: **Date:** Thursday, 16th May 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 & Digital 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 & Digital 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	Non-Executive Member - Finance, Estates & Digital	Audit & Governance Committee Finance, Estates & Digital Committee People & Culture Committee Quality & Performance Committee 111 Mobilisation Oversight Board	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 & Digital Committee ICS Executive Team Meeting Clinical & Professional Leadership Group	Husband is contracted by Amber Valley CVS to deliver services to the ICS				✓	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 & Digital 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. Sheffield based - unlikely to bid in work in Derbyshire
				Director and Trustee of SOAR Community			✓		01/09/22	Ongoing	

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					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 & Digital 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	
Sunderland	Sue	Non-Executive Member - Audit & Governance	Audit and Governance Committee Finance, Estates & Digital Committee Public Partnership Committee IFR Panels CFI Panels	Audit Chair NED, Nottinghamshire Healthcare Trust		✓			01/07/22	Ongoing	The interests should be kept under review and specific actions determined as required - declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Audit Chair of Joint Audit Risk & Assurance Committee for the Office of the Police & Crime Commissioner and Chief Constable of Derbyshire		✓			01/07/22	Ongoing	
				Husband is an independent person sitting on Derby City Audit Committee				✓	01/07/22	Ongoing	Unlikely for there to be any conflicts to manage

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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, 18th January 2024

via Microsoft Teams

Unconfirmed Minutes

Present:		
Richard Wright	RW	ICB Chair (Meeting Chair)
Tracy Allen	TA	Chief Executive DCHSFT / Participant to the Board for Place
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
Prof Dean Howells	DH	ICB Chief Nurse
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)
Andy Smith	ASm	Strategic Director of People Services – Derby City Council (Local Authority Partner Member)
Sue Sunderland	SS	ICB Non-Executive Member
Dr Chris Weiner	CW	ICB Chief Medical Officer
In Attendance:		
Stephen Bateman	SB	CEO, DHU Health Care CIC
Jacinta Bowen-Byrne	JBB	BSL Interpreter
Michele Moran	MM	Non-Executive Director - DHU
Maria Muttick	MLM	ICB Corporate Development Officer
Sarah Noble	SN	Director of Midwifery - UHDBFT
Fran Palmer	FP	ICB Corporate Governance Manager
Suzanne Pickering	SP	ICB Head of Governance
Gisela Robinson	GR	Executive Medical Director - UHDBFT
Sean Thornton	ST	ICB Deputy Director Communications and Engagement
Guy Tuxford	GT	Divisional Director for Women and Children's - UHDBFT
Samantha Waters	SW	BSL Interpreter
Apologies:		
Ellie Houlston	EH	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)
Mark Powell	MP	Chief Executive DHcFT (NHS Trust and FT Partner Member)

Item No.	Item	Action
ICBP/2324/117	**Welcome, introductions and apologies:** Richard Wright (RW) welcomed everyone to the meeting confirming that this Board represents the wider NHS family, for Derby and Derbyshire, and was formed to coordinate the work of the NHS and partners to	

	address the wider determinants of health. Health is not just about looking after people when they are ill, but also keeping them healthy in the first place, something that is increasingly important as the growing and aging population lives longer. The NHS and partners, which include the local government and voluntary sector, have joined together to form an Integrated Care Partnership (ICP) and produced a strategy which is helping shape and drive all activities in the future. That ICP Strategy is particularly important because it is informed by the Joint Strategic Needs Assessments and consultation with the population of Derbyshire. It reflects what is important to them as well as what is believed internally in the NHS. The ICP Strategy is built around Start Well, Stay Well and Age and Die Well which influences the priorities and longer term vision into next year. This is a very busy time for the NHS with winter pressures and the industrial action, which will be reflected in today's papers, in particular the Integrated Assurance and Performance Report which now covers the wider NHS. It is recognised that improvements can be made in many areas, however it takes hard work to balance the conflict in demands and find the resources whether that be facilities, skill, people, or money. There is an increased emphasis on understanding how to use those resources better and more efficiently which is reflected in the plan going forward. The aim is to build a system that is resilient, performs efficiently and has a relentless focus by the people in the NHS to achieve this. Nobody feels the disappointment of not reaching the standards, more than the staff, who strive for continuous improvement. Apologies for absence were noted as above.	
ICBP/2324/118	**Confirmation of quoracy** It was confirmed that the meeting was quorate.	
ICBP/2324/119	**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/ No declarations of interest were made.	
ICBP/2324/120	**Minutes of the meeting held on 16th November 2023** **The Board APPROVED the minutes of the above meeting as a true and accurate record of the discussions held.**	
ICBP/2324/121	**Action Log – November 2023** Actions updated in the log.	

	The Board NOTED the Action Log.	
ICBP/2324/122	**Chair's Report – December 2023** 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 expressed sadness on the death of General Practitioner Dr Louise Jordan from Motor Neurone Disease, an area in which Dr Jordan campaigned to raise awareness and funding. Dr Chris Clayton (CC) confirmed that condolence letters have been sent to Dr Jordan's family and Baslow Health Centre on behalf of the Board. • CC thanked RW for all the work he has done as Chair for the Board so far and will continue to do until Dr Kathy McLean OBE takes up her new post as Chair on 1st May 2024. **The Board NOTED the Chair's report.**	
ICBP/2324/123	**Chief Executive's Report – December 2023** CC presented his report, a copy of which was circulated with the meeting papers; the following points of note were made: • 2023/24 has been a challenging year to date and is not yet concluded, many challenges will be taken forward into next year. • The system continues to work through the winter plan whilst collectively dealing with other challenges such as the recent industrial action over December and January, and the prior industrial action. • Assisting with ambulance turn around times has been a priority and a huge thanks goes to both Chesterfield Royal Hospital NHS Foundation Trust (CRHFT), University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT) and all colleagues that have helped with this. • Thanks were given to those in the community, general practice and local authority social care that have supported and continue to support flow. There have been many discussions regarding domiciliary care over the last few weeks and whilst this remains a challenge collectively, it is in a better position. • A continued watch remains on the backlog of care, with a focus on the 78 week waiting patients and intent to reduce delays in cancer. • A 2023/24 Integrated Care Strategy and Joint Forward Plan stock take will take place at the February ICB Board meeting, as well as looking at how this affects the advance of strategic intent in 2024/25. • The ICB has been selected to deliver the WorkWell services. Chris Weiner (CW) will lead with the Department of Work and Pensions and Department of Health and Social Care. Huge thanks to Andy Smith (ASm) for his work in the anchor space. • Derby and Derbyshire have been selected as one of the few areas that has a focus on GP retention thanks to the work carried out by the GP Provider Board. • GP appointments have increased by 22% over the last 4 years which is great progress.	

	• Welcome to the new CRHFT Chair Mahmud Nawaz, and the new EMAS Director of Quality Improvement and Patient Safety Keeley Sheldon. • Congratulations to DHcFT for being awarded the prestigious Chief Nursing Officer Healthcare Support Worker Award. Questions/Comments Dr Deji Okubadejo (DO) referred to the CEO report mentioning the need to continue to deal with today's and tomorrow's challenges and finding a balance. Does the ICB continue to have the capacity to maintain that balance? CC confirmed that the ICB capacity will be challenged. Further details will be outlined in the Operational Plan 2024/25 which the ICB hope to share at the Board meeting in February 2024. CW clarified that WorkWell is a multiphase decision-making process and the ICB has received support to continue to the next stage, however the final bids, and who moves into those 15 pilot projects across the country, will be confirmed in the new financial year. **The Board NOTED the Chief Executive's report.**	
ICBP/2324/124	**ICB Risk Register Report – December 2023** Helen Dillistone (HD) presented the Risk Register, which provides assurance to the Board on the operational risks faced by the organisation. The report highlights the highly rated risks and where there has been change/movement. Each risk is allocated, actively monitored, and managed by one of the ICB's Corporate Committees. This report sits alongside the Board Assurance Framework (BAF) which is reported at the DDICB Board Meeting quarterly and will be presented at the next meeting. During December there has been two risks that are recommended to be decreased in score and one risk to be increased in score: Risk 9: *There is a risk to patients on Provider waiting lists due to the continuing delays in treatment resulting in increased clinical harm;* Risk to be decreased from score 16 to 9 due to significant strides in working in collaboration with the providers around adherence to quality standards and measures taken to address any issues. Each provider has assessed its key performance indicators to ensure they are either on track or a plan is in place for them to be on track. No moderate or severe harms were reported in Quarter 1 and Quarter 2 across the Derbyshire System. 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.* Risk to be decreased from score 25 to 16 due to individual organisations now being able to apply for payment. Risk 6: *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.*	

	Risk to be increased from score 16 to 20 due to the likelihood of the challenges around the deficit position for the remainder of 2023/24. <u>Questions/Comments</u> DO queried Risk 9 from a quality perspective, as this should be heavily weighted towards the impact on patients, rather than the impact on organisations. Prof Dean Howells (DH) advised that the Quality and Performance Committee will be conducting a more detailed/forensic review from the provider risk assessment, certainly over the 78 week point around personalised risk assessment based on waiting lists. Sue Sunderland (SS) asked for more explanation to understand why Risk 9 was reducing when further industrial action is planned, and performance is still scoring 'red' around patients waiting over 65 weeks. DH advised that the reduction is due to no evidence of harm, so whilst remaining a high risk, it no longer reaches the score of 16 on the thematic risk element. The Quality and Performance Committee will be conducting a more detailed/forensic review from the provider risk assessment, certainly over the 78 week point around personalised risk assessment based on waiting lists. CC confirmed it is always the wording of a risk that affects the view of it and consideration needs to be given on the description of the risk and the question of harm, and agreed that Quality and Performance Committee reviewing this would be very helpful. RW added that in a changing, developing system it is impossible not to have risk, however the way that risk is managed and maintained at an acceptable level, and the good control that is in place, does make the risk register a dynamic document and a good management tool. Jill Dentith (JED) commented that a number of these risks are from the System Quality Group and not the Quality and Performance Committee and questioned if the committee should assess them before they are presented at the ICB Board. HD confirmed that the System Quality Group is equal with the Quality and Performance Committee in terms of governance, however they do need to link where appropriate. At the moment the committees are working through committee effectiveness. Risk management, risk tolerance and risk appetite do need to be included in those conversations, particularly as risks are taken into the new financial year. The corporate team are happy to help with those conversations. **Action: Quality and Performance Committee to conduct a forensic review on Risk 9.** **Action: HD to ensure Risk conversations take place in the Committee Effectiveness Meetings.** **The Board RECEIVED and NOTED:** • **the Risk Register Report;** • **Appendix 1, as a reflection of the risks facing the organisation as of 31st December 2023;** • **Appendix 2, which summarises the movement of all risks in December 2023. The changes in scores are subject to the review by Quality and Performance Committee and the Committee Effectiveness Meetings including risk conversations.**	**DH** **HD**

ICBP/2324/125	**Integrated Assurance and Performance Report** <u>Quality</u> DH presented the slides on Quality, highlighting the following areas: • Care Quality Commission (CQC) Activity within Primary Care – an ongoing focus is anticipated from the CQC. The ICB are working closely with primary care partners and there is a lot of activity in this area. • Infection, Prevention and Control (IPC) Improvement – There is significant focus in this area with strong IPC improvement within teams in place across all organisations. DH monitors this weekly with support from NHS England (NHSE). • Ellern Mede (Derby) – This provider has had a system review and follow ups are continuing with NHSE and broader colleagues on the daily and weekly risk assessment of placement in that area. <u>Performance</u> Michelle Arrowsmith (MA) presented the slides on Performance, highlighting the following areas: • Ambulance Category 2 Performance – EMAS's overall trajectory for December 2023 was 55 mins and 3 secs, and they achieved 56 mins 19 secs missing the target by 1 min 16 secs. Derby and Derbyshire achieved 1hr 11 secs. The team are driving this and monitoring daily to try and improve this position. • A&E Waiting Time Under 4 hours – CRHFT year to date is 77.6% with December at 71.8%, and UHDBFT year to date is 73.1%, with December at 71.6%. The Operational Plan target is 76% by end of March 2024. • 78 Week Wait – The region has 1,159 patients in this cohort, 318 of these are in Derby and Derbyshire which is 27% (data from 7th January 2024). There is a plan for both CRHFT and UHDBFT to decrease that to zero by the end of March 2024. • Cancer – The harm point is stable and in the 104 weeks actual there are 4 patients where harm reviews are being taken to the Quality and Performance Sub-Committee. <u>Workforce</u> Linda Garnett (LG) presented the slides on Workforce, highlighting the following areas: • Total Workforce – All areas, except Derbyshire Community Health Services NHS Foundation Trust (DCHSFT), are above planned numbers of staff. There has been an increase in substantive positions, mainly Registered Nursing, Midwifery and Health Visiting Staff, Allied Health Professionals and Support to Ambulance Staff categories. • Bank and Agency - There has been focus in reducing bank and agency costs in admin and estates, which has resulted in an overall reduction. However, there is currently no agency reduction in clinical staff, therefore this continues to be an area of focus.	

- Next Steps – To continue to support providers to obtain the correct amount of substantive and temporary staff, with the right skill mix and maintaining the overall financial trajectories.

Finance

Keith Griffiths (KG) presented the slides on Finance, highlighting the following areas:

- Financial Position – At the end of Month 8, the System is overspent by £37.7m. A £47m deficit has been agreed by year end which has been agreed through the governance of each organisation. The deficit is unrelated to the cost of the unfunded pay award, previous industrial action, and inflation. The System will have achieved £140m in efficiency savings by the end of the financial year, however costs have increased at a rate faster than can be saved. The deficit however may increase as it does not include the recent industrial action in December and January or any future industrial action that may happen before the end of March 2024.
- Winter Plan – This winter has been particularly challenging operationally in the first few weeks of January, with extra capacity being opened above what was expected and although finances are being micromanaged the demand and industrial action, which is impossible to predict, may affect the deficit.

Questions/Comments

Margaret Gildea (MG) commented on the workforce report, advising on the importance of alignment of the finance, people and activity numbers, and acknowledged that this is difficult as the organisations have interpreted the requirements differently. With manpower above that planned but no results of this showing in the waiting lists, the System must take any actions to improve the productivity, efficiency or even the way it works together, to improve the outcomes of patients. Steven Posey (SPo) agreed that the System step into the space of understanding the activity linked to the workforce, also linked to the impact on patients.

RW stated that extra money is needed to open wards, however the System has more substantive staff than planned, so why cannot those people be used to run the wards. SPo advised that the vast majority of additional posts in UHDBFT have been deployed into urgent and emergency care and maternity, as they are the two principal drivers to improve quality, however neither of those areas will be reflected in activity numbers or productivity for elective or cancer waiting time.

DO questioned why statistical process control charts (SPCC) are not used in the board report and advised that they would allow better interpretation of data month on month. Secondly, the finance report suggests that Month 8 was predicting a breakeven position, however that is not our current position in terms of prediction at year end. CW advised that the Business Intelligence function is currently being reviewed along with the processes and how data is managed, and the increased use of SPCCs is something he envisages going forward. KG commented on DO's question around the Month 8 breakeven position, confirming that at the time of producing the report there was a national ask to continue to report at breakeven. However, to remain transparent this report has

	contained, for several months, the best, worse and most likely scenarios, with the most likely scenario being £47m deficit. RW asked CC why the diagnostic's waiting list is showing reduced numbers but the last report from NHSE Midlands indicated these were increasing. MA confirmed the numbers on the diagnostic waiting list may not tally with the numbers on the elective or any other waiting list because not every patient on the elective pathway requires a diagnostic test. CC advised that the productivity question remains an area of focus, and the triangulation of people, finance and output is really important. This position is still being worked on, but productivity effectiveness is going to be a strategic intent in 2024/25. LG alongside with Human Resources colleagues across the system are trying to understand the people impacts on productivity, the challenges around morale and staff fatigue and what impact that may or may not have on productivity, which is not easy to quantify. **The Board NOTED:** • **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.**	
ICBP/2324/126	**Financial Plan Update** KG advised that normally at this stage in the year they are able to report the headlines from the national team around the planning expectations for 2024/25, however they are still awaiting this guidance. The impact of the industrial action has clearly had an impact on the national modelling, given the impact it has had on waiting times and financial resources. Ideally a plan would be signed over by all boards by 31st March 2024, however this will be a challenge. In the interim, work continues with the System in collating information and being as prepared as possible for when the guidance arrives. **The Board NOTED the update provided**	
ICBP/2324/127	**University Hospitals of Derby and Burton Foundation Trust Maternity Care Assurance Report** DH presented the above report confirming that this is a high profile report for the System which has national and regional context and thanked all that contributed to this and the Maternity Improvement Plan. Since the report was published in November 2023 there have been very detailed conversations at the November and December System Quality and Performance Committee around process and improvement with regard to the enforcement notices under Sections 31 and 29A of the Health and Social Care Act 2008. DH thanked Chris Harrison, Quality Non-Executive Director Lead for his input on this. DH and Nina Morgan, Chief Nurse for NHS Midlands, have enacted an additional Maternity Oversight Group which will run for the next year and have already met twice. DH thanked Sandra Smith, Regional Chief Midwife for her input. DH has also engaged with Ruth May, Chief Nurse	

Officer, NHSE and Kate Brintworth, Chief Midwifery Officer, NHSE to ensure that the progress made has been fed back to the National team.

The response in this report, is not just about the Care Quality Commission (CQC) actions. This is a cultural and safety response that is key and the sustainability around that improvement is a core focus for the ICB and UHDBFT. The required sustainability is going to continue to present a challenge over the next year, however there is confidence in how that it is going to be managed. Strong compliance will be shown against the short-term actions, and this will be demonstrated continually via the quality structure to CQC, The Nursing and Midwifery Council and General Medical Council. The team is working well and are very visible internally in supporting staff and patients, and they are also creating a higher level of confidence around delivery.

SPo advised that UHDBFT has been determined as an organisation to be open in terms of its issues, and in terms of seeking support/expertise from elsewhere. They have really benefited from national, regional and system support and would like to thank all partners. The team is determined to improve and deliver the standards of care that they know their communities deserve and are extremely focused on delivering at pace.

Gisela Robinson (GR) advised in terms of patient safety that the team have embedded best evidence and are following best practice and they are ensuring the clinical guidance reflects that. There is a maternity dashboard which is used to help measure safety and the midwifery governance tier has been strengthened, to ensure that if safety incidents occur, they are investigated promptly, and the learning captured. Obstetrics and maternity is a high risk specialty, major obstetric haemorrhages will always happen, and the team must provide assurance that they benchmark equitably nationally and are following best practice. The OBS Cymru Pathway is now embedded as part of managing that in terms of patient engagement. The team have been lucky to secure Aaron Horsey as a Patient Safety Partner. Aaron was a husband of a lady who sadly passed away in maternity, and the team are engaging with him as part of the maternity improvement. There are also good links with the Maternity and Neonatal Voices Partnership.

Sarah Noble (SN) confirmed that staff were hugely impacted by having their service called inadequate in the report and therefore it was important to keep morale high and staff engaged and motivated so that they could deliver the Maternity Improvement Plan. The team had great support from the Communications and Engagement Team, and a pack was created which helped clinicians answer difficult questions from families. Communications will continue for both families and staff keeping them informed of where the team are in their improvement journey. The team has appointed two consultant midwives who will be starting in February.

Guy Tuxford (GT) advised it has been a challenging time and the team have been strongly scrutinised, however this has been conducted in a supportive way both within the organisation and externally through the ICB and regional colleagues, and this balance is recognised and appreciated. The Ockenden saving babies lives report, had 1,600 recommendations which were mapped and used to create the Maternity Improvement Programme (created prior to the CQC report) which is well governed in terms of executive leadership and reports through to the Trust Board. From the CQC report, there were 214 CQC actions

identified, however 138 of these actions were duplicated leaving 76 distinct actions. The themes prioritised in the Maternity Improvement Programme are also what emerged from the CQC report and therefore areas the team was already focussed on. The priority projects are around culture and communications.

DH advised the team and SPo are actively engaged and have regular updates with the CQC. This ongoing relationship is key as it is anticipated that the CQC will be in contact to review progress and the team will be ready for this. It is possible that an unannounced visit could occur, which the team would welcome.

Questions/Comments

DO commented that he was pleased that culture is being considered as it is important to get this right.

JED asked how is the learning from this being embedded into the structures and culture and is that learning being shared in terms of service delivery and support within the System? SPo confirmed that this is often discussed, and the team is testing itself against this on a daily and weekly basis. The team have been to several different organisations that are going through a similar journey and have taken a lot of learning from that. Shrewsbury and Telford host a lot of NHS organisations and UHDBFT wish to do this in the future as they begin to improve.

MG expressed interest in the introduction of the Compassionate and Inclusive Leadership Programme, and asked if this might be of interest across the System? SPo advised the programme has been developed with the King's Fund and Aqua. Over 600 leaders from UHDBFT will be going through this programme. This will make its contribution to the System, as it is about values and behaviours and the impact that leaders have on outcomes of care. The Local Maternity and Neonatal Systems (LMNS) is also a vehicle for sharing practice across Derbyshire.

Andy Smith (ASm) asked if the wider partnership could be involved/work alongside UHDBFT for those wider elements of improvement? SPo confirmed that there will undoubtedly be a role for partners to support the maternity service as they look into health inequalities and what the data produces, because individual providers do not have all the answers, or all of the levers of power and influence, so they will be looking for partners to support the Maternity Improvement Journey.

CC reminded the board that maternity services have been discussed previously (16th March 2023, Item 099) following the HSIB investigation and report, plus the predecessor CCG organisations also conducted joint reviews across the county. Therefore, what has been done during this time? Can evidence of improvement, seriousness of attention, provide a comprehensive approach to understand all of the issues and commitment be shown?

RW asked with so many actions, is there a person who is overseeing this as a whole? DH advised that the Quality and Performance Committee hold an overall objective view on progress over the next year. Nina Morgan, Chief Nurse for NHS Midlands, and DH have distinct roles as well with a partnership approach. Furthermore, NHSE and DH meet monthly. The National Improvement Programme is also key in ensuring that the improvement journey continues. SPo confirmed he and Dr Kathy

	McLean, Chair, UHDBFT are clear on the strategic role of the Trust Board, quality assurance and the importance of standing back and looking at the whole picture with a strategic perspective. SPo and the Maternity team were thanked for a comprehensive, useful honest and open report. **The Board NOTED University Hospitals of Derby and Burton Foundation Trust Maternity Care Assurance Report**	
ICBP/2324/ 128	**Audit and Governance Committee Assurance Report – December 2023** SS presented the above report, highlighting firstly the limited assurance received on data and performance management and advised that this will be picked up as part of the organisational restructuring. Secondly, there is a concern at the number of contracts due for renewal at the end of March and how this will be managed effectively. **The Board NOTED the Audit and Governance Committee's Assurance Report for December 2023.**	
ICBP/2324/ 129	**Finance, Estates and Digital Committee Assurance Report – November/ December 2023** JED presented these reports, which were taken as read. There are still issues in terms of the cash position for organisations. Workforce was discussed and the triangulation between the efficiencies, finance, and staff. Efficiencies are acceptable non-recurrently, however these need to be on a recurrent basis. A presentation took place, on the Derbyshire Shared Care Record. The Elective Recovery Fund was discussed. It was agreed that although it has been a difficult few months for the System, working together has really come to the forefront and that culture is starting to embed. KG advised that UHDBFT and CRHFT have both had their applications for cash support approved from the treasury. No questions were raised. **The Board NOTED the System Finance, Estates and Digital Committee Assurance Report for November and December 2023.**	
ICBP/2324/ 130	**Quality and Performance Committee Assurance Report – November 2023t** DO presented this report which was taken as read and advised that a Maternity Update will be added to the monthly agenda. No questions were raised. **The Board NOTED the Quality and Performance Committee Assurance Report for November 2023.**	
ICBP/2324/ 131	**People and Culture Committee Assurance Report – December 2023** MG presented this report which was taken as read, advising that a good debate took place regarding Freedom to Speak Up (FTSU) and the	

	particular arrangements around the reflective tool at UHDBFT. There was concern around General Practice FTSU arrangements as they are currently receiving funding for a guardian from outside the practices, but this funding is due to end. There is a fantastic initiative between Derby City Council and DCHSFT called Community First, which pools funding and resources together so that organisations work together to help get patients home from hospital as soon as possible. RW asked how confident MG was that the 37,000 people across the NHS in Derby and Derbyshire do feel confident enough to be able to speak up? MG confirmed she felt assured that the independent foundation trusts have very strong freedom to speak up arrangements. There is less assurance in Primary Care. This remains a regular item on the People and Culture Committee and if anyone needs any help or support they would be happy to provide. No further questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/132	**Freedom to Speak Up Update – General Practice** MG presented this report which were taken as read. No questions were raised. **The Board NOTED the update on the Freedom to Speak Up (FTSU) role in General Practice.**	
ICBP/2324/133	**East Midlands ICB Collaborative Arrangements (Information only)** CC asked the Board to give some attention to this report and note the current position of collaboration between the East Midlands and the ICB and the potential for ongoing collaboration in the 12 to 24 months ahead. RW advised this is working well, although it is not without its challenges. **The Board NOTED the latest developments of the East Midlands ICB Collaborative Arrangements.**	
ICBP/2324/134	**ICB Constitution – approval letter from NHS England (Information only)** **The Board NOTED the approval from NHS England (NHSE) on the amendments to the ICB Constitution.**	
ICBP/2324/135	**Emergency Preparedness, Resilience and Response Annual Report 2022/23 (Information only)** **The Board NOTED the Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2022/23.**	

ICBP/2324/136	**Ratified Minutes of ICB Corporate Committees** • Audit and Governance Committee – 12.10.2023 • Public Partnership Committee – 6.9.2023 • Quality and Performance Committee – 31.10.2023 **The Board RECEIVED and NOTED the above minutes for information.**	
ICBP/2324/137	**Forward Planner** **The Board NOTED the forward planner for information**	
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. No	
ICBP/2324/138.2	Did any of the discussions prompt us to want to change any of the risk ratings up or down? Yes, Risk 9 reduction is subject to the Quality and Performance Committee conducting a forensic review.	
ICBP/2324/139	**Any Other Business** RW confirmed an NHS System Development Event will be taking place on Thursday 15th February 2024 at Coney Green Business Park, Unit 13, Wingfield View, Clay Cross, Chesterfield, Derbyshire S45 9JW. It is important for all to attend as they will be doing a stock take of the current position and looking at the 5 year plan.	
ICBP/2324/140	**Questions received from members of the public.** No questions were received from members of the public.	

Date and Time of Next Meetings

Date: Thursday, 21st March 2024
Time: 9am to 10.45am
Venue: via MS Team

ICB BOARD MEETING IN PUBLIC

ACTION LOG – JANUARY 2024

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.	18/1 This will be an agenda item in March 2024	**May 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.	18/1 RW has met with MA and Craig Cook they recognised that this is more comprehensive and will need to be rationalised to reflect that this is strategic high level, and possibly move some of the information into the committee structure. A further conversation will take place with HD. A discussion also took place on how the report should show what progress is being made to the longer term vision.	**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	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. 18/1 RW has raised this with NHSE and is awaiting a reply.	**Ongoing**

			this year, and baselines for future years.		
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.	18/1 MA to present a paper in March 2024.	**May 2024**
ICBP/2324/124 18.1.2024 #1	ICB Risk Register Report – December 2023	Prof Dean Howells	Quality and Performance Committee to conduct a forensic review on Risk 9.	Review to be undertaken at the March Quality and Performance Committee meeting.	**March 2024**
ICBP/2324/124 18.1.2024 #2	ICB Risk Register Report – December 2023	Helen Dillistone	HD to ensure risk conversations take place in the Committee Effectiveness Meetings.	Committee effectiveness discussions are addressing risks and reviewing positions for year end and also identifying any new risks as we move into 2024/25.	**Complete**

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: 146

Report Title	Chair's Report – March 2024							
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	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 Chair's Report for March 2024.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
Planning & Board Assurance The Chief Executive's report describes the process we are following in developing our 2024/25 Operational Plan, as well as the line of sight we are seeking to maintain on our delivery of our 5-Year NHS Plan. The Board has been suitably involved in these conversations, with two sessions held through the autumn and winter to identify and agree the key system programmes of the future, and a further session planned for April where we will look at the detail of the plan for the next year. This will be year 2 of our original five-year forward view, and we continue to work very hard reflect things that we have talked about for so long but have not been able to pin down due to relentless operational pressures. As Chair, and as a Non-Executive Member, I champion the importance of next year's plan being set in the context of our strategic objectives, which are in part driven by the Integrated Care Strategy. We continue to recognise the importance of our approach being informed by the Joint Strategic Needs Assessment and insight. Whilst a one-year plan in isolation cannot show significant change, the rolling five-year view will give a better reflection of what we hope to achieve, along with the magnitude of the change required in the medium term. This is especially the case in areas like prevention, and the advantages it will bring to the population.

Public Partnership

It is no coincidence that an Engagement Strategy was required as one of the key documents submitted to support the establishments of ICBs in 2022. Ensuring our population is at the heart of decision-making has long been an aim of the NHS; the work underway in developing our Insight Framework is as ground-breaking as it is necessary, and we are on the cusp of truly sharing power in decisions with our population. It's clear that NHS clinicians and managers have a significant part to play in setting the course in improving local health. We have access to the data that tells us the conditions and illnesses patients are presenting with when they need NHS treatment, and we know the ways in which these conditions need to be treated to support recovery. The missing link is understanding more about the 'why' and 'how' – why are patients developing illnesses, how are their lives contributing to them and how can we help to prevent them? We can only understand the 'why' and the 'how' by routinely asking our population, investing ourselves into their lives, seeking insight into their priorities and needs, and aligning that with the data and clinical expertise. Embedding this approach across all our work is the long-term goal, and my first two meetings as Chair of the Public Partnership Committee have outlined that we are heading in the right direction.

Hypertension Project Wins NHS Communicate 2024 Award

Evidence of the approach of working closely with communities has been our work on hypertension in Derby. The programme's communications and engagement approach won the Working in Partnership Award at the NHS Communicate Awards, held on 7th March. Led by the ICB's Medicines Management Team, the project set out to increase the number of blood pressure checks carried out in Derby City, particularly among the South Asian and Black African Caribbean population who are at higher risk of cardiovascular disease.

Working in collaboration with the ICB Communications and Engagement Team, Derby Health Inequalities Partnership and Community Action Derby, the project was shortlisted for the award for their efforts in engaging with community groups to produce high-quality, culturally specific communications materials to support volunteers when carrying out blood pressure checks in their communities. The campaign was driven by local insight with a strategy focusing on long-term educational outcomes and recognising the importance of community engagement and building relationships. The project has supported over 4,000 additional blood pressure checks in communities to date.

It is also worth noting that Derbyshire Healthcare NHS FT was highly commended in the same award category for their efforts to work with charities and other health providers to promote the expansion of mental health crisis services across Derbyshire. Partnership working was established between the Communications and Engagement team and key stakeholders, including NHS Derby and Derbyshire Integrated Care Board, Richmond Fellowship, Derbyshire P3, Derbyshire Mind and Zink, to ensure these services were promoted as widely as possible.

Integrated Care Strategy Guidance

The Department of Health and Social Care (DHSC) has published updated guidance on the preparation of integrated care strategies, based on user feedback. It includes new case studies and reflects developments since it was first published in July 2022. In summary, the updated guidance includes:

- additional guidance on localised decision-making at place level, including how place-level plans and strategies (including shared outcomes frameworks) should shape the integrated care strategy
- greater clarity on the opportunity for integrated care strategies to consider the wider determinants of health in setting the overall direction for the system (for example, housing and crime) and health-related services (services that are not directly health or social care services but could have an impact on health)
- greater clarity on the expectation for integrated care partnerships (ICPs) to promote widespread involvement when developing their integrated care strategies.

Tracy Allen to step down as Chief Executive of Derbyshire Community Health Services
Tracy Allen, DCHS Chief Executive and partner member of the ICB Board, has announced she will step down from her role in September 2024. Under Tracy's leadership, NHS community health services in Derbyshire have evolved, first as a standalone provider in 2011, to become an NHS trust and then an NHS foundation trust in 2014, achieving a CQC 'outstanding' rating in 2019, which it has maintained over the past four years.

In recent years Tracy has played a pivotal leadership role within the local integrated health and care system, as a partner member on the Derby and Derbyshire Integrated Care Board; NHS lead for Place development and as an elected trustee of NHS Providers, representing community/foundation trusts, in 2022/23. Tracy has often been named in the HSJ's Top 50 NHS chief executives' list since 2015. Tracy's intelligence, strategic thinking and compassion will be missed and we must make the most of her remaining six months as a local NHS leader to ensure her system memory and legacy are retained.

Measles Cases Prompt MMR Vaccine Call
UKHSA has reported an increase in measles across the country and is encouraging people to check that they and their children have had two doses of the MMR vaccine. The free MMR vaccine is a safe and effective way of protecting against measles, as well as mumps and rubella.

In Derbyshire, vaccination coverage is relatively high, but it remains important for parents to take up the offer of MMR vaccination for their children when offered at 1 year of age and as a pre-school booster at three years, four months of age. If children and young adults have missed these vaccinations in the past, it's important to take up the vaccine now from GPs, particularly in light of the recent cases. Most healthy adults will have developed some immunity to measles but can still receive two doses of the vaccine from their GP too.

Anyone with symptoms is also being advised to stay at home and phone their GP or NHS 111 for advice. Measles symptoms to be aware of include:

- high fever
- sore, red, watery eyes
- coughing
- aching and feeling generally unwell
- a blotchy red brown rash, which usually appears after the initial symptoms.

New Dental Recovery Plan
The NHS and Department for Health and Social Care (DHSC) have published a joint plan to recover and reform access to NHS dental care. This plan is an important next step in improving patient access to NHS dental care and supporting dental services to return to pre-pandemic levels of activity. Supported by £200m of new government investment, the plan sets out how we will grow the workforce, including providing targeted funding for dentists to work in areas that have historically struggled to recruit and retain staff, raising the minimum Unit of Dental Activity value to £28 to help make NHS work more attractive to dental teams, and offering dental practices a new patient premium payment to treat patients who have not been seen for over two years.

Locally, Treeline Dental Care has been appointed by the ICB as the new provider of NHS dental services in Bolsover. BUPA closed its dental practice on 30 June 2023. Since then NHS Derby and Derbyshire has been working to support local people to put in place a contract for a new provider. Treeline will operate from the premises previously occupied by BUPA at Market Place, Bolsover. Patients can now express interest in receiving dental treatment when it opens by providing their contact details via Treeline's website.

Future commissioning of specialised services approved

Throughout March Integrated Care Boards (ICBs) in the Midlands are holding public board meetings at which the delegation of 59 specialised services will be discussed and decided on. NHS England has previously 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.

If approved, responsibility and budgets for these services will be delegated to each ICB, which will work together on East and West Midlands footprints in all decision making. Delegation would mean that ICBs become responsible for the whole pathway of care and could focus resource on prevention or primary care services to improve overall patient outcomes and reduce the need for specialised services. Clinical advances could also be implemented closer to home rather than just being in a specialised setting – for instance diagnostic services – maintaining specialist capacity for those that need it most. It should also help reduce inequity of access – there is good evidence that currently access varies across geographies with those living furthest from specialised provision experiencing delay in access.

East Midlands Combined Council Authority Sign Off

The government has officially signed into law approval of the new East Midlands Combined County Authority (EMCCA), paving the way for £1.14 billion investment into the region and the first-ever East Midlands mayoral election in Derbyshire and Nottinghamshire on 2nd May.

Devolved funding will be available 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.

ICB colleagues will seek to forge relationships with the mayoral candidates and EMCCA lead officers during the coming weeks, to seek to ensure the ICS agenda in supporting the wider determinants of health is factored into planning.

NHS Confederation Manifesto

Ahead of the General Election, the NHS Confederation has set out what its members have said they want from the next Government in their new report, Building the health of the nation. This report identifies five critical factors to help secure the future of the service, namely; putting the NHS on a more sustainable footing, increasing NHS capital spending and reform how the capital regime operates, committing to fund and deliver the NHS Long Term Plan, providing more care close to home and delivering a strategy for national health.

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**	There is a risk that the system does not create and enable a health and care 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 risks identified.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

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:**

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

Not applicable to this report

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Not applicable to this report.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: 147

Report Title	Chief Executive Officer's Report – March 2024							
Author	Dr Chris Clayton, Chief Executive Officer							
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer							
Presenter	Dr Chris Clayton, Chief Executive Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Not applicable							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Not applicable							

Recommendations
The ICB Board are recommended to **NOTE** the Chief Executive Officer's Report for March 2024.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
The final month of the NHS financial year is a period of planning and forecasting for the year to come, in parallel with maintaining or seeking to still improve operational performance prior to year-end. All partners have been working through their plans, under the leadership of the Executive Planning Group, and the NHS system has submitted to NHS England our initial forecast outturns for performance against constitutional performance standards for 24/25. We have sought to balance delivery ambition with reality to ensure our predictions are credible and deliverable. Discussions will continue within the regulatory space and our first full planning submission will be made on 21 March 2024, with the final submission deadline on 2 May 2024. As an aside to remarks about operational performance, significant national attention has been placed on the achievement by the end of March 2024 of 76% of patients attending our Emergency Departments being treated within four hours, a commitment that is not being achieved across the country. There has been significant regional and national attention on our progress, including daily sitrep discussions and breach validation to ensure an accurate position. As a system, we are close to achieving this target as things stand.

As well as shorter-term operational planning, we continue to seek to set longer-term priorities in the delivery of the NHS system's 5-Year Plan (Joint Forward Plan). The 2024/25 submission is year two of this work, and we need to confirm the longer-term aspirations for population health improvement. There have been two Board-level workshops to enable this clarity, and a further session in early April to seek to bring conclusion to the conversation and enable our teams to fully embrace the work required to deliver the transformation needed. As our financial reports set out, the position here is challenged and is a clear factor in how we make the transition from an NHS which treats people when ill, to a greater proportion of our resource being committed to ill-health prevention activities. This remains our vision, despite operational, financial and workforce challenges.

Impacting progress, including our ability to recover surgery waiting times, our hospitals system has 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. 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.

It has been an unsettling period for ICB staff following the recent consultation on our structures; the consultation has now closed and our revised structures have been agreed by the Remuneration Committee. Processes are now being progressed to settle staff into the structures, and it remains our aim to minimise any requirement for compulsory redundancy. Our staff have continued to show compassion and empathy towards colleagues who do not yet have their position confirmed. Despite this uncertainty, staff have continued to work relentlessly with colleagues in the wider health and care system to seek to improve the health of local people and it is factual to say that we have made much progress, and on many fronts. In our role as strategic commissioner we have awarded major contracts for our 111 and GP out of hours providers, which were significant, technical undertakings loaded with risk given the size and scale of the contracts. In our first year of delegated responsibility for dental commissioning, we have been able to confirm the start of a new dental provider in Bolsover following the withdrawal of the previous provider last year, and reflects the hard work of our dental commissioning team to put alternative arrangements in place. Working in the system space, we have seen relative improvements to our discharge capacity, our ED performance and our ambulance response times, and without the episodes of industrial action, I am confident we would have made great inroads into our elective care waiting lists. We've been award-winning in our medicines management work on opioids, the communications and engagement supporting our condition management work on hypertension and we have also been very successful in our approach to social prescribing. There is more to do, on many fronts, but all this work, along with a significant amount of other success, deserves to be noted and celebrated. As I noted in my previous report to Board, we remain in escalation during these challenging periods but can see the results of our longer-term thinking bearing fruit.

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

Teens choose NHS as first choice for their future career
A BBC Bitesize survey found that the NHS is the first choice of employer for teenagers. Both Doctor and Nurse made the top five in career preferences in a survey of 4,000 young people, with one in ten saying that Doctor was their top career pick. The survey also showed that the NHS was the most popular employer with 13–16-year-olds – ahead of FIFA and various tech firms.

Ambulance handovers improve despite increased demand and ongoing winter pressures
New data shows ambulance handover delays have improved despite increased demand, alongside continued pressure from winter viruses and industrial action.

Martha's Rule
'Martha's Rule' will be rolled out across England from April 2024 to at least 100 NHS sites, enabling patients and families to seek round-the-clock access to a rapid review from a separate care team if they are worried about a person's condition. This follows the family of Martha Mills campaigning to help improve the care of patients experiencing acute deterioration.

NHS urges young adults to catch up on missed MMR vaccine
More than 900,000 adults aged 19 to 25 in England are being invited to book an appointment for their missed measles, mumps, and rubella (MMR) vaccine, as the NHS catch-up campaign continues. **Paid leave for NHS staff experiencing pregnancy loss**
NHS staff who suffer a miscarriage will now receive up to 10 days additional paid leave, under new guidance issued to local hospitals today. Women who experience a miscarriage in the first 24 weeks of pregnancy will be offered up to 10 days paid leave and their partners will be offered up to 5.

NHS staff report record levels of discrimination from the public
A national staff survey has revealed frontline NHS staff are facing record levels of discrimination from the public. One in 12 NHS staff that responded to the poll said they faced discrimination while treating patients at work – the highest percentage since the question was first asked in 2019.

NHS Parliamentary Award nominations to celebrate exceptional NHS staff open
Nominations for the 2024 NHS Parliamentary Awards are now open. The annual awards are an opportunity for MPs get to recognise staff who go above and beyond to deliver excellence in healthcare.

Millions more dental appointments to be offered under NHS Dental Recovery Plan
Patients will benefit from millions more NHS dental appointments over the next year, following a major new plan to ensure easier and faster access to NHS dental care across England.

NHS campaign to help patients get treatment from their pharmacy
The Pharmacy First campaign aims to raise awareness of the recently launched initiative that allows pharmacists to treat seven common conditions, without the need to visit a GP practice. The campaign raises awareness through posters and materials to share in waiting rooms, staff areas, together with video on demand, posters in locations such as bus shelters and also screens in some GPs and A&Es. In Derbyshire 100% of pharmacists have signed up for the scheme.

Local developments

DHU Healthcare confirmed as preferred provider for out of hours GP services
DHU Healthcare has been awarded a new contract to provide GP out of hours services, following a procurement process led by NHS Derby and Derbyshire Integrated Care Board. DHU Healthcare is the existing provider of primary care out of hours services, but this is a new contract with a different specification.

Derbyshire wins big at the 2024 Care Awards
Health Innovation East Midlands announced the winners of the 2024 Care Awards at an event in March. The winners, across six categories, were shining examples of care provided in Care Homes and in people's homes across the region, and some of these remarkable awards recognised the services provided in Derbyshire:

Care Home Support Team of the Year
Award Winner: Forget Me Not Team – Ashfields Care Home

Care Home Manager of the Year
Award Winner: Malik Mandani – Langdale Heights

Home Care Provider of the Year
Award Winner: Bespoke Care and Training
Highly Commended: Golden Years Support Services

Care Home of the Year
Highly Commended: Bankwood Care Home
Highly Commended: Brookfields Private Nursing Home

Tracy Allen to step down as chief executive of Derbyshire's community NHS services
Tracy Allen has announced plans to step down as chief executive of Derbyshire Community Health Services NHS Foundation Trust in September 2024, after 13 years in the role.

New provider of NHS dental services Bolsover area
Treeline Dental Care has been appointed by NHS Derby and Derbyshire as the new provider of NHS dental services in Bolsover. Treeline will operate from the premises previously occupied by BUPA at Market Place, Bolsover - the opening date is still to be confirmed.

NHS Communicate winners
NHS Derby and Derbyshire Integrated Care Board and Community Action Derby took home the 'Working in Partnership' award at the NHS Communicate Awards in early March. The award recognised the partnership approach to communications and engagement between the ICB's Communications and Engagement and Medicines Management teams and Community Action Derby as part of the 'hypertension, going further and faster', project.

Social prescribers in Derbyshire help thousands to get better
Social prescribers in Derby and Derbyshire supported thousands of people to improve their health and wellbeing over the past year. All GP practices have a social prescriber who is there to support people through non-clinical ways, often by connecting them with local community activities and services.

Police and Crime Commissioner and East Midlands Combined Authority Mayoral elections

The Derbyshire Police and Crime Commissioner and East Midlands Combined Authority Mayoral elections are scheduled to take place on Thursday 2 May 2024.

Publications that may be of interest:

Joined Up Care Derbyshire – February 2024 Newsletter

Identification of Key Risks

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

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

Not applicable to this report.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

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

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

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: 148

Report Title	Board Assurance Framework – Quarter 3 2023/24							
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 – Quarter 3 2023/24 BAF strategic risks 1 to 10							
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 Quality and Performance Committee People and Culture Committee Public Partnership Committee							

Recommendations

The ICB Board are recommended to:

- **RECEIVE** the Quarter 3 BAF strategic risks 1 to 10; and
- **NOTE** the increase in risk scores for Strategic Risk 4 from a very high score of 16 to a very high score of 20.

Purpose

The purpose of this report is to present to the ICB Board the Quarter 3 2023/24 Board Assurance Framework.

Background

A fundamental aspect of the ICB's governance structure is the establishment and implementation of sound risk management arrangements. The effective design and embedment of these arrangements will ensure that the Board is kept informed of the key risks facing the ICB and the wider system, and is assured that robust processes are in place to manage and mitigate them.

The Board Assurance Framework is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's aims and objectives. The BAF provides the Board with a framework to support identification of key areas of focus for the system and updates as to how those key areas are being addressed.

Nine Strategic Risks were initially identified at the ICB Board's BAF development workshops to achieve the ICB's three core aims. These were agreed at the ICB Board on the 17th November 2022 and were used as the basis for developing the full Board Assurance Framework.

The strategic risks are the risks that face the system, including the ICB. The ICB however will take a system coordination role to develop the framework that underpins the delivery and will require the input of system partners to mitigate complex risks. It will require strong alignment with system partner BAFs and assurance will be drawn from a range of internal and external sources.

System organisations have a duty to support the ICB in the management of the BAF and the achievement of the ICB's objectives.

Report Summary

Quarter 3 BAF 2023/24

During Quarters 1 and 2, the BAF has been modified to include the cross referencing of gaps in control and assurance to the relevant actions. A significant review was undertaken of gaps in controls and assurances to ensure they address the risk areas. Where gaps did not address the risk areas they have been removed. Actions to address gaps in controls and assurances have been reviewed, updated and marked as complete where required. Updates for Quarter 3 are highlighted in blue. Text has strikethrough applied to illustrate that this will be removed and details the replacement text where superseded.

Appendix 1 provides the summary of the Quarter 3 BAF and the detailed Quarter 3 2023/24 BAF strategic risks 1 to 10.

1. Quality and Performance Committee – Strategic Risks 1 and 2

Strategic Risk 1*: There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and both upper tier Councils to deliver consistently safe services with appropriate standards of care.*

Strategic Risk 2*: There is a risk that short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.*

The Quality and Performance Committee BAF Task and Finish Working Group meets on a monthly basis to review their BAF Strategic Risks.

Strategic risk 1 is currently scored at a very high 16, having been decreased in score in Quarter 2 from a very high score of 20.

Strategic risk 2 is also currently scored at a very high 16, having been decreased in score in Quarter 2 from a very high score of 20.

The Quality and Performance Committee have closely scrutinised BAF risks 1 and 2 and given the current system pressures the Committee supports the risk scores remaining the same.

2. Population Health and Strategic Commissioning Committee (PHSCC) – Strategic Risks 7, 8 and 9

Strategic Risk 7: *There is a risk that 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.*

Strategic Risk 8: *There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.*

Strategic Risk 9*: 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.*

BAF Strategic Risk 7

Strategic Risk 7 has two actions with reference to Threat 1 and Threat 4 that are now complete relating to Surge Planning, as a result of the Plan being submitted in October 2023. As such, the Committee level of assurance for action 7T2.1A and 7T4.3A has been changed from 'Partially Assured' to 'Assured' to reflect this completion.

Following the review of actions, the Committee have agreed that the risk profile for this risk remains at risk score 12.

BAF Strategic Risk 8

This Strategic Risk is currently scored at a high 12.

Updates have been included where appropriate, however, there are actions detailed where these are dependent on the ICB Staff re-structure agreement which is currently in process.

BAF Strategic Risk 9

This Strategic Risk is currently scored at a very high 16.

Following discussion at the Population Health and Strategic Commissioning meeting held on 11th October 2023, the description relating to Threat 1 has been amended slightly. The description *'adversely affect'* has been replaced by *'outstrips/surpasses'* as detailed below:

> The breadth of requirements on the system ~~adversely affect~~ outstrips/surpasses our ability to prioritise our resources (financial/capacity) towards reducing health inequalities.

The risk profiles of risk 9 have been reviewed and considered by the Committee and have not changed during quarter 3.

3. Finance, Estates and Digital Committee – Strategic Risks 4 and 10

Strategic Risk 4: *There is a risk that 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.*

Strategic Risk 10: *There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.*

BAF Strategic Risk 4

At the November meeting of the System Finance, Estates and Digital Committee, it was recommended that Strategic Risk 4 was increased in risk score from a very high score of 16 to a very high score of 20, effective from November 2023. 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.

BAF Strategic Risk 10

The risk score for Strategic Risk 10 has been reviewed and the current risk score of a high 12 remains appropriate at this time. Whilst the digital funding streams are under pressure to support other critical activity, the risks are being managed appropriately.

4. People and Culture Committee – Strategic Risks 5 and 6

Strategic Risk 5: *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.*

Strategic Risk 6: *There is a risk that the system does not create and enable One Workforce to facilitate integrated care.*

BAF Strategic Risk 5

The risk score for Strategic Risk 5 remains at a very high 20. However, since discussing this report at Audit and Governance Committee on 14th March 2024, for Quarter 4 the committee would like a review of this risk description to reflect the national guidance on workforce growth and recruitment, instead focussing on ensuring the right workforce model is in place.

BAF Strategic Risk 6

The risk description for Strategic Risk 6 has been amended. This change was agreed at the December 2023 People and Culture Committee meeting and is shown in blue type below:

There is a risk that the system does not create and enable a health and care Workforce to facilitate integrated care.

This change is to reflect that the System is no longer using 'One Workforce' as a definition.

Threat 1: There is not an agreed definition of what "One Workforce" means.

Threat 1 has been removed from Strategic Risk 6 to also reflect that 'One Workforce' is no longer used as a definition. As such, the associated System Controls, Assurances and gaps have also been removed. These are currently shown with a strikethrough to highlight the deletion.

A Workforce Strategy is being developed and this is detailed in Threat 3.

Whilst agreement has been made to sign up to joint objectives, these are focussing on workforce supply and economic development. A diagnostic exercise is underway in support of the

Organisational Development plan; however no funding has been identified to support implementation.

The risk score for Strategic Risk 6 remains at a high 12.

5. Public Partnership Committee – Strategic Risk 3

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.

Each action within the BAF Strategic Risk 3 treatment plan has been expanded to provide greater visibility on the steps required to implement measures to mitigate the risk. These measures will be material in delivering against the JUCD Engagement Strategy, so are strategic measures to improve process and outcomes and strengthen public involvement, and not merely measures put in place to mitigate risk.
The timetable and actions within the treatment plan will be used to populate the business planner for the committee, and will be refreshed in full after Quarter 4.

The risk profile has been considered and remains a very high 16.

6. Actions completed during Quarter 3

The following table details actions which have been completed during Quarter 3 across the Strategic Risks.

Action Reference Number	Action	Action date completed
1T1.4A	Development of Recovery Action Plan which is submitted at the Learning Disabilities & Autism (LDA) Mental Health Delivery Board.	31.12.23
7T2.1A 7T4.3A	Surge planning process established / all year-round planning approach – this does not prevent operational pressures but helps to predict and plan better the response.	31.10.23
4T3.2A	A process looking at value and waste in clinical pathways.	31.12.23
10T1.1A	Secure agreement on digital and technology resource funding.	30.11.23
10T2.1A	Formalise link to Public Partnership Committee.	30.09.23
3T1.2A	Evaluation Framework – planning workshop Insight Framework – Tool drafted and socialised.	03.07.23 30.05.23
3T1.3A	Tool drafted and socialised	30.05.23
3T1.4A	Clarification of NHS FT resource and role in engagement delivery Meeting with ICB commissioning directors to discuss process	28.11.23 13.10.23
3T1.5A	Forge closer team links and shared work programmes with behavioural psychology team	17.10.23
3T2.2A	Meet with ePMO colleagues to understand change model approach to system transformation, including financial context for 23/24	31.12.23

3T2.4A	Develop proposal and business case for UEC behaviour/insight programme following social marketing principles	01.09.23
3T3.1A	ICB team undertake scoping in line with portfolios	30.06.23
3T4.2A	Confer with regional ICB leads on appetite for potential benchmarking approach to understand approaches, team roles, capacity	30.09.23

Each responsible Executive and the Committee reviewed and approved their final Quarter 3 2023/24 strategic risks at the Committee meetings during January 2024.

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**	There is a risk that the system does not create and enable a health and care 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 nor 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

[To be completed by the Finance Team ONLY]

Yes ☒	No☐	N/A☐

Details/Findings

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.

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?

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.

Appendix 1 – ICB Board Assurance Framework Quarter 3 2023/24

The key elements of the BAF are:

- A description of each Strategic Risk, that forms the basis of the ICB's risk framework
- Risk ratings – initial, current (residual), tolerable and target levels
- Clear identification of strategic threats and opportunities that are considered likely to increase or reduce the Strategic Risk
- Key elements of the risk treatment strategy identified for each threat and opportunity, each assigned to an executive lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate the three lines of defence: (1) **Management** (those responsible for the area reported on); (2) **Risk and compliance** functions (internal but independent of the area reported on); and (3) **Independent assurance** (Internal audit and other external assurance providers)
- Clearly identified gaps in the control framework, with details of planned responses each assigned to a member of the Senior Leadership Team (SLT) with agreed timescales

Key to lead committee assurance ratings:

Green = Assured: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity

- no gaps in assurance or control AND current exposure risk rating = target OR
- gaps in control and assurance are being addressed

Amber = Partially assured: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy

Red = Not assured: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each Strategic Risk and also to identify any further action required to improve the management of those

Risk scoring = Probability x Impact (P x I)

Impact		Probability				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
5	Catastrophic	5	10	15	20	25
4	Major	4	8	12	16	20
3	Moderate	3	6	9	12	15
2	Minor	2	4	6	8	10
1	Negligible	1	2	3	4	5

This BAF includes the following Strategic Risks to the ICB's strategic priorities:

Reference	Strategic risk	Responsible committee	Executive lead	Last reviewed	Target risk score	Previous risk score	Current risk score	Risk appetite risk score	Movement in risk score	Overall Assurance rating
SR1	There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to delivery consistently safe services with appropriate levels of care.	Quality & Performance	Prof Dean Howells	17.01.2024	10	16	16	12	⟷	Partially assured
SR2	There is a risk that short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	Quality & Performance	Prof Dean Howells	17.01.2024	10	16	16	12	⟷	Partially assured
SR3	There is a risk that the population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	Public Partnership Committee	Helen Dillistone	23.01.2024	9	16	16	12	⟷	Partially assured

Reference	Strategic risk	Responsible committee	Executive lead	Last reviewed	Target risk score	Previous risk score	Current risk score	Risk appetite risk score	Movement in risk score	Overall Assurance rating
SR4	There is a risk that 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.	Finance, Estates and Digital Committee	Keith Griffiths	17.01.2024	9	16	20	12	↑	Partially assured
SR5	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.	People & Culture Committee	Linda Garnett	17.01.2024	16	20	20	16	↔	Partially assured
SR6	There is a risk that the system does not create and enable a health and care Workforce to facilitate integrated care.	People & Culture Committee	Linda Garnett	17.01.2024	9	12	12	9	↔	Partially assured
SR7	There is a risk that 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.	Population Health & Strategic Commissioning Committee	Michelle Arrowsmith	03.01.2024	9	12	12	12	↔	Partially assured
SR8	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	Population Health & Strategic Commissioning Committee	Dr Chris Weiner	03.01.2024	8	12	12	12	↔	Partially assured
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.	Population Health & Strategic Commissioning Committee	Michelle Arrowsmith	03.01.2024	12	16	16	12	↔	Partially assured
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.	Finance, Estates and Digital Committee	Jim Austin	12.12.2023	9	12	12	12	↔	Partially assured

ICB – Board Assurance Framework (BAF)

Strategic Risk SR1 – Quality and Performance Committee

Strategic Aim – To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	Committee overall assurance level	Partially assured	
	ICB Lead: Prof Dean Howells, Chief Nursing Officer **ICB Chair** :Adedeji Okubadejo, Chair of Quality & Performance Committee	**System lead:** Prof Dean Howells, Chief Nursing Officer, Dr Robyn Dewis **System forum:** Quality and Performance Committee	**Date of identification:** 17.11.2022 **Date of last review:** 17.01.2024

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and both upper tier Councils to deliver consistently safe services with appropriate standards of care.**	**Risk appetite: target, tolerance and current score** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee**	**12**		**Initial**	**Current**	**Target**
					20	**16**	**10**

Strategic threats (what might cause this risk to materialise)	**Impact** (what are the impacts of each of the strategic threats)
1. Lack of timely data to improve healthcare intervention 2. Lack of system ownership and capacity by the Integrated Care Partnership (ICP) and County and City Councils 3. Ineffective Commissioning of services across Derby and Derbyshire	1. No intelligence and data to support the improvement healthcare intervention 2. Lack of clarity of direction and expectations, with all parts of the system identifying their own role in achieving the objectives 3. Inability to deliver safe services and appropriate standards of care across Derbyshire

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 Lack of timely data to improve healthcare intervention	• Derbyshire ICS Integrated Quality and Performance Report has been refined and is reported and managed by the System Quality and Performance Committee monthly. These will highlight areas of significant concern. • System Deep Dives provide further assurance at the Quality and Performance Committee. Deep dives are identified where there is lack of performance/ or celebration of good performance • The Integrated Assurance and Performance Report has been developed and is reported to public ICB Board bimonthly. Specific section focuses on Quality. • Health inequalities programme of work supported by the strategic intent function of the ICS, the anchor institution and the plans for data and	1T1.1C 1T1.2C 1T1.3C 1T1.4C 1T1.6C	Intelligence and evidence are required to understand health inequalities, make decisions and review ICS progress. Plan for data and digital need to be developed further. Lack of real time data collections. Requirement for streamlining Data and Digital needs of all Partners (Including LA's). Lack of confidence with data associated with the Transforming Care Programme (TCP). NHSE Confidence is increasing as ICB had moved from monthly to quarterly surveillance with NHSE.	• Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • System Quality Group assurance to the Quality and Performance Committee and ICB Board. • System Quality Group assurance on System risks and ICB Risks. • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • Agreed ICB Quality Risk escalation Policy. • Risk Escalations from SQG to Q&P. • Quality and Safety Forum provides assurance into the System Quality Group and meets bi-monthly. This provides the detailed sense check of reporting.	1T1.1AS 1T1.2AS 1T1.3AS	The Integrated Assurance and Performance Report is in place and will continue to be developed further as reported to ICB Board. Consistent escalation reporting across the system to be agreed. Maternity Recovery Action Plan to develop and report into LNMS and Q&P. (NA)

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	digital management. This reports to the PHSCC. • Agreed ICB Quality Risk Escalation Policy. • Risk Escalations from System Quality Group to Quality and Performance Committee. • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023. • ICB and ICS Exec Teams in place. • Integrated Care Strategy in place and published. • Maternity surveillance from NHSE	1T1.7C	Lack of confidence in the delivery of the 3 year maternity plan and operational challenges withing Provider Trusts. Differences in assurances from each Provider Trust. Challenges with Senior Midwifery Leadership at UHDB.	• Recovery Action Plan submitted at the LDA Mental Health Delivery Board. • Maternity Reporting into the Local Maternity and Neo natal System (LMNS). • Reporting against annual plan and operational plan through Q&P and Integrated Assurance and Performance Report which is reported to ICB Board. • Deep dive on Maternity to be undertaken at Quality & Performance Committee. • CQC Maternity Report at CRH and UHDB.		
Threat 2 Lack of system ownership and capacity by the Integrated Care Partnership (ICP) and County and City Councils	• Agreed System Quality infrastructure in place across Derbyshire • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023. • Agreed System Quality and Performance Dashboard to include inequality measures • Agreed NHSE Core20PLUS5 Improvement approach to support the reduction of health inequalities. • ICB Board and Derbyshire Trusts approved and committed to the delivery of the Derbyshire ICS Green Plan. • Agreed Derby and Derby City Air Quality Strategy. • Integrated Care Strategy in place and published. • Derbyshire ICS Health Inequalities Strategy has been developed and woven into the ICS Strategy and has been approved by the ICP.			• Dr Robyn Dewis, Director of Public Health Derby City is the Chair of Health Inequalities Group across the System • Approved Integrated Care Partnership (ICP) Terms of Reference by the ICP and ICB Board. • ICP is now formally meeting in Public from February 2023. • County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Agreed Core20PLUS5 approach across Derbyshire. • Derbyshire ICS Health Inequalities Strategy has been developed and woven into the ICS Strategy and has been approved by the ICP.		
Threat 3 Ineffective Commissioning of services across Derby and Derbyshire	• Derbyshire Cost Improvement Programme (CIP) in progress and Service Benefit Reviews challenge process is in place to support efficiencies. • Agreed Prioritisation tool is in place. • Population Health Strategic Commissioning Committee providing clinical oversight of commissioning and decommissioning decisions. • Robust system QEIA process for commissioning/ decommissioning schemes	1T3.2C	Increase Patient Experience feedback and engagement.	• Agreed ICS 5 Year Strategy in place • Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • Population Health Strategic Commissioning Committee assurance to the ICB Board via the Assurance Report. • System Quality Group assurance to the Quality and Performance Committee and ICB Board. • System Quality Group assurance on System risks and ICB Risks		

Key: All assurances are classified as internal assurances unless specified as an External Assurance (EA)
All assurances are classified as positive assurance unless specified as a Negative Assurance (NA)

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	• Agreed targeted Engagement Strategy – to implement engagement element of Comms & Engagement strategy. • Robust Citizen engagement across Derbyshire and reported through Public Partnerships Committee. • Integrated Care Strategy in place and published. • Joint Forward Plan in place and now published.			• Public Partnerships Committee Public assurance to ICB Board. • NHSE Assurance Reviews and Assurance Letters provide evidence of compliance and any areas of concern. • Winter Plan developed.		

Key: All assurances are classified as internal assurances unless specified as an External Assurance (EA)
All assurances are classified as positive assurance unless specified as a Negative Assurance (NA)

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1 -	1T1.1A	Development of Intelligence and dashboard to evidence Core20PLUS5 principles Following the ICB staff re-structure completion, a performance dashboard will be developed by the Business Intelligence Team. The concept has been formulated as the start of this. The integrated performance report will continue in its current state, whilst this development work progresses.	1T1.1C 1T1.2C 1T1.3C 1T1.4C	Dr Chris Weiner	Quarter ~~2~~ 4 2023/24	Commenced	Population Health and Strategic Commissioning Committee	Partially assured
	1T1.4A	Development of Recovery Action Plan which is submitted at the Learning Disabilities & Autism (LDA) Mental Health Delivery Board. There is a live Recovery Action Plan to support delivery of the national standard for Transforming Care programme (reduction in people with LD&A receiving inpatient care). There are also assurance meetings monthly with the ICB and NHS providers and bi-monthly assurance meetings with NHS E regional team.	1T1.6C	~~Jo Hunter~~ Jennifer Stothard	Quarter 3 2023/24	Completed December 2023	LDA Mental Health Delivery Board	Assured
	1T1.5A	Production of Maternity Reporting process into the Local Maternity and Neo natal System (LMNS). Reporting monthly to Quality and Performance Committee and System Quality Group.	1T1.7C	~~Jo Hunter~~ Tracy Burton/Letitia Harris	Quarter 3 2023/24	Commenced	LMNS Board Quality and Performance Committee	Partially assured
	1T1.6A	The Integrated Assurance and Performance Report is in place and will continue to be developed further as reported to ICB Board. This is progressing, the first elements are in place, currently systemising the process. This is ongoing and any subsequent changes are reflected in the report.	1T1.1AS	Sam Kasibwa	Continuous development process	Commenced – Presented to ICB Board bi monthly	Quality and Performance Committee, ICB Board, System Quality Group	Partially assured
	1T1.7A	Integrated Care System (ICS) Quality Risk Escalation Policy ensures decisions to move quality risks through the escalation process are taken as close to the point of care as possible. Examples: Wound Care, Community Podiatry	1T1.2AS	Jo Hunter	ICS Quality Risk Escalation Policy expires November 24	Commenced	Quality and Performance Committee	Significantly assured
	1T1.8A	Maternity Recovery Action Plan to develop and report into LNMS and Q&P. (NA)	1T1.3AS	Tracy Burton/Letitia Harris	Continuous process – Mar 26 as 2 year plan	Commenced	Monthly reporting at Quality and Performance Committee re LMNS	Partially assured
Threat 3	1T3.1A	Development of Patient Experience Plan Draft completed – to be reported at February 2024 System Quality Group.	1T3.2C	Elaine Belshaw	31.12.23 – Draft completed Dec 23. February 2024 submission to System Quality Group	Commenced	System Quality Group	Partially assured

Key: All assurances are classified as internal assurances unless specified as an External Assurance (EA)
All assurances are classified as positive assurance unless specified as a Negative Assurance (NA)

ICB – Board Assurance Framework (BAF)

Strategic Risk SR2 – Quality and Performance Committee

Strategic Aim – To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	Committee overall assurance level	Partially assured	
	ICB Lead: Prof Dean Howells, Chief Nursing Officer **ICB Chair** :Adedeji Okubadejo, Chair of Quality & Performance Committee	**System lead:** Prof Dean Howells, Chief Nursing Officer, Dr Robyn Dewis **System forum:** Quality and Performance Committee	**Date of identification:** 17.11.2022 **Date of last review: 17**.01.2024

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.**	**Risk appetite: target, tolerance and current score**	**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee **12**	**20**	**16**	**10**

Strategic threats (what might cause this risk to materialise)	**Impact** (what are the impacts of each of the strategic threats)
1. Lack of system ownership and collaboration 2. The ICS short term needs are not clearly determined 3. Lack of coordination across Derby and Derbyshire results in health outcomes and life expectancy improvements not being achieved	1. No intelligence and data to support the improvement healthcare intervention 2. Lack of clarity of direction and expectations, with all parts of the system identifying their own role in achieving the objectives 3. Inability to deliver safe services and appropriate standards of care across Derby and Derbyshire

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control Ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 Lack of system ownership and collaboration	• ICB and ICS Exec Teams in place • Agreed System Quality infrastructure in place across Derbyshire • System Committees are in place and established since July 2022. • Integrated Care Partnership (ICP) was established in shadow form and met in formally Public from February 2023. • JUCD Transformation Co-ordinating Group in place with responsibility for delivery of transformation plans across system. • Provider Collaborative Leadership Board in place overseeing Delivery Boards and other delivery groups. • System Delivery Boards in place - providing a mechanism to share decisions and challenge actions enhancing transparency and shared understanding of impact. • Agreed System Quality and	2T1.1C 2T1.2C 2T1.3C 2T1.4C	Intelligence and evidence to understand health inequalities, make decisions and review ICS progress. In some cases, the 'scope' of System Delivery Board focus is not sufficiently broad enough to tackle the root cause of problems and thus there is an issue that system partners are crowded out from influencing the business of the Board. Level of maturity of Delivery Boards and PCLB Level of maturity of the ICP/ICS/ICB	• Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • System Quality Group assurance to the Quality and Performance Committee and ICB Board. • System Quality Group assurance on System risks and ICB Risks. • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE • Consistent management reporting across the system to be agreed • NHS Executive Team in place • NHSE Assurance Reviews and Assurance Letters provide evidence of compliance and any areas of concern. (EA) • Winter Plan in development for discussion at ICB Board on 19.10.23	2T1.1AS 2T1.2AS	The Integrated Assurance and Performance Report is in place but will continue to be developed further as reported to ICB Board. Quality governance link to Place being developed.

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	Performance Dashboard to include inequality measures. • All Providers are undertaking clinical harm reviews linked to long waiting lists and waits at the Emergency Department.			• Quality sub group of MHLD Delivery Board established.		
Threat 2 The ICS short term needs are not clearly determined	• Agreed ICS 5 Year Strategy sets out the short-term priorities • Agreed ICB Strategic Objectives • Integrated Care Partnership (ICP) was established in shadow form and met in formally Public from February 2023. • System planning & co-ordination group managing overall approach to planning • Agreed Commissioning Intentions in place • ICP Strategy now approved.	2T2.1C 2T2.2C	Commissioning to focus on patient cohorts, with measures around services to be put in place to support reduction of inequalities. Increase Patient Experience feedback and engagement.	• The ICB Board Development Sessions provide dedicated time to agree ICB/ ICS Priorities. • ICB Board agreement of Strategic Objectives • BAF Operational Group - Regular review of the ICB BAF via established working group prior to reporting to Quality and Performance Committee.		
Threat 3 Lack of coordination across Derby and Derbyshire results in health outcomes and life expectancy improvements not being achieved	• Agreed NHSE Core20PLUS5 Improvement approach to support the reduction of health inequalities • Agreed System Quality & Performance dashboard to include inequality measures • County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Integrated Care Partnership (ICP) was established in shadow form and met in formally Public from February 2023. • Robust Citizen engagement across Derbyshire and reported through Public Partnerships Committee • Derbyshire ICS Health Inequalities Strategy has been developed and woven into the ICS Strategy and has been approved by the ICP.	2T3.3C	Alignment between the ICS and the City and County Health and Wellbeing Boards.	• County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Public Partnerships Committee Public assurance to ICB Board. • Derbyshire ICS Health Inequalities Strategy has been developed and woven into the ICS Strategy and has been approved by the ICP. • Winter Plan in development for discussion at ICB Board on 19.10.23. • Showcase of Health Inequalities and wider Determinants of Health at November Quality & Performance Committee.	2T3.1AS	Public Health Summary Report to be developed and report into Quality & Performance Committee.

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	2T1.1A	Develop the Intelligence and evidence to understand health inequalities A Quality Equality Impact Assessment is completed for all projects. •GetUBetter – MSK digital enabler to support patients to manage and prevent deterioration of conditions and ensure patients access the right local services at the right time.	2T1.1C	Ged Connolly-Thompson/ Angela Deakin	~~Quarter 2 2023/24~~ TBC	Commenced	JUCD Data & Digital Board and subsequent sub groups/Population Health & Strategic Commissioning Committee	Partially assured

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		•Recap Health – Digital enabler secured to support Cardiac Rehab patients. •Digital Weight Management Programme – Offer of patient self-referral mechanism. •Virtual Wards – Digital enablement onboarded. SUS Outpatient data has the ability to identify F2F / virtual activity.						
	2T1.3A	Provider Collaborative Leadership Board and System Delivery Boards	2T1.2C 2T1.3C	Helen Dillistone	Quarter 4 2023/24	Commenced	ICB Board	Partially assured Partially assured
	2T1.4A	Annual Review of the Integrated Care Partnership to determine alignment and relationships between ICP, Health and Wellbeing Boards and the ICS	2T1.4C 2T1.3C	Helen Dillistone/ICP Chair	Quarter 4 2023/24	Not yet commenced	Integrated Care Partnership	
	2T1.5A	Quality governance link to Place being developed. As part of the work to understand how quality and governance links/sit in Place, a Place Quality/Governance Workshop was held in December to help identify how this will/could work in the landscape.	2T1.2AS	Phil Sugden	Quarter 4 2023/23	Commenced	Place Quality/Governance Workshop	Partially assured
Threat 2	2T2.1A	Develop Patient Experience Plan Draft completed – to be reported at February 2024 System Quality Group.	2T2.1C 2T2.2C	Elaine Belshaw	31/12/2023 Draft completed Dec 23. February 2024 submission to System Quality Group	Commenced	System Quality Group	Partially assured
Threat 3	2T3.2A 2T3.3A	Alignment between the ICS and the City and County Health and Wellbeing Boards. Public Health Summary Report to be developed and report into Quality & Performance Committee.	2T3.3C 2T3.1AS	Dr Robyn Dewis TBC	Work in progress Work in progress	Work in progress Work in progress	TBC TBC	

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR3 – Public Partnership Committee

Strategic Aim – To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Helen Dillistone, Chief of Staff **ICB Chair:** Richard Wright, Chair of Public Partnership Committee	**System lead:** Helen Dillistone, Chief of Staff **System forum:** Public Partnership Committee	**Date of identification:** 17.11.2022 **Date of last review:** 23.01.2024

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.**	**Risk appetite: target, tolerance and current score** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **12**		**Initial** **16**	**Current** **16**	**Target** **9**

Strategic threats (what might cause this risk to materialise)	**Impact** (what are the impacts of each of the strategic threats)
1. The public are not being engaged and included in the strategy development and early planning stage of service development therefore the system will not be able to suitably reflect the public's view and benefit from their experience in its planning and prioritisation. 2. Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised. 3. The complexity of change required, and the speed of transformation required leads to patients and public being engaged too late in the planning stage, or not at all leading to legal challenge where due process is not being appropriately followed. 4. The communications and engagement team are not sufficiently resourced to be able to engage with the public and local communities in a meaningful way.	1. Potential legal challenge through variance/lack of process. 2. Failure to secure stakeholder support for proposals. 3. inability to deliver the volume of engagement work required; risk of transformation delay due to legal challenge; reputational damage and subsequent loss of trust among key stakeholders. 4. Services do not meet the needs of patients, preventing them from being value for money and effective.

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control Ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 The public are not being engaged and included in the strategy development and early planning stage of service development therefore the system will not be able to suitably reflect the public's view and benefit from their experience in its planning and prioritisation.	• Agreed system Communications & Engagement Strategy. • Agreed targeted Engagement Strategy – to implement engagement element of C&E strategy. • Agreed Guide to Public Involvement, now being rolled out to ICB and then broader system. • Public Partnership Committee now established and identifying role in • assurance of softer community and stakeholder engagement. • Communications and Engagement Team leaders are linked with the emerging system strategic approach,	3T1.3C 3T1.4C	All aspects of the Engagement Strategy need to be developed and implemented. This includes the Insight Framework, Co-production Framework and Evaluation Framework. The Governance Framework also needs further development. Once Insight Framework proof of concept work is up and running, establish how we make better use of insight in the system. Collect it, collate it, analyse and interpret it, and put it in a format that the system can use to ensure public participation is informing	• Senior managers have membership of IC Strategy Working Group to influence • Comprehensive legal duties training programme for engagement professionals • Public Partnership Committee assurance to ICB Board • Public Partnership Committee Assurance to ICB Board on identified risks • ePMO gateway structure ensures compliance with PPI process • National Oversight Framework ICB annual assessment evidence • Benchmarking against comparator ICS	3T1.2AS 3T1.3AS 3T1.4AS	Further work is needed with providers to embed the guide to PPI, especially around system transformation programmes. Assurance on skills relating to cultural engagement and communication across all JUCD partners ICB self-assessment and submission (EA)

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	including the development of place alliances. • Insight summarisation is informing the priorities within the strategy. • Insight Framework has been developed and its implementation will ensure that we have insight around what matters to people to feed into future strategic priorities. Proof of Concept Project starting in New Year. • Agreed gateway for PPI form on the ePMO system.	3T1.5C 3T1.6C	decision making. Further work is needed with providers to embed the guide to PPI, especially around system transformation programmes. Assurance on skills relating to cultural engagement and communication across all JUCD partners	approaches.		
Threat 2 Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.	• Agreed system Communications & Engagement Strategy, with ambitions on stakeholder relationship management. • Membership of key strategic groups, including Executive Team, Delivery Board, Senior Leadership Team and others to ensure detailed understanding of progression. • Functional and well-established system communications and engagement group.	3T2.1C 3T2.2C 3T2.3C 3T2.4C	Development of system stakeholder communication methodologies understand and maintain/improve relationships and maximise reach Systematic change programme approach to system development and transformation not yet articulated/live. Staff awareness of work of ICS and ICB programme, to enable to recruitment of advocates for the work Behaviour change approach requires development to support health management and service navigation. Proposal required for UECC Delivery Board and other areas to develop this, requiring resource.	• NHS/ICS ET membership and ability/requirement to provide updates • ePMO progression • Public Partnership Committee Assurance to ICB Board on identified risks • ePMO gateway structure ensures compliance with PPI process • Benchmarking against comparator ICS approaches • National Oversight Framework ICB annual assessment evidence	3T2.1AS	ICB self-assessment and submission (EA)
Threat 3 The complexity of change required, and the speed of transformation required leads to patients and public being engaged too late in the planning stage, or not at all leading to legal challenge where due process is not being appropriately followed.	• Agreed system Communications & Engagement Strategy. • Agreed Guide to Public Involvement, now being rolled out to ICB and then broader system. • Public Partnership Committee now established and identifying role in • assurance of softer community and stakeholder engagement. • ePMO gateway process includes engagement assessment check • Training programme underway with managers on PPI governance requirements and process	3T3.1C	Clear roll out timescale for transformation programmes	• Comprehensive legal duties training programme for engagement professionals • PPI Governance Guide training for project/programme managers • Public Partnership Committee assurance to ICB Board • ePMO progression • Public Partnership Committee Assurance to ICB Board on identified risks • ePMO gateway structure ensures compliance with PPI process • National Oversight Framework ICB annual assessment evidence	3T3.1AS	ICB self-assessment and submission (EA)

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Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 4 The communications and engagement team are not sufficiently resourced to be able to engage with the public and local communities in a meaningful way.	• Detailed work programme for the engagement team • Clearly allocated portfolio leads across team to share programmes • Distributed leadership across system communications professionals supports workload identification and delivery.	3T4.1C 3T4.2C 3T4.3C	Clear roll out timescale for transformation programmes to enable resource assessment Quantification of required capacity challenging Delivery of Communications & Engagement Strategy infrastructure work requires completion and is competing factor	• Wrike Planning Tool • Risk/threat monitored by Public Partnership Committee	3T4.1AS	Benchmarking against comparator ICS approaches (EA)

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started? Update**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	**3T1.2A**	Ongoing implementation of Engagement Strategy frameworks Evaluation Framework – planning workshop Evaluation Framework – PPC discussion Co-production Framework – first scoping session Insight Framework – Tool drafted and socialised. Board development session ahead of seeking pilots. Insight Framework – pilots underway Governance Framework – PPI and HOSC Guides developed. Final framework to follow conclusion of other frameworks.	3T1.3C 3T1.1AS	Karen Lloyd HM HM BF AK LK AK KL	31 March 2024 3.7.23 28.11.23 20.6.23 30.5.23 TBC 15.9.23 31.3.24	Commenced Complete 3.7.23 Commenced Commenced Complete 30.5.23 Not started Commenced Commenced	Public Partnership Committee	Partially assured
	3T1.3A	Ongoing implementation of Insight Framework approach Tool drafted and socialised. Board development session Piloting of tool	3T1.4C 3T1.1AS	Karen Lloyd KL KL/ST/HD KL/AK	31 March 2024 8.6.23 TBC 31.3.24+	Commenced Complete 30.5.23 Not started Commenced	Public Partnership Committee	Partially assured
	3T1.4A	Programme of work to roll out PPI Guide with system partners, including general practice Clarification of PPI expectations for GP Clarification of NHS FT resource and role in engagement delivery Meeting with ICB commissioning directors to discuss process Ongoing opportunities to promote approach.	3T1.5C 3T1.1AS 3T1.2AS	Karen Lloyd KL KL KL/ST KL	31 March 2024 31.03.24 28.11.23 13.10.23 31.3.24+	Commenced Ongoing Complete 28.11.23 Complete 13.10.23 Commenced	Public Partnership Committee	Partially assured
	3T1.5A	Assess current team skills in cultural engagement and communications, including channel assessment, and devise action plan to close gaps/implement training and development. Health literacy bite-sized training (various team members and team discussion) Team skills audit and PDPs Community profiles development, including knowledge of communications preferences for population segments. Confirm pilot areas. Internal channels benchmarking and evaluation External channels benchmarking and evaluation Forge closer team links and shared work programmes with behavioural psychology team.	3T1.6C 3T1.1AS 3T1.3AS	Sean Thornton Various MH ST/KL DLB CC CC	30 September 2023+ 31.03.24+ 31.3.24 31.3.24 31.3.24 31.3.24 30.9.23	Commenced Ongoing (Re-opened) Delay Delay Delay Delay Complete 17.10.23	Communications and Engagement Team	Partially assured
	3T1.6A	Completion of ICB self-assessment and submission to NHSE	3T1.4AS 3T2.1AS 3T3.1AS	Helen Dillistone	End of Quarter 4	Commenced	Corporate Delivery Team/Public Partnership Committee/Audit and Governance Committee	
Threat 2	**3T2.1A**	Delivery of Communications and Engagement Strategy Stakeholder chapter to scope	3T2.1C	Sean Thornton	31 March 2024+	Commenced	Public Partnership Committee	Partially assured

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		processes on relationship managing and stakeholder perceptions, resulting in business case.	3T2.1C 3T2.2C 3T2.4C					
		Configuration of tool for ICB purposes		GC-T	TBC	Cancel – tool NFFP. To be replaced with different tool.	Communications and Engagement Team	Partially assured
		Population of tool with local data, inc. GDPR compliance		DLB	31.3.24	Delay		
		Use of tool for distribution purposes		DLB	31.3.24+	Delay		
		Development of tool for stakeholder management purposes, including profiling		DLB	31.3.25	Delay		
	3T2.2A	Meet with ePMO colleagues to understand change model approach to system transformation, including financial context for 23/24.	3T2.1C 3T2.3C	Sean Thornton	30 June 2023+	Complete 31.12.23	Communications and Engagement Team	Assured
	3T2.3A	Delivery of Communications and Engagement Strategy Internal Communications chapter to create platform for engagement with ICB and system staff, building on existing mechanisms.	3T1.1C	David Lilley-Brown	31 March 2024	Commenced	Communications and Engagement Team	Partially assured
		Internal channels benchmarking and evaluation		DLB	31.3.24	Delay		
		Team Derbyshire programme continues		DLB	Ongoing	Commenced		
		Scope communications support for GP Provider Board (inc. PCNs) and GP Task Force		ST	31.03.24	Commenced		
		System leader key message briefings to start		DLB/ST	29.02.24	Delay		
		Roll out of online engagement platform tool for staff		DLB/HofC	1.2.24	Commenced		
	3T2.4A	Develop proposal and business case for UEC behaviour/insight programme following social marketing principles.	3T2.1C	Donna Broughton	1 September 2023	Complete 1.9.23	Communications and Engagement Team	Assured
	3T2.5A	Completion of ICB self-assessment and submission to NHSE	3T2.1AS	Helen Dillistone	End of Quarter 4	Commenced	Corporate Delivery Team/Public Partnership Committee/Audit and Governance Committee	Partially assured
Threat 3	**3T3.1A**	Allied to ePMO programme review, implement scoping exercise across system/ICB delivery boards and other groups to establish baseline of work.	3T3.1C	Sean Thornton	30 September 2023+	Commenced	Communications and Engagement Team	Partially assured
		System C&E leads undertake delivery board and committee scoping		System C&E	31.03.24	Delay		
		ICB team undertake scoping in line with portfolios		ICB C&E	30.6.23	Completed 30.6.23		
		Collation of all priorities and capacity assessment		ICB/System C&E	29.2.24	Delay		
		Resource/capacity assessment presented to NHS Executive Team		ST	29.2.24	Delay		
	3T3.2A	Programme of work to roll out PPI Guide with system partners, including general practice.	3T3.2A	Karen Lloyd	31 March 2024+	Commenced	Public Partnership Committee	Partially assured
	3T3.3A	Completion of ICB self-assessment and submission to NHSE	3T3.1AS	Helen Dillistone	End of Quarter 4	Commenced	Corporate Delivery Team/Public Partnership Committee/Audit and Governance Committee	Partially assured

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Threat 4	**3T4.1A**	Allied to ePMO programme review, implement scoping exercise across system/ICB delivery boards and other groups to establish baseline of work.	3T4.1C	Sean Thornton	30 September 2023	Commenced	Communications and Engagement Team	Partially assured
	3T4.2A	Confer with regional ICB leads on appetite for potential benchmarking approach to understand approaches, team roles, capacity.	3T4.1C 3T4.2C 3T4.1AS	Sean Thornton	31 March 2024	Completed 30.9.23	Communications and Engagement Team	Assured
	3T4.3A	Implement remaining elements of Communications and Engagement Strategy chapters.	3T4.1C 3T4.3C	Sean Thornton & team	31 March 2024+	Commenced	Public Partnership Committee	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR4 – Finance, Estates and Digital Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Keith Griffiths, Chief Finance Officer **ICB Chair:** Jill Dentith, Finance, Estates and Digital Committee Chair	**System lead:** Keith Griffiths, Chief Finance Officer **System forum:** Finance, Estates and Digital Committee	**Date of identification:** 17.11.2022 **Date of last review**: 17.01.2024

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that 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.**	**Risk appetite: target, tolerance and current score**	**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee **12**	**16**	**20**	**9**

Strategic threats (what might cause this risk to materialise)	**Impact** (what are the impacts of each of the strategic threats)
1. Rising activity needs, capacity issues, and availability and cost of workforce 2. Shortage of out of hospital provision across health and care impacts on productivity levels 3. The scale of the challenge means break even can only be achieved by structural change and real transformation. failure to deliver against plan and/or to transform services 4. National funding model does not reflect clinical demand and operational / workforce pressures 5. National funding model does not recognise that Derbyshire Providers receive £900m from other ICBs	1. Unable to meet financial plan / return to sustainable financial position. Severe cash flow issues and additional cost of borrowing 2. Increasing bed occupancy to above safe levels and poor flow in/out of hospital 3. Provider performance levels drop and costs increase 4. Any material shortfall in funding means even with efficiency and transformation and structural change there could still be a gap to breakeven, whilst also preventing any investment in reducing health inequalities and improving population health 5. Allocations received by the ICB do not recognise the breadth and location of services delivered by Providers

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control Ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 Rising activity needs, capacity issues, and availability and cost of workforce	• Given the scale of the challenge there is no single control that can be put in place to totally mitigate this risk now. • Detailed triangulation of activity, workforce and finances in place • Provider Collaborative overseeing 'performance' and transformation programmes to deliver improvement in productivity	4T1.1C 4T1.2C 4T1.3C 4T1.4C 4T1.5C	New Workforce and Clinical Models Plan. Triangulated activity, workforce, and financial plan. Do not understand the low productivity to address the clinical workforce modelling. Benchmark against pre Covid data and activity as a starting point to get to sustainable levels. Do not have the management processes in place to deliver the plans	• Financial data and information is trusted but needs further work to translate into a sustainable plan. Workforce planning is in its infancy and improving but is not yet robust enough to be fully triangulated with demand, capacity, and financial plans. • Five-year financial plan has been prepared to accelerate and influence change. • Operational Plan and strategic plan being agreed at Board level. • Integrated Assurance and Performance Report.	4T1.1AS	The Integrated Assurance and Performance Report is in place and will continue to be developed further as reported to ICB Board.

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
			and level of productivity / efficiency required.			
		4T1.6C	The integrated assurance and performance report needs to be developed further to triangulate areas of activity, workforce, and finance.			
Threat 2 Shortage of out of hospital provision across health and care impacts on productivity levels	• Not aware of effective controls now, and the solution requires integrated changes across social care and the NHS • Collaborative escalation arrangements in place across health and care to ensure maximum cover out of hospital and flow in hospital is improved. • Programme delivery boards for urgent and elective care review	4T2.1C	National shortage in supply of out of hospital beds and services for medically fit for discharge patients prevents full mitigation.	• Integrated assurance and performance report and tactical responses agreed at Board level. Assurances for permanent, long-term resolution not available. • National productivity assessment tool now available to assist all systems across the country, which will be used to influence 23/24 planning and delivery.(EA)	4T2.1AS	The Integrated Assurance and Performance Report is in place and will continue to be developed further as reported to ICB Board.
		4T2.2C	New Workforce strategy and Clinical Model required, alongside clear priorities for improving population health.			
		4T2.3C	Triangulated activity, workforce, and financial plan.			
		4T2.4C	Do not fully understand the low productivity levels and the opportunities to improve via the clinical workforce.			
		4T2.5C	Benchmark against pre Covid data and activity as a starting point to get to sustainable levels.			
Threat 3 The scale of the challenge means break even can only be achieved by structural change and real transformation. failure to deliver against plan and/or to transform services	• The CIP and Transformation Programme is not owned by leads, managed, implemented, and reported on for Finance to build into the system financial plan. • EPMO system has been established and is led by Transformation Director. • EPMO has list of efficiency projects only that are not developed to a level where the financial impact can be assured. • Long term national funding levels are insufficient and uncertain, meaning despite radical improvements in efficiency and structural, transformational change, a financial gap to breakeven will remain. • Development of Financial Sustainability Board to understand and alleviate the financial challenges.	4T3.1C	Need to embed and cascade ICB savings target / CIP plan – staff at all levels to understand imperative and role in identification of savings / innovation.	• Reconciliation of financial ledger to EPMO System. • SLT monthly finance updates provided – including recalibration of programme in response to emerging issues. • Finance and Estates Committee oversight. • Weekly system wide Finance Director meetings focussed on long term financial stability, with real evidence of effective distributive leadership and collegiate decision making.		
		4T3.2C	Ownership of system resources held appropriately.			
		4T3.3C	The EPMO System is not fully developed, owned, and managed to make the savings required.			
		4T3.4C	Programme delivery boards need to refocus on delivering cash savings as well as pathway change.			
		4T3.5C	The provider collaborative needs to drive speed and scope through the programme delivery boards			

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Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 4 National funding model does not reflect clinical demand and operational / workforce pressures	• National political uncertainty alongside national economic and cost of living crisis means long term, stable and adequate financial allocations are unlikely to emerge in the short to medium term	4T4.1C	No assurance can be given	• All opportunities to secure resources are being maximised, alongside which a strong track record of delivery within existing envelopes is being maintained. This should give assurance regionally and nationally. • Executive and non-executive influencing of regional and national colleagues needs to strengthen, and a positive, inspiring culture maintained across the local health and care system.	4T4.1AS	No assurance can be given
Threat 5 National funding model does not recognise that Derbyshire Providers receive £900m from other ICBs	• ICB allocations are population based and take no account of the fact that UHDB manages and Acute and two Community hospitals outside the Derbyshire boundary added to this EMAS only provide 20% of their activity in Derbyshire. Regional and National teams have been made aware of this anomaly and recognise this disadvantages Derbyshire.	4T5.1C	No assurance can be given	• The impact of this will continue to be calculated and will be demonstrated when appropriate.	4T5.1AS	No assurance can be given

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	**4T1.1A**	Development of Triangulated Activity ~~Demand~~, Workforce and Financial plan for 24/25 Financial Sustainability Group continues to oversee progress of efficiency progress for the wider system. Financial reset has given further clarity over both workforce and operational performance with the finances.	4T1.1C 4T1.2C 4T1.6C	Michelle Arrowsmith	~~31.01.24~~ Ongoing as continuous process.	Commenced	Finance/Performance/Quality Committees ICB Board Financial Sustainability Group	Partial assurance given the transparency and debate at Board level, recognising the socio-economic environment the health and care sectors are currently navigating and the scale of the tasks that lie ahead – both operationally and culturally.
	4T1.2A	Benchmark exercise and Report against pre covid levels of activity	4T1.1C 4T1.4C	Linda Garnett, Keith Griffiths	In Progress - Q4 2023/24	Commenced	People and Culture/Finance Estates and Digital Committee	
	4T1.3A	Develop management processes to deliver plans and level of productivity required Implementation and maintenance of the e-PMO to track efficiencies Delivery boards looking at efficiency and productivity in addition to internal provider actions e.g. planned care board and Get it right first time (GIRFT) Pipeline schemes/opportunities being recorded on ePMO, workshops with trust teams to develop 2024/2025 plans.	4T1.1C 4T1.3C 4T1.5C	Chair of Provider Collaborative/ Tamsin Hooton/Provider DOFs	In Progress - 2024/25	Commenced	PCLB/ Director of Finance Group	
	4T1.4A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met The Integrated Assurance and Performance Report is in place and will continue to be developed further as reported to ICB Board.	4T1.1C 4T1.1AS	Executive Team	In Progress – 2024/25	Commenced	ICB Board	
Threat 2	**4T2.1A**	Develop the workforce planning approach to inform the 2024/25 plan and future projections ~~Development of new Workforce~~ and Clinical Models Plan. Examples - Clinical Models Plan: Cardio Vascular plan currently being developed to target population health management and health inequalities across Derby and Derbyshire on a PLACE based approach. Socialising plan is now with system partners and will be presented at PHSCC in January for ratification. At the December CPLG meeting, the concept was agreed. COPD winter plan has been developed and launched with GP Practices. Rescue pack and co-interdependency with virtual wards.	4T1.2C 4T2.2C 4T2.4C 4T1.2C 4T2.2C 4T2.4C 4T1.2C 4T2.2C	Linda Garnett/ Chris Weiner Chris Weiner/ Angela Deakin Chris Weiner/ Angela Deakin	End of Quarter 3/Q4 2023/24 Q1 2024/25 Due to funding allocations November 2023	Commenced Commenced Completed	People and Culture Committee/ CPLG CPLG and PHSCC PHSCC	Partial assurance given the transparency and debate at board level, recognising the socio-economic environment the health and care sectors are currently navigating and the scale of the tasks that lie ahead – both operationally and culturally

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
		• Diabetes T2Day targeted at young adults. • Pulmonary rehab in year 2 of a 5 year plan, includes increase in the existing workforce to support waiting list pressures.	4T2.4C			November 2023		
	4T2.2A	Development of Triangulated Activity ~~Demand~~, Workforce and Financial plan Financial Sustainability Group continues to oversee progress of efficiency progress for the wider system. Financial reset has given further clarity over both workforce and operational performance with the finances.	4T2.1C 4T2.3C	Executive Team	~~End of Quarter 3 2023/24~~ Ongoing, as continuous process	Commenced	People and Culture Committee/ Finance Estates and Digital Committee	
	4T2.3A	Benchmark exercise and report against pre covid levels of activity	4T2.1C 4T2.5C	Executive Team/Michelle Arrowsmith	In Progress Quarter 4 2023/24	Commenced	People and Culture/Finance Estates and Digital Committee	
Threat 3	**4T3.1A**	Develop and embed EPMO System The system e-PMO has developed significantly in Quarter 2. It is now being used by all providers (to varying degrees) Delivery Boards and programmes. Financial efficiencies are being recorded, and we now have £114m plans on e-PMO, previously £98m. A report on system efficiencies is being generated from the e-PMO for Financial Sustainability Board (FSB) and SFEDC as well as going to the TCG and PCLB.	4T3.3C 4T3.4C 4T3.5C	Tamsin Hooton	Ongoing – Q4 2023/24	Commenced	Finance, Estates and Digital Committee / PCLB	Partial assurance through evidence of improving reporting and accountability, although real delivery is yet to be seen
	4T3.2A	A process looking at value and waste in clinical pathways has commenced, with data pack shared with Delivery Boards and CPLG in November 2023. PCLB agreed priorities in relation to value which will be built into 2024/2025 plans.	4T3.1C 4T3.4C 4T3.5C	Tamsin Hooton	End of Quarter 3 2023 Completed December 2023	Completed December 2023	Delivery and Trust Boards CPLG, PCLB	Assured
	4T3.3A	Development of a consistent approach to measuring productivity. Benchmarking work on corporate efficiencies, work underway on people supply, digital and procurement. Work to identify additional opportunities for savings underway. Procurement, HR and digital are current priority workstreams within corporate efficiencies. PCLB to establish a shared programme on productivity (end date Q1 2024/2025).	4T3.2C	Tamsin Hooton	~~Quarter 3 2023/24~~ Quarter 1 2024/2025	Commenced	Delivery and Trust Boards, PCLB, SFEDC	Partially assured

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 4	**4T4.1A**	National Allocations unclear	4T4.1C 4T4.1AS	Executive Directors / NEMs	2024/25	Commenced	TBC	Not assured
Threat 5	**4T5.1A**	The ICB will continue to lobby the Regional and National teams	4T5.1C 4T5.1AS	Keith Griffiths	2023/25	Commenced	TBC	A significant change in allocation policy at National level will need to take place to rectify this issue.

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR5 – People and Culture Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Linda Garnett, Interim Chief People Officer **ICB Chair:** Margaret Gildea, Chair of People and Culture Committee	**System lead:** Linda Garnett, Interim Chief People Officer **System forum:** People and Culture Committee	**Date of identification:** 17.11.2022 **Date of last review:** 17.01.2024

Strategic risk (what could prevent us achieving this strategic objective)	**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.**	**Risk appetite: target, tolerance and current score** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **16**		**Initial** **20**	**Current** **20**	**Target** **16**

Strategic threats (what might cause this risk to materialise)	**Impact** (what are the impacts of each of the strategic threats)
1. Lack of system alignment between activity, people and financial plans 2. Staff resilience and wellbeing is negatively impacted by environmental factors e.g. the industrial relations climate and the financial challenges in the system 3. Employers in the care sector cannot attract and retain sufficient numbers of staff to enable optimal flow of service users through the pathways and the scale of vacancies across health and care and some specific professions	1. There is an under supply of people to meet the activity planned and the funding available 2. Increased sickness absence, deterioration in relationships and higher turnover particularly people retiring early leading to gaps in the staffing required to deliver services 3. People are going to better paid jobs in other sectors which means that patients cannot be discharged from hospital due to lack of care packages causing long waiting times in the Emergency pathways, poorer quality of care.

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 Lack of system alignment between activity, people and financial plans	• An Integrated planning approach has been agreed across the system covering finance activity and workforce. • Agreed System level SRO for Workforce Planning supported by Workforce Strategy and Planning Assistant Director • The System People and Culture Committee provides oversight of workforce across the system	5T1.3C	Develop 24/25 workforce plan.	• Monthly monitoring of workforce numbers and temporary staffing spend vs budget and agency spend. • Approved System Workforce Strategy and Workforce plan • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • The Workforce Advisory Group brings together all component part to discuss workforce and planning and system engagement of the plan. • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce.	5T1.1AS 5T1.2AS	Work is progressing to develop an integrated performance assurance report which includes Quality, Performance, Workforce and Finance. Activity delivered should be informing everything but there remain further issues requiring resolution in that area. Consistent escalation reporting across the system to be agreed.

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 2 Staff resilience and wellbeing is negatively impacted by environmental factors e.g. the industrial relations climate and the financial challenges in the system	• A Comprehensive staff wellbeing offer is in place and available to Derbyshire ICS Employees • Engagement and Annual staff opinion surveys are undertaken across the Derbyshire Providers and ICB • The System People and Culture Committee provides oversight of workforce across the system • Enhanced Leadership Development offer to support Managers and promoting Health and Wellbeing.	5T2.1C 5T2.3C	Funding for wellbeing offer is not recurrent The Leadership Development offer is not yet fully embedded in each organisation.	• Monthly monitoring of absence and turnover • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce. • System Wellbeing Group provides performance information to the People Services Collaborative Delivery Board. • Health Assessments continue to provide impact and now embedded within People Services to support long-term sickness.	5T2.1AS 5T2.2AS	Work is progressing to develop an integrated performance assurance report which includes Quality, Performance, Workforce and Finance. Activity delivered should be informing everything but there remain further issues requiring resolution in that area. Despite measures being in place the situation is deteriorating in terms of staff health and being due to a range of factors (NA)
Threat 3 Employers in the care sector cannot attract and retain sufficient numbers of staff to enable optimal flow of service users through the pathways and the scale of vacancies across health and care and some specific professions	• Promotion of social care roles as part of Joined Up careers programme • The System People and Culture Committee provides oversight of workforce across the system • Integrated Care Partnership (ICP) was established in shadow form and now meets in Public (February 2023 onwards)	5T3.1C 5T3.2C 5T3.3C	More work required to understand how the NHS can provide more support to care sector employers Lack of Workforce representation on the ICP. Insufficient connection with People and Culture and the ICP	• Monthly monitoring of vacancies via Skills for Care data • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce. • Approved Integrated Care Partnership (ICP) Terms of Reference by the ICP and ICB Board. • County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Better Care funding supports the Joined Up Careers team to work in partnership with Health and Social Care. • Action Plan including range of widening participation and resourcing proposals to support with DCC Homecare Strategy 23/24	5T3.1AS 5T3.2AS	Work is progressing to develop an integrated performance assurance report which includes Quality, Performance, Workforce and Finance. Activity delivered should be informing everything but there remain issues requiring resolution in that area. Insufficient connection with People and Culture and the ICP (NA)

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	5T1.3A	Develop the workforce planning approach to inform the 2024/25 plan and future projections	5T1.3C	Sukhi Mahil	Q3/ Q4 2023/24	Commenced	People & Culture Committee	Partially assured

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Threat 2	5T2.1A	Continue to spread and embed well-being offer. Review and evaluate feedback from Health and Wellbeing survey to continue to develop and improve wellbeing service offering. Work is ongoing with good levels of engagement across JUCD in activities, and over 4000 colleagues participating in activities each month. The evaluation from the HNA has been completed and will inform future planning. A new timetable of support is implemented quarterly along with the development of specialist groups, interventions for emotional and physical health.	5T2.3C 5T2.2AS	Nicola Bullen	Ongoing from quarter 3 2023/24	Ongoing	People & Culture Committee People Services Collaborative Delivery Board	Partially assured
	5T2.2A	Review Occupational Health Services to ensure they are focused on promoting health and wellbeing. The health promotional activity largely sits within the JUCD Wellbeing programmes of work including activity timetable, lifestyle and wellbeing and health inequalities, with Occupational Health supporting the health Surveillance programmes. There is a significant programme of work around health surveillance as well as a quarterly activity programme that is produced for all staff across Derbyshire.	5T2.2AS	Nicola Bullen	Quarter 2 2024/25	Ongoing	People & Culture Committee People Services Collaborative Delivery Board	Partially assured
	5T2.3A	Pursue alternative funding sources, consider measures to mitigate impact of services reducing, utilise wellbeing support in place across the system. Funding will be received through NHS Midlands a combined bid with Northants ICB, this will provide mental health hub activity across the East Midlands.	5T2.1C	Nicola Bullen	Ongoing from Quarter 2 2023/24	Commenced	People & Culture Committee People Services Collaborative Delivery Board	Partially assured
Threat 3	5T3.1A	Continue to develop system wide recruitment campaigns to meet demand for health and care across Derbyshire.	5T3.1C 5T3.2C 5T3.3C	Susan Spray	System Recruitment campaigns planned as a rolling programme	Commenced	People & Culture Committee	Partially assured
	5T3.2A	Programme of work agreed to be presented to the ICP	5T3.1C 5T3.2C 5T3.3C	Linda Garnett/ Susan Spray	December 2023	Commenced	People & Culture Committee	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR6 – People and Culture Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Linda Garnett, Interim Chief People Officer **ICB Chair:** Margaret Gildea, Chair of People and Culture Committee	**System lead:** Linda Garnett, Interim Chief People Officer **System forum:** People and Culture Committee	**Date of identification:** 17.11.2022 **Date of last review:** 17.**01.2024**

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the system does not create and enable a health and care Workforce to facilitate integrated care.**	**Risk appetite: target, tolerance and current score**	**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee. **9**	**12**	**12**	**9**

Strategic threats (what might cause this risk to materialise)	**Impact** (what are the impacts of each of the strategic threats)
1. ~~There is not an agreed definition of what "One Workforce" means~~. 2. There is insufficient funding to undertake skills and cultural development needed to support integration. 3. Lack of system ownership and commitment to developing an integrated Workforce.	1. ~~System partners are not aligned in workforce development and integration.~~ 2. It is more challenging to transition from current ways of working to a more integrated approach. 3. The system is not integrated on the Workforce Strategy and workforce development

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control Ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
~~**Threat 1**~~ ~~There is not an agreed definition of what "One Workforce" means~~	• ~~Work is underway to develop a One Workforce Strategy and plan aligned to the Integrated Care Strategy and Joint Forward Plan involving all system partners.~~ • ~~The Draft Integrated Care Strategy is in development by the ICB Board and ICP~~ • ~~Development and implementation of the One Workforce Strategy will be overseen by the Workforce Advisory Group and assurance given to the People and Culture Committee~~ • ~~The System People and Culture Committee provides oversight of workforce across the system.~~ • ~~Agreed People Services Collaborative Programme~~	~~6T1.1C~~	~~Development and implementation of the One Workforce Strategy will be overseen by the HRD's Delivery Group and assurance given to the PCC~~	• ~~Monthly monitoring of workforce numbers and temporary staffing spend vs budget and agency spend.~~ • ~~Approved System Workforce Strategy and implementation plan~~ • ~~Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE.~~ • ~~The Workforce Advisory Group provides assurance to the System People and Culture Committee~~ • ~~People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce.~~ • ~~The Workforce Advisory Group brings together all component part to discuss workforce and planning and system engagement of the plan.~~	~~6T1.1AS~~ ~~6T1.2AS~~	~~The Integrated Care Strategy approved by the ICB Board and ICP~~ ~~The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board.~~

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 2 There is insufficient funding to undertake skills and cultural development needed to support integration	• A system wide training needs analysis is to be carried out so that learning and development needs can be identified and prioritised for investment. • The System People and Culture Committee provides oversight of workforce triangulation across the system.	6T2.1C	Agreement needed that any education and training funding will be invested in accordance with the priorities identified.	• The outcome of the training needs analysis and decisions on investment of education and training funding will be overseen by the Workforce Advisory Group. • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • The Workforce Advisory Group brings together all component part to discuss workforce and planning and system engagement of the plan. • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce. • Commitment to develop a system OD programme	6T2.1AS 6T2.2AS	The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. Consistent escalation reporting across the system to be agreed.
Threat 3 Lack of system ownership and commitment to an integrated Workforce	• Work is underway to develop a Workforce Strategy and plan aligned to the Integrated Care Strategy and Joint Forward Plan involving all system partners	6T3.1C	Development and implementation of the Workforce Strategy will be overseen by the People and Culture Committee	• Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • People and Culture Committee assurance to the Board via the ICB Board Integrated Assurance Report and Integrated Assurance and Performance Report which includes workforce.	6T3.2AS 6T3.3AS	The Integrated Assurance and Performance Report is in place and will continue to be developed further as reported to ICB Board. Consistent escalation reporting across the system to be agreed.

Actions to treat threat.

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Subgroup Assurance	Committee level of assurance
~~**Threat 1**~~	~~6T1.1A~~	~~Develop a Workforce Strategy aligned to support delivery of the Integrated Care Strategy, and Joint Forward Plan (JFP) and includes the response to the NHS Long Term Workforce Plan and NHS People plan.~~	~~6T1.1C~~	~~Sukhi Mahil~~	~~Initial draft to be aligned to JFP timescales~~	~~Commenced~~	~~ICS Executive~~	~~Partially assured~~
Threat 2	6T2.1A	System Wide TNA process to be developed and implemented. An operational project lead has recently freed up capacity to work on this with a view to deliver this before end of financial year	6T2.1C	Faith Sango	Quarter 4 2023/24	Commenced	People Services Collaborative Delivery Board	Partially assured
Threat 3	6T3.1A	Develop Workforce Strategy in response to the Integrated Care Strategy, JFP and anticipated People plan.	6T3.1C 6T3.1AS	Sukhi Mahil	Initial draft to be aligned to JFP timescales	Commenced	ICS Executive	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR7 – Population Health and Strategic Commissioning Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Michelle Arrowsmith, Chief Strategy and Delivery Officer **ICB Chair:** Richard Wright, Chair of PHSCC	**System lead:** Michelle Arrowsmith, Chief Strategy and Delivery Officer **System forum:** Population Health and Strategic Commissioning Committee	**Date of identification:** 17.11.2022 **Date of last review:** 03.01.2024

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that 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.**	**Risk appetite: target, tolerance and current score** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **12**		**Initial** **12**	**Current** **12**	**Target** **9**

Strategic threats (what might cause this risk to materialise)	**Impact** (what are the impacts of each of the strategic threats)
1. Lack of joint understanding of strategic aims and requirements of all system partners. 2. Demand on organisations due to system pressures/restoration may impact ability to focus on strategic aims. 3. Time for system to move more significantly into "system think". 4. Statutory requirements on individual organisations may conflict with system aims.	1. System partners interpret aims differently resulting in reduced focus or lack of co-ordination. 2. System partners may be required to prioritise their own organisational response ahead of strategic aims. 3. If the system does not think and act as one system, support is less likely to be there to achieve strategic aims. 4. Individual boards to take decisions which are against system aims.

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control Gap Ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Gap Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 Lack of joint understanding of strategic aims and requirements of all system partners.	• Strategic objectives agreed at ICB Board; dissemination will occur via Board members who represent system partners. • ICB and ICS Exec Teams in place • JUCD Transformation Co-ordinating Group in place with responsibility for delivery of transformation plans across system. • System Delivery Boards in place - providing a mechanism to share decisions and challenge actions enhancing transparency and shared understanding of impact • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis • Delivery Boards engagement with	7T1.1C 7T1.2C 7T1.3C 7T1.4C	In some cases, the 'scope' of System Delivery Board focus is not sufficiently broad enough to tackle the root cause of problems and thus there is an issue that system partners are crowded out from influencing the business of the Board. Level of maturity of Delivery Boards Values based approach to creating shared vision and strong relationships across partners in line with population needs Scoping, baselining, strategic overview, and solution choice to be carried out to ensure right solution is adopted to fit the business problem	• Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE • PHSCC assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • Audit and Governance committee oversight and scrutiny • Board Assurance Framework • Internal and external audit of plans (EA) • Health Oversight Scrutiny Committees • ICB Strategic objectives and strategic risks • System Delivery Board agendas and minutes • Provider Collaborative Leadership Board minutes • Health and Well Being Board minutes • ICB Scheme of Reservation and	7T1.1AS 7T1.2AS	The Integrated Assurance and Performance Report is in place and continues to be developed further as reported to ICB Board. Consistent management reporting across the system to be agreed

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Gap Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Gap Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	JUCD Transformation Board. • Provider Collaborative Leadership Board in place overseeing Delivery Boards and other delivery groups. • System planning & co-ordination group managing overall approach to planning • Formal risk sharing arrangements in place across organisations (via Section 75s/ Pooled Budgets) • Health Oversight Scrutiny Committees (HOSCs)/ Health and Wellbeing Boards are in place with an active scrutinising role • Dispute resolution protocols jointly agreed in key areas e.g. CYP joint funded packages – reducing disputes • Currently the system part funds the GP Provider Board (GPPB) which provides a collective voice for GP practices in the system at a strategic and operational level • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023.	7T1.5C	Understand impact of changes, how they support operational models, how best value can be delivered, and prioritised.	Delegation • Agreed process for establishing and monitoring financial and operational benefits • GPPB proposal for future operating model and funding planned for ICB Board discussion in April 23. • 2023/24 Operational Plan in place Integrated Care Strategy approved by the ICB Board and ICP. • Joint Forward Plan, Derby and Derbyshire NHS Five Year Plan 23/24 to 27/28 in place and published		
<u>Threat 2</u> Demand on organisations due to system pressures/restoration may impact ability to focus on strategic aims.	**As above and:** • System performance reports received at Quality & Performance Committee will highlight areas of concern. • ICB involvement in NOF process and oversight arrangements with NHSE. • As above – GPPB and LMC both provide some resourced 'headspace' giving GP leaders time and opportunity to focus on strategic aims. • PCN funding gives GP Clinical Directors some time to focus on the development of their Primary Care Networks • System Planning and Co-ordination Group ensuring strategic focus alongside operational planning	7T2.1C 7T2.2C	Prolonged operational pressures ahead of winter and expected pressures to continue / increase. Level of maturity of Delivery Boards	• NHSEI oversight and reporting (EA) • Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • System Quality Group assurance to the Quality and Performance Committee and ICB Board. • System Quality and Performance Report • Monthly reports provided to ICB/ ICS Executive Team/ ICB Board and NHSE • Measurement of relationship in the system: embedding culture of partnership across partners • Coproduction • Workforce resilience • Demand in the system • Audit and Governance Committee oversight and scrutiny • Board Assurance Framework • 2023/24 Operational Plan in place Integrated Care Strategy approved by the ICB Board and ICP. • Joint Forward Plan, Derby and Derbyshire NHS Five Year Plan 23/24 to 27/28 in place and published	7T2.1AS 7T2.2AS	The Integrated Assurance and Performance Report is in place and continues to be developed further as reported to ICB Board. Consistent management reporting across the system to be agreed.
<u>Threat 3</u>	• SOC/ICC processes – ICCs supporting ICB to collate and submit information	7T3.1C	As above, extent of operational pressures and time required to focus on reactive management.	• Daily reporting of performance and breach analysis – identification of learning or areas for improvement	7T3.1AS	The Integrated Assurance and Performance Report is in place and

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Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Gap Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Gap Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Time for system to move more significantly into "system think".	• As above – GPPB and LMC both provide some resourced 'headspace' giving GP leaders time to focus on system working • Development and delivery of Integrated Care System Strategy • Embedded Place Based approaches that focus partners together around community / population aims not sovereign priorities			• Measurement of relationship in the system: embedding culture of partnership across partners • Resilience of OCC in operational delivery including clinical leadership • Coproduction • Workforce resilience • Demand in the system • NHSE oversight and daily reporting (EA) • 2023/24 Operational Plan in place Integrated Care Strategy approved by the ICB Board and ICP. • Joint Forward Plan, Derby and Derbyshire NHS Five Year Plan 23/24 to 27/28 in place and published		continues to be developed further as reported to ICB Board.
Threat 4 Statutory requirements on individual organisations may conflict with system aims.	• Strategic objectives agreed at ICB Board; dissemination will occur via Board members who represent system partners. • ICB and ICS Exec Teams in place • JUCD Transformation Co-ordinating Group in place with responsibility for delivery of transformation plans across system. • System Delivery Boards in place - providing a mechanism to share decisions and challenge actions enhancing transparency and shared understanding of impact • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis • Delivery Boards engagement with JUCD Transformation Board. • Provider Collaborative Leadership Board in place overseeing Delivery Boards and other delivery groups. • GPPB and LMC both provide some resourced 'headspace' giving GP leaders time and opportunity to focus on strategic aims. • PCN funding gives GP Clinical Directors some time to focus on the development of their Primary Care Networks • System Planning and Co-ordination Group ensuring strategic focus alongside operational planning	7T4.1C 7T4.2C 7T4.3C 7T4.4C 7T4.5C	Process to ensure consistent approach is adopted to share outputs from ICS and ICB Exec team meetings. Lack of process to measure impact of agreed actions across the system. Prolonged operational pressures ahead of winter and expected pressures to continue / increase. Level of maturity of Delivery Boards System Oversight of Individual boards decisions which may be against system aims.	• Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE • Audit and Governance committee oversight and scrutiny • ICB Strategic objectives and strategic risks • System Delivery Board agendas and minutes • Provider Collaborative Leadership Board minutes • Health and Well Being Board minutes • Measurement of relationship in the system: embedding culture of partnership across partners • Coproduction • 2023/24 Operational Plan in place Integrated Care Strategy approved by the ICB Board and ICP. • Joint Forward Plan, Derby and Derbyshire NHS Five Year Plan 23/24 to 27/28 in place and published		

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	7T1.1A	Produce and embed the use of a universal prioritisation framework to guide resource allocation decisions. *(Also 7T3.1A).* This is being carried out as part of the development of the Joint Forward Plan implementation and 24/25 operational planning.	7T1.1C 7T1.3C 7T1.4C 7T1.5C	Michelle Arrowsmith Sam Kabiswa	~~Quarter 3 –~~ Quarter 4 2023/24	Commenced	PHSCC	Partially Assured
	7T1.2A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met. *(Also 7T3.2A).* This is progressing, the first elements are in place, currently systemising the process. This is ongoing and any subsequent changes are reflected in the report.	7T1.1AS	Michelle Arrowsmith Sam Kabiswa	Continuous development process	Reported to Board Bi monthly	ICB Board	Partially Assured
	7T1.3A	Delivery Boards to develop a process to share decisions and challenge actions enhancing transparency and shared understanding of impact.	7T1.2C	Tamsin Hooton	Quarter 4 2023/24	Commenced	Delivery Boards/ Provider Collaborative Leadership Board	Partially assured
		TCG co-ordinates overall transformation reporting and escalation of risks.			Quarter 4 2023/24	Commenced	TCG/PCLB/SFEDC	Partially assured
		Workshop session held 27/9/23, to agree a process to develop programme plans in a co-ordinated way, proposal for a system wide benefits realisation approach to understand impact, and interface with a system prioritisation approach. This now needs to be aligned with system planning approach.			Quarter 4 2023/24	Commenced	TCG/System Planning Group	Partially assured

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 2	7T2.1A	Surge planning process established / all year-round planning approach – this does not prevent operational pressures but helps to predict and plan better the response. Surge Planning Plan submitted October 2023.	7T2.1C	UECC Board / UECC SRO / MA	End of Quarter 3 2023/24.	Completed October 2023.	UECC Board	Assured
		H2 planning – first draft 25.09.23. Awaiting formal feedback. Ongoing, in progress – continuous planning approach.	7T2.1C	Sam Kabiswa	In progress	Commenced	UECC Board	Partially assured
	7T2.2A	Delivery Boards to develop a process to share decisions and challenge actions enhancing transparency and shared understanding of impact. Workshop session held 27/9/23, to agree a process to develop programme plans in a co-ordinated way, proposal for a system wide benefits realisation approach to understand impact, and interface with a system prioritisation approach. This now needs to be aligned with system planning approach.	7T2.2C	Tamsin Hooton	Quarter 4 2023/24	Commenced	Delivery Boards/ Provider Collaborative Leadership Board	Partially assured
	7T2.3A	Consistent management reporting across the system to be agreed. System wide performance report compiled jointly with the Quality Team. The Joint Forward Plan has an agreed Outcomes Framework to drive the activities and interventions to include measurable System Objectives and development in key areas.	7T2.2AS	Sam Kabiswa	Quarter 4 2023/24	Commenced	Quality and Performance Committee ICB Board	Partially assured
Threat 3	7T3.1A	Prioritisation process agreed in the system to better manage our time and use of resource. This is being carried out as part of the development of the Joint Forward Plan implementation and 24/25 operational planning.	7T3.1C	ICB / ICP	~~Quarter 3 –~~ Quarter 4 2023/24	Commenced	PHSCC	Partially assured
	7T3.2A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met. This is progressing, the first elements are in place, currently systemising the process. This is ongoing and any subsequent changes are reflected in the report.	7T3.1AS	Michelle Arrowsmith	Continuous development process	Reported to Board Bi-monthly	ICB Board	Partially assured

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 4	7T4.1A	Development of log System ICB/ICP Board decisions	7T4.1C	Chrissy Tucker	Quarter 4 2023/24	Commenced	ICB Board/ICP Board	Partially assured
	7T4.2A	Develop a process to measure impact of agreed actions across the system. To be delivered as part of the Joint Forward Plan implementation – System wide Evaluation Strategy of the impact of the Joint Forward Plan and the Integrated Care Strategy.	7T4.2C	Sam Kabiswa	Quarter 4 2023/24	Commenced	ICB Board/ICP Board	Partially assured
	7T4.3A	Surge planning process established / all year-round planning approach – this does not prevent operational pressures but helps to predict and plan better the response. Surge Planning Plan submitted October 2023.	7T4.3C	Michelle Arrowsmith	End of Quarter 3 2023/24	Completed October 2023	Urgent Care Delivery Board	Assured
	7T4.4A	Delivery Boards to develop a process to share decisions and challenge actions enhancing transparency and shared understanding of impact. Transformation report and escalation report produced monthly and shared with TCG/PCLB. Workshop session held 27/9/23, to agree a process to develop plans in a co-ordinated way, including a system wide benefits realisation approach to understand impact, and interface with a system prioritisation approach. The proposed approach will be further discussed via the TCG and taken to the PCLB and System planning group for support.	7T4.4C	Tamsin Hooton	Quarter 4 2023/24	Commenced	Delivery Boards/ Provider Collaborative Leadership Board	Partially Assured
	7T4.5A	Development of a process to support system oversight and delivery of system aims and Joint Forward Plan.	7T4.5C	Chrissy Tucker	Quarter 4 2023/24	Not yet commenced	ICB Board/ICP Board	Partially Assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR8 – Population Health and Strategic Commissioning Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Chris Weiner ICB Medical Director **ICB Chair:** Richard Wright, Chair of PHSCC	**System lead:** Chris Weiner, ICB Medical Director **System forum:** Population Health and Strategic Commissioning Committee	**Date of identification:** 17.11.2022 **Date of last review:** 03.01.24

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.**	**Risk appetite: target, tolerance and current score** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **12**		**Initial** **12**	**Current** **12**	**Target** **8**

Strategic threats (what might cause this risk to materialise)	**Impact** (what are the impacts of each of the strategic threats)
1. Agreement across the ICB on prioritisation of analytical and BI activity is not realised and therefore funding and associated resources are not identified to deliver the analytical capacity.	1. As a result of incomplete and non-timely data provision/analysis, the ICB will be hampered in the making optimal strategic commissioning decisions and it will require complex and inefficient people structures to ensure system oversight of daily operations. This will result in a: • reduced ability to effectively support strategic commissioning and service improvement work • failure to meet national requirements on population health management, • reduced ability to analyse how effectively resources are being used within the ICB • failure to deliver the required contribution to regional research initiatives • continued paucity of analytical talent development and recruitment resulting in inflated costs

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 Agreement across the ICB on prioritisation of analytical and BI activity is not realised and therefore funding and associated resources are not identified to deliver the analytical capacity	• Agreed and publicly published Digital and Data Strategy • Digital and Data Board (D3B) in place. This provides board support and governance for the delivery of the agreed Digital and Data strategy. • D3B responsible for reporting assurance to ICB Finance and Estates Committee and assurance and direction from the Provider Collaborative Leadership Board. • Strategic Intelligence Group (SIG) established with oversight of system wide data and intelligence capability and driving organisational improvement to optimise available workforce and ways of working • Analytics and business intelligence identified as a key system enabler and priority for strategic planning and operationally delivery in the Digital and Data strategy • NHSE priorities and operational planning guidance 23/24 requires the right data architecture in place for population health management • Digital and Data identified as a key enabler in the Integrated Care Partnership strategy	8T1.1C 8T1.2C 8T1.3C 8T1.4C 8T1.5C	Senior system analytical leadership role to be created within ICB structures Senior analytical leadership role to co-ordinate: - Delivering value from NECS contract - Co-ordinating work across SIG - Identifying opportunities for more effective delivery of PHM Identified three priority areas of strategic working: - System surveillance intelligence - Deep dive intelligence - Population Health Management. Strategic Intelligence Group (SIG) needs formalising and structured reporting through to D3B and direct link to ICB Strategic Intent function and ICB planning cell JUCD Information Governance Group needs formalisation and work required on using data for planning purposes.	• Data and Digital Strategy • CMO and CDIO from ICB executive team are vice chairs of the D3B. • Regional NHSE and AHSN representation at D3B provide independent input. • D3B minutes demonstrating challenge and assurance levels • Provider Collaborative Leadership Board Minutes demonstrating challenge and assurance levels • Monthly Reporting to Finance and Estates Committee, ICB Board, NHSE and NHS Executive Team • Evidence of compliance with the ICB Scheme of Reservation and Delegation • A staffed, budgeted establishment for ICB analytics (workforce BAF link required) • Data Sharing Agreements in place across all NHS providers, ICB, hospices and local authorities for direct care purposes.	8T1.1AS	The Integrated Assurance and Performance Report is in place and continues to be developed further as reported to ICB Board.

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	8T1.2A	Agree structure of ICB analytics team and role of Chief Data Analyst Work dependent on restructure agreement.	8T1.1C 8T1.2C	Chris Weiner	~~December 2023~~ February 2024	Commenced	Executive Team	Partially assured
	8T1.3A	Recruitment of analytics team Work dependent on restructure agreement.	8T1.2C	Chris Weiner	Quarter 4 2023/24	Not started	To be agreed	Partially assured
	8T1.4A	Co-ordination and local prioritisation through SIG with leadership provided by internal business intelligence team SIG is looking at health inequalities, population health management and how this data can be shared across the whole system. Senior analytical leadership role to be confirmed due to structures.	8T1.3C 8T1.4C	Chris Weiner	April 2024	Commenced	Business Intelligence Team	Partially assured
	8T1.5A	Execution of planned investment in analytical skills development in line with ICB plan Work dependent on restructure agreement.	8T1.4C	Chris Weiner	February 2024 due to restructures and consultation moved from Oct 23	Commenced	Business Intelligence Team	Partially assured
	8T1.6A	Formalise JUCD IG group and draft data sharing agreements for using data for purposes other than direct care	8T1.5C	Chris Weiner/ Ged /CT	Q4 as work in progress	Commenced	JUCD IG Group	Partially assured
	8T1.7A	SIG being reconstituted and reset	8T1.4C	Chris Weiner	~~Quarter 2 2023/24~~ now Q3 TOR being presented Dec 23 for agreement	Commenced	Strategic Intelligence Group	Partially assured
	8T1.8A	Continue to strengthen the ICB Board Integrated Assurance and Performance Report data and information. This is progressing, the first elements are in place, currently systemising the process. This is ongoing and any subsequent changes are reflected in the report.	8T1.1AS	Executive Officers Sam Kabiswa	Continuous development process	Commenced Presented to ICB Board bi monthly	Quality and Performance Committee, ICB Board	Partially assured

ICB – Board Assurance Framework (BAF)

Strategic Risk SR9 – Population Health and Strategic Commissioning Committee

Strategic Aim – Reduce inequalities in health and be an active partner in addressing the wider determinants of health.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Michelle Arrowsmith, Chief Strategy and Delivery Officer **ICB Chair:** Richard Wright, Chair of PHSCC	**System lead:** Dr Robyn Dewis **System forum:** Population Health and Strategic Commissioning Committee	**Date of identification:** 17.11.2022 **Date of last review:** 03.01.2024

Strategic risk (what could prevent us achieving this strategic objective)	**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.**	**Risk appetite: target, tolerance and current score** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **12**		**Initial** **16**	**Current** **16**	**Target** **12**

Strategic threats (what might cause this risk to materialise)	**Impact** (what are the impacts of each of the strategic threats)
1. The breadth of requirements on the system ~~adversely affect~~ outstrips/surpasses our ability to prioritise our resources (financial/capacity) towards reducing health inequalities. 2. The population may not engage with prevention programmes.	1. Delay or non-delivery of the health inequalities programme. The ICS fails to make any impact rather than focusing on a small number of priority areas where the ICS can make an impact. 2. The population are not able to access support to improve health.

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control Ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 The breadth of requirements on the system outstrips/surpasses our ability to prioritise our resources (financial/capacity) towards reducing health inequalities.	• Integrated Care Partnership Board in place with Terms of Reference and strategy agreed. • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023. • NHS and ICS Executive teams in place. • Core 20 Plus 5 work programme. • Delivery Boards remit to ensure work programme supports HI. • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis inclusive of access and inequality considerations • System-wide EQIA process supports identification of equalities risks and mitigations and reduces risk of projects/ programmes operating in	9T1.1C 9T1.2C 9T1.3C 9T1.4C	Financial position and requirement to break-even / lack of funds to invest or double-run whilst transforming. Capacity to support strategy and its delivery. The national formula for funding GP practices (Carr-Hill) probably provides insufficient weighting for deprivation Under performance against key national targets and standards (Core 20 Plus 5 work programme)	• Measurement of relationship in the system: embedding culture of partnership across partners • PHSCC assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • System Delivery Board agendas and minutes • Provider Collaborative Leadership Board minutes • Health and Well Being Board minutes • ICP Agenda and minutes • Coproduction • Workforce resilience • Demand in the system • Audit and Governance Committee oversight and scrutiny • Health Overview and Scrutiny Committee (HOSC)	9T1.1AS	The Integrated Assurance and Performance Report is in place and continues to be developed further as reported to ICB Board.

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	isolation – and specifically decommissioning decisions • Ambulance handover action plan developed – improvement trajectory agreed with NHSI – monthly improvement trajectories monitored at Boards			• EDI Committee reporting • Derbyshire ICS Greener Delivery Group and minutes • 2023/24 Operational Plan in place Integrated Care Strategy approved by the ICB Board and ICP. • Joint Forward Plan, Derby and Derbyshire NHS Five Year Plan 23/24 to 27/28 in place and published Development of Health Inequalities Group, Provider facing for Mental Health • Performance Data from MHSDB		
Threat 2 The population may not engage with prevention programmes.	• Prevention work - winter plan and evidence base of where impact can be delivered • General Practice is still trusted by the vast majority of people and has a proven track record of helping people engage with prevention programmes • Integrated Care Partnership (ICP) established. • ICP Strategy in place which will support improving health outcomes and reducing health inequalities.	9T2.1C 9T2.2C	Core 20 plus 5 work - This programme forms a focus of the Health Inequalities requirement for the NHS but does not cover the entire opportunity for the system to tackle Health Inequalities. Time and resource for meaningful engagement	• Alignment between the ICS and the City and County Health and Wellbeing Boards • Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • Population Health Strategic Commissioning Committee assurance to the ICB Board via the Assurance Report. • ICB Board and minutes • ICP and minutes • Derbyshire ICS Health Inequalities Strategy has been developed and approved.		

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	9T1.1A	Monthly monitoring of financial position and the ICB requirement to break-even.	9T1.1C	Darran Green	Quarter 4 2023/24	On-going - Annually	Finance, Estates and Digital Committee/ ICB Board	Partially assured
	9T1.2A	Prioritisation of actions needed to implement strategy – Progress.	9T1.2C	Kate Brown	~~Quarter 3 2023/24~~ In progress – 2024/25	Commenced	ICB Board/ICP Board	Partially assured
	9T1.3A	Review alternative funding formula to Carr Hill – scope cost and logistics Initial discussion held with Leicester, Leicestershire and Rutland ICB (LLRICB) who completed this work during quarter 3. Significant additional costs likely if ICB is to 'level up' to support new formula which gives greater weighting to deprivation. Would be challenging given current system financial position. Further work needed to scope but not prioritised for 23/24. Will reconsider in action plan for 24/25.	9T1.3C	GPPB/Clive Newman/Finance	~~April 2024~~ April 2025	Commenced	GPPB/PHSCC	Partially assured
	9T1.4A	NHS England Regional Prevention Group monitor Core 20 plus 5 performance and review and agree any mitigations should targets fall below threshold.	9T1.4C	Angela Deakin	In Progress – 2024/25	Commenced	Long Term Plan Prevention Programmes Working Group meeting	Partially assured
	9T1.5A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met. This is progressing, the first elements are in place, currently systemising the process. This is ongoing and any subsequent changes are reflected in the report.	9T1.1AS	Michelle Arrowsmith Sam Kabiswa	Continuous development process	Commenced Presented to ICB Board bi monthly	Quality and Performance Committee, ICB Board	Partially assured
Threat 2	9T2.1A	Prevention and Health Inequalities Board being set up Derby City Council has partnered with Community Action Derby to create the Derby Health Inequalities Partnership (DHIP) and is led by the voluntary sector.	9T2.1C	Chris Weiner / Angela Deakin	~~November 2023~~ In the process of being confirmed	Monthly	Population Health Strategic Commissioning Committee	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR10 – Finance, Estates and Digital Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Jim Austin, Chief Digital Technology Officer **ICB Chair:** Jill Dentith, Chair of Finance, Estates and Digital Committee	**System lead:** Keith Griffiths, Executive Director of Finance **System forum:** Finance and Estates Committee Data and Digital Board	**Date of identification:** 17.11.2022 **Date of last review:** 12.12.2023

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.**	**Risk appetite: target, tolerance and current score** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **12**		**Initial** **12**	**Current** **12**	**Target** **9**

Strategic threats (what might cause this risk to materialise)	**Impact** (what are the impacts of each of the strategic threats)
1. Agreement across the ICB on prioritisation of digital and technology activity may not be realised and therefore budget allocation and reconciliation process across ICB for digital and technology are not agreed. 2. Digital improvements and substitutions to clinical pathways are not delivered through either a lack of citizen engagement and/or clinical engagement	Threat 1 – Processes are not agreed and the ICS fail to meet the opportunities and efficiencies that digital enablement can realise. Threat 2 • Failure to secure patient, workforce and financial benefits from digitally enabled care and implementation of alternative care pathways highlighted in ICB plan; e.g. limited adoption of alternative (digital) clinical solutions (e.g. PIFU, Virtual Ward, self-serve on line) • Failure to meet the national Digital and Data strategy key priorities (eg attain HIMMS level 5; cyber resilience)

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control Ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
<u>Threat 1</u> Agreement across the ICB on prioritisation of digital and technology activity may not be realised and therefore budget allocation and reconciliation process across ICB for digital and technology are not agreed.	• Agreed and publicly published Digital and Data Strategy • Digital and Data Board (D3B) in place. This provides board support and governance for the delivery of the agreed Digital and Data strategy. • D3B responsible for reporting assurance to ICB Finance and Estates Committee and assurance and direction from the Provider Collaborative Leadership Board. • Representation from Clinical Professional Leadership Group on D3B • Digital programme team leading and supporting key work in collaboration with system wide Delivery Boards e.g., Urgent and Emergency Care, Elective	10T1.1C 10T1.2C	ICB prioritisation and investment decision making process is required to fully implement the digital and data strategy priorities. Digital literacy programme to support staff build confidence and competency in using technology to deliver care.	• Data and Digital Strategy approved by ICB and NHSE • CMO and CDIO from ICB executive team are vice chairs of the D3B. • Regional NHSE and AHSN representation at D3B provide independent input. • D3B minutes demonstrating challenge and assurance levels • Provider Collaborative Leadership Board Minutes demonstrating challenge and assurance levels • Clinical Professional Leadership Board Minutes demonstrating challenge and assurance levels • Evidence of compliance with the ICB Scheme of Reservation and Delegation • exploitation of Derbyshire Shared Care Record capabilities; demonstrated		

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	to embed digital enablement in care delivery • Digital and Data identified as a key enabler in the Integrated Care Partnership strategy • NHSE priorities and operational planning guidance 23/24 requires the right data architecture in place for population health management • Digital and Data has contributed to ICB 5 year plan Clear prioritisation of clinical pathway transformation opportunities need formalising through Provider Collaborative and ICB 5 year plan. • Formal link to the GP IT governance and activity to the wider ICB digital and technology strategy in place via Chief Data Information Officer. • GP presence on Derbyshire Digital and Data Board			through usage data • Acceptance and adoption of digital improvements by operational teams (COO, primary care and comms support needed – links to digital people plan and Delivery Board outcomes) • A staffed, budgeted establishment for ICB digital and technology (workforce BAF link required)		
Threat 2 Digital improvements and substitutions to clinical pathways are not delivered through either a lack of citizen engagement and/or clinical engagement	• Digital and Data Board (D3B) enabling delivery board and support governance established and responsible for the delivery of the agreed Digital and Data strategy • D3B responsible for reporting assurance to ICB Finance and Estates Committee and assurance and direction from the Provider Collaborative Leadership Board • Citizen's Engagement forums have a digital and data element • ICB and provider communications team engaged with messaging (e.g. Derbyshire Shared Care Record)	10T2.1C 10T2.2C 10T2.3C 10T2.4C	Data and Digital communication and engagement strategy required to increase awareness of digital technology and solutions available to support care delivery. Development of a 'use case' library to help promote the benefits of digitally enabled care and now under construction for Shared Care Record Improved information and understanding of Citizen and Community forums that could be accessed to discuss digitally enabled care delivery Increased collaboration with the Voluntary Sector across Derby and Derbyshire to harness capacity and expertise in place with Rural Action Derbyshire	• ICB and provider communications plans with evidence of delivery • Staff surveys showing ability to adopt and influence change • Patient surveys and D7F results • D3B minutes demonstrating challenge and assurance levels • Provider Collaborative Leadership Board Minutes demonstrating challenge and assurance levels • Clinical Professional Leadership Board Minutes demonstrating challenge and assurance levels • Evidence of compliance with the ICB Scheme of Reservation and Delegation • Data and Digital Strategy adoption reviewed through Internal Audit • ICB Board Finance and Estates Committee Assurance Report to escalate concerns and issues. • Public Partnerships Committee minutes demonstrating challenge and assurance levels		

Key: All assurances are classified as internal assurances unless specified as an External Assurance (EA)
All assurances are classified as positive assurance unless specified as a Negative Assurance (NA)

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	10T1.1A	Secure agreement on digital and technology resource funding. 23/24 budget agreed and recurrent Digital Programme budget agreed from 24/25 onwards.	10T1.1C	Jim Austin / Darran Green	24/25 funding Completed November 2023	Completed November 2023	D3B	Fully assured
	10T1.2A	Develop and roll out staff digital literacy programme. Linked to Project Derbyshire (Digital HR) – no resource allocated / prioritised at this time. Planning work commenced	10T1.2C	Jim Austin / Workforce lead/AR	From 24/25 financial year	Commenced	D3B , Digital Implementation Group	Partially assured
	10T1.3A	Adopt ICB prioritisation tool to enable correct resource allocation	10T1.1C	Jim Austin / Darran Green	TBC – requires prioritisation tool	Not started	D3B	Not assured
Threat 2	10T2.1A	Formalise link to Public Partnership Committee, Presented to the committee September 2023, on-going dialogue established. The relationship has been established and open invitation.	10T2.1C	Jim Austin /Sean Thornton	Quarter 3 2023/24 Completed September 2023	Completed September 2023	Public Partnership Committee	Assured
	10T2.2A	Work with ICB communications team and Provider communications teams to integrate digital strategy messaging into current engagement programme.	10T2.3C	Jim Austin /Sean Thornton	In Progress – 2024/25	Commenced	Public Partnership Committee	Partially assured
	10T2.3A	Deliver digital (and data) messaging through ICB communications plan.	10T2.3C	Jim Austin /Sean Thornton	June 2023+	Commenced	Public Partnership Committee/ DB3	Partially assured
	10T2.4A	Meetings with Rural Action Derbyshire completed, Derbyshire County Council and ICB engagement team to develop joint engagement strategy.	10T2.4C	Jim Austin /Sean Thornton	In progress – 2024/25	Commenced	Public Partnership Committee/ DB3	Partially assured

Key: All assurances are classified as internal assurances unless specified as an External Assurance (EA)
All assurances are classified as positive assurance unless specified as a Negative Assurance (NA)

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: 149

Report Title	Integrated Care Board Risk Register Report – February 2024							
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 – February 2024							
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 29th February 2024;
- Appendix 2, which summarises the movement of all risks in February 2024,

and **APPROVE** the:

- **CLOSURE** of risk 18 relating to patients accessing their health records; and
- **CLOSURE** of risk 26 (former confidential risk 11C) relating to additional investment and recruitment to increase appropriately trained staff and therefore the resilience of the LMNS PMO team.

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 a health and care 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

[To be completed by the Finance Team ONLY]

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 9 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.

For information, three risks owned by the System Quality Group have been transferred from the Confidential Risk Register, as agreed by System Quality Group at the meeting held on 2nd January 2024. This is because the risks do not require further confidential discussion as the subject matter is in the public domain.

Risk Matrix

Impact	1 – Rare	2 – Unlikely	3 – Possible	4 – Likely	5 – Almost certain
5 – Catastrophic					
4 – Major			2	6	3
3 – Moderate		3	4	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 direct to Urgent Treatment Centre pathway has been signed off and went live on 19th February 2024.	Overall score 20 **Very High** (5 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	<u>January performance:</u> • CRH reported 72.8% (YTD 76.6%) and UHDB reported 73.4% (YTD 73.1%). • CRH: The Type 1 attendances and Type 3 streamed attendances remain high, with an average of 229 Type 1 and 54 streamed attendances per day. • UHDB: The volume of attendances remains high, with Derby seeing an average of 216 Type 1 adult attendances per day, 113 children's Type 1s and 143 co-located Urgent Treatment Centre (UTC). • At Burton there was an average of 200 Type 1 attendances per day and 15 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 10 Resuscitation patients and 207 Major patients per day and Burton seeing 76 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:** • Winter resilience meetings and support to general practice continues. Non recurrent funding has been identified to support NHS 111 cover for Practice QUEST from April 2025. • A Quality and Outcomes Framework (QOF) template has been developed to support practice discussions for 23/24 achievement. A paper outlining this will be presented to Primary Care Sub Group in March 2024 • A Filtering Face Piece (FFP3) training offer for Primary Care Networks (PCNs) has been agreed and will be communicated to general practices during March 2024 with training due to commence in April 2024. • A change in the provider of Clinical Waste for all practices is in place and will commence from March 2024 and this will ensure there is no gap in provision. • A Practice Resilience Forum has been established with the Local Medical Council (LMC) and GP Provider Board (GPPB) to scope the approach for 24/25. • There is no change to the risk score due to the pressures in general practice, uncertainty around the GP contract and financial pressures as a result of increases in staff costs that are not covered through the national contract uplifts.	Overall score 16 **Very High** (4 x 4)	Population Health and Strategic Commissioning Committee

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
Risk 06	*Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.* **Update:** • The Month 10 forecast out-turn (FOT) remains at a £44.7m deficit as notified to NHSE, although this excludes the impact of any industrial action since November 2023 and any impact from agreeing the Health Care Support Worker re-banding. • There is a significant degree of confidence that this FOT will be delivered. • Recurrent baselines continue to be worked upon and there is a need to understand how additional recurrent costs above 2022/23 planned levels have increased over the financial year. • Early indications are that the recurrent position heading into 2024/25 will have deteriorated further due to the level of non-recurrent benefits supporting the 2023/24 position.	Overall score 20 **Very High** (5 x 4)	Finance, Estates and Digital Committee
Risk 09	*There is a risk to patients on Provider waiting lists due to the continuing delays in treatment resulting in increased clinical harm.* **Update:** • A decrease in risk score to a 9 was approved at the System Quality Group on 2nd January 2024, however the decrease in risk score not agreed at ICB Board meeting on 18th January 2024 and risk description is recommended to be re-worded. • The ICB Board have requested further re-working on the description for this risk and this is being worked on by the risk owner. • As February 2024 Quality & Performance Committee is a planned Development Session, at the Quality and Performance Committee planned for 28th March, there will be further discussions around the risk, description and challenge regarding the risk score. • In light of the risk re-wording requirement and the ICB Board not approving the decrease in risk score, the risk score will remain at a very high score of 16 until these issues are resolved.	Overall score 16 **Very High** (4x4)	Open Risk

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
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:** • Following a recent discussion at the Strategic Discharge Group in relation to the Corporate Risk Register and this risk, a small Working Group has been established to develop the wording, mitigations, risks score, etc to reflect the current issues/risks. • An initial meeting has been carried out which took place on 15th February 2024. • Work is currently being carried out to finalise the wording for this risk and at the next Strategic Discharge Group planned for 8th March, the revised wording will be discussed.	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.* **Update:** • The Home Office/ and Serco have now closed two of the seven hotels - one in the City and one in the County and they are looking to close the other hotels, but no timeframe at this stage. This is a positive move of change. • The risk remains for the residents in relation to the other hotels and the residents living in a hotel setting for a lengthy period of time and impact on services still remains an issue. Therefore, there is no change to the risk score.	Overall score 16 **Very High** (4 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
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 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. • We have now received some requests for information from the national team as several organisations who provide services to the System have appealed for this funding.	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:** • There is work underway to re-word the risk description and this will be available for March reporting. • There is a challenge in re-wording the risk description to ensure all aspects are captured that impact the risk and also the specific challenges and cancer recovery plan.	Overall score 16 **Very High** (4 x 4)	System Quality Group
25 *(Former Confidential 09C)*	*There is a risk of significant waiting times for moderate to severe stroke patients for community rehabilitation. This means, patients may have discharges from acute delayed, be seen by non-stroke specialist therapists and require more robust social care intervention.* **Update:** • Case for Change development is ongoing and will be completed this month. • NHSE have requested to review the document.	Overall score 16 **Very High** (4x4)	Open Risk

RISK MOVEMENT

Appendix 2 details the movement of risk scores during February 2024 and the graphs detail the movement since April 2023.

One risk was increased in score in January:

Risk 15: *The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI.*

This risk is recommended to be increased from a moderate score of 6 (probability 3 x impact 2) to a high score of 9 (probability 3 x impact 3).

Risk score increased slightly due to the complexity of services transferring and the lack of clarity as to the operational model.

The delegation agreement between NHSE and ICBs, Collaboration Agreement between ICBs, and Operating Framework documents are all currently in draft and waiting final versions for signature. A meeting scheduled for early February 2024 between the ICB and NHSE Senior Programme Director to better understand exactly what will move to the hosting ICB for management, and what the responsibilities of the remaining ICBs will be.

This was approved by the Audit and Governance Committee at the meeting held on 8th February 2024.

CLOSED RISKS

Two risks are recommended to be closed:

Risk 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.*

There have been no concerns or issues raised with the Primary Care Quality Team since the Go Live Date and no further practice feedback has been received and therefore the risk is recommended to be closed.

The proposed closure was approved by the Population Health and Strategic Commissioning meeting held on 14th March 2024.

Risk 26 *(Former Confidential 11C): There is a risk that the Local Maternity & Neonatal System (LMNS) is unable to undertake perinatal quality surveillance satisfactorily and complete the necessary assurance and oversight of maternity and neonatal services without additional investment and recruitment to increase appropriately trained staff and therefore the resilience of the LMNS PMO team.*

The LMNS Project manager is now in post and the LMNS Board agreed to close the risk at the meeting held on 23rd January 2024. It is proposed to close this risk from the ICB Corporate Risk Register.

The proposed closure was approved by the System Quality Group meeting held on 6th February 2024.

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 29th February 2024;
- Appendix 2, which summarises the movement of all risks in February 2024;

and **APPROVE** the:

- **CLOSURE** of risk 18 relating to patients accessing their health records;
- **CLOSURE** of risk 26 (former confidential risk 11C) relating to additional investment and recruitment to increase appropriately trained staff and therefore the resilience of the LMNS PMO team.

Appendix 1 - Derby and Derbyshire ICB Risk Register - as at February 2024

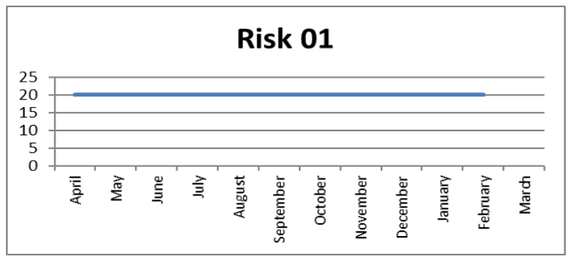
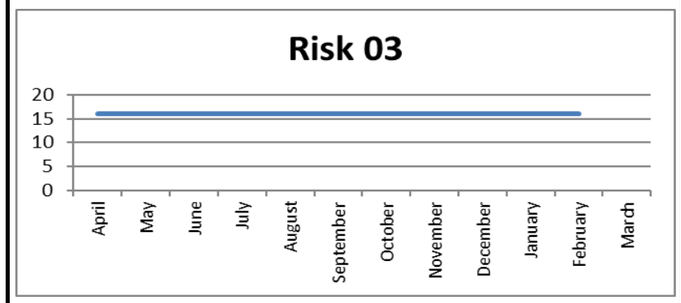
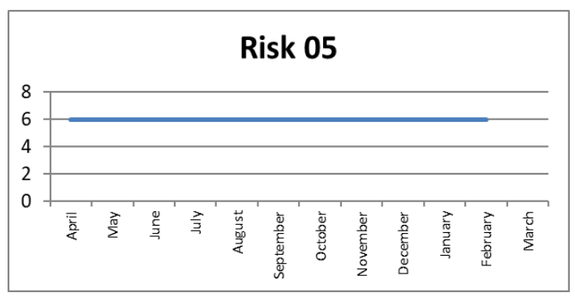
NHS Derby and Derbyshire Integrated Care Board

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
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 Tactical Group (silver command/tactical) and System Strategic 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. - Ambulance Handover Improvement Group (UHDB/EMAS/ICB) is in place weekly to review handover data trends, review pathways/processes and alternative pathways to ED such as direct to UTC/SDEC. This will support reducing the demand on our emergency departments. The direct to UTC pathway has been signed off and went live on 19/02/2024.	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. Conversations are ongoing between UEC Team and UTC Providers to ensure that business continuity processes are in place to support the system during times of pressure.	January 2024 performance CRH reported 72.8% (YTD 76.6%) and UHDB reported 73.4% (YTD 73.1%). CRH: The Type 1 attendances and Type 3 streamed attendances remain high, with an average of 229 Type 1 and 54 streamed attendances per day. UHDB: The volume of attendances remains high, with Derby seeing an average of 216 Type 1 adult attendances per day, 113 children's Type 1s and 143 co-located UTC. At Burton there was an average of 200 Type 1 attendances per day and 15 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 10 Resuscitation patients & 207 Major patients per day and Burton seeing 76 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	Feb-24	Mar-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	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.	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. Cloud Based Telephony Systems – 15 practices within DDICB were included in phase 1 for CBT funding due to analogue telephony systems being in place. All 15 practices have signed new contracts with suppliers approved on the Better Purchasing Framework and are in the process of installing their new CBT systems. NHSE have asked that all installations for Phase 1 practices be completed by 25th March 2024. 29 practices were included in Phase 2 Cohort B for CBT funding. All 29 practices have now signed new contracts with suppliers approved on the Better Purchasing Framework.	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 intelligence, core offer and support for practices in crisis. Further work is taking place prior to the September meeting to develop a more advanced quality dashboard to support the early identification of practices who would benefit from additional support. 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/January: 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. February 2024. Continuing winter resilience meetings and support to general practice. Non recurrent funding identified to support 111 cover for Practice QUEST from April 2025. QOF template developed to support practice discussions for 23/24 achievement. Paper to PCSG in March 2024. FFP3 training offer for PCNs agreed and to be communicated to practices during March 2024 with training to commence April 2024. Change in provider of Clinical Waste for all practices in place to commence March 2024 and ensure no gap in provision. Practice resilience forum established with LMC and GPPB to scope approach for 24-25. There is no change to the risk score due to the pressures in general practice, uncertainty around the GP contract and financial pressures as a result of increases in staff costs that are not covered through the national contract uplifts.	4	4	16	4	4	16	4	3	12	On going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Feb-24	Mar-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	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	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. January Awaiting finalisation of ICB Restructure to confirm ICB EPRR Team in place, work continues to be delivered as above albeit hampered by Industrial Action Response. February Awaiting finalisation of ICB Restructure to confirm ICB EPRR Team in place, work continues to be delivered as above albeit hampered by Industrial Action Response, new dates have now been announced for Junior Drs IA that EPRR have been requested to lead on planning and assurance for the system.	2	3	6	2	3	6	2	2	4	On going	SR4 SR5 SR6 SR8	Feb-24	Mar-24	Helen Dillistone - Chief of Staff	Chris Leach Head of EPRR
06	23/24	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.	Finance, Estates and Digital Committee	Finance	4	4	16	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.	Feb 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. There is an increasing urgency to identify recurrent cost out transformation in order to move closer to financial sustainability.	Feb Update: The M10 FOT remains at a £44.7m deficit as notified to NHSE deficit, although this excludes the impact of any industrial action since November 2023 and any impact from agreeing the Health Care Support Worker rebanding. There is a significant degree of confidence that this FOT will be delivered. Recurrent baselines continue to be worked upon and there is a need to understand how additional recurrent costs above 2022/23 planned levels have increase over the financial year. Early indications are that the recurrent position heading into 2024/25 will have deteriorated further due to the level of non-recurrent benefits supporting the 2023/24 position.	5	4	20	5	4	20	2	3	6	On going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Feb-24	Mar-24	Keith Griffiths, Chief Financial Officer	Darran Green, Acting Operational Director of Finance Donna Johnson Acting Assistant Chief Finance Officer
07	23/24	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	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.	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. January - Review of files to transfer to Scarsdale and leavers for storage commenced. February - Review of files to transfer to Scarsdale and leavers for storage continuing. Additional administrative resource identified and planned completion by 31 March 2024.	2	3	6	2	3	6	1	2	2	Apr-24	SR8	Feb-24	Mar-24	Helen Dillistone - Chief of Staff	James Lunn, Head of People and Organisational Development
09	23/24	There is a risk to patients on Provider waiting lists due to the continuing delays in treatment resulting in increased clinical harm.	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	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 remain 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. *Decrease in risk score approved at System Quality Group on 2nd January 2024, however the decrease in risk score not agreed at ICB Board meeting on 18th January 2024 and risk description needs re-wording.* ICB Board have requested further re-working on the description for this risk. Linking with risk owner to work on this. As February 2024 Quality & Performance Committee is a planned Development Session, at March Quality and Performance Committee, there will be further discussions around the risk, description and challenge regarding the risk score. In light of the risk re-wording requirement and ICB Board not approving the decrease in risk score, the risk score will remain at a very high score of 16 until these issues are resolved.	4	4	16	4	4	16	3	2	6	Feb-24	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Feb-24	Mar-24	Prof Dean Howells Chief Nursing Officer	Letitia Harris Assistant Director of Clinical Quality Lisa Falconer Head of Clinical Quality (Acute)
11	23/24	If the ICB does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	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	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. February: The Derbyshire ICS Green Plan is supported by the Green Action Plan which details the key priorities and actions for 2023/24. The ICS is making good progress in the achievement of the zero targets and as part of the NHSE Greener NHS Maturity self assessment, has been assessed as a Tier 3, maturing organisation. Although we have received this level of assurance, the ICS is still required to deliver a further 50% achievement of 2023/24 priorities. Delivery of this will continue into 2024/25 and beyond. Therefore, we consider the risk score of a high 9 to be appropriate and realistic.	3	3	9	3	3	9	3	2	6	Mar-24	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Feb-24	Mar-24	Helen Dillistone - Chief of Staff	Suzanne Pickering Head of Governance

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
13	23/24	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.	Public Partnerships Committee	Corporate	4	4	16	• Detailed work programme for the engagement team • Clearly allocated portfolio leads across team to share programmes * Assessment of transformation programmes in ePMO system underway to quantify engagement workload. January: Ongoing assessment of ePMO programmes nearing conclusion. January: System comms leads have agreed distributed leadership approach to assessing work programmes within delivery boards and other system groups. Mapping to take place January & February, with review session planned for 2 March. 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.	•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. January: ICB Staff Consultation has closed, now into approval phase via REMCOM. Head of Communications position advertised with prior approval by Executive Team. A range of temporary appointments in the team requiring ongoing negotiation with host organisations to maintain capacity, with 31st March being a hard stop for some arrangements and will reduce capacity in the absence of further action. February: Staff structures approved. Head of Communications position appointed to, start date mid-April 2024. Temporary appointments within the engagement team remain, awaiting understanding of final destination of existing, substantive post holders. Temporary mitigations in place until 31 March.	3	3	9	3	3	9	2	2	4	Mar-24	SR3 SR4 SR5 SR6 SR8 SR9	Feb-24	Mar-24	Helen Dillistone - Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement
15	23/24	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	Audit and Governance Committee	Corporate	4	4	16	The former CCG team worked closely with the NHSEI team to understand current and future operating model, the work transferred, the staff required and the governance arrangements. This work enabled understanding of the detail of the transfer and shaped the transfer so that capacity could be ensured or better understand and plan for any gap. If a gap was identified, this would be escalated within the ICB for further discussion. Discussing were taking place around the possibility of the existing team remaining as presently - as a centrally managed team. This would limit the risk that the team fragments and any loss of economy of scale.	Pre-delegation assurance framework process September 2022. It is likely that the NHSEI East/West Midlands team will be retained but risks remain re potential contractual costs and capacity. Derbyshire is not required to take on delegated functions until 2023.	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 January - Delegation agreement between NHSE and ICBs, Collaboration Agreement between ICBs, and Operating Framework documents all currently in draft and awaiting final versions for signature. Meeting scheduled for early Feb between ICB and NHSE Senior Programme Director to better understand exactly what will come to the hosting ICB for management, and what the responsibilities of the remaining ICBs will be. Risk score increased slightly due to the complexity of services transferring and the lack of clarity as to the operational model February - The delegated functions to be transferred from 1 April 24 are 57 of the Specialised Commissioning services. For the first year, the operational team working in this area will continue to be hosted and managed by NHSE, with staff transferring from 1 April 2025. Current work is focussed on the formal documentation required prior to 1 April 2024, namely the Delegation Agreement, the Collaboration Agreement and the Standard Operating Framework, all of which are going through final drafts prior to being issued to ICBs at the end of February for sign off. Governance will be via a Joint Committee. As much of the detail as to how this will work operationally and it is not yet clear what the individual responsibilities of ICBs will be, the score is appropriate at a 9.	3	3	9	3	3	9	2	2	4	Apr-24	SR4 SR6 SR7 SR9	Feb-24	Mar-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.	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%). January: The formal collective consultation period ended on 7th January 2024. A significant amount of feedback has been received by ICB colleagues and this has been considered by Executive Team when making their final decisions, which will be presented to the Remuneration Committee on 26th January 2024. An all staff briefing has been arranged for 8th February 2024 with any individual 'heads up' meeting taking place beforehand. ICB colleagues receive regular updates via Team Talk and the weekly staff bulletin. HR team continue to promote wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider. Sickness absence levels increased in December to 3.4% (last year for December = 3.6%). February: All staff close of consultation briefing held on 8th February 2024, Following this structures and job descriptions published and individual letters confirming position sent . ICB to commence filling posts in the new structure with priority status for colleagues 'at risk' of redundancy. HR team to support individual 'at risk' to find suitable alternative employment within the ICB and wider NHS. HR team continue to promote wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider. Sickness absence levels reduced slightly in January to 3.3% (last year for January = 3.32%).	4	3	12	4	3	12	3	2	6	Mar-24	SR4 SR6 SR8	Feb-24	Mar-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 Partnerships Committee	Corporate	4	3	12	The system has an agreed Communications & Engagement Strategy which continues to be implemented. This includes actions supporting broadening our communications reach across stakeholders, understanding current and future desired relationships and ensuring we are reaching deeper into the ICB and components parts to understand priorities and opportunities for involvement. The Public Partnership Committee is now established and is identifying its role in assurance of softer community and stakeholder engagement. Communications and Engagement Team leaders are linked with the emerging system strategic approach, including the development of place alliances, seeking to understand the relationships and deliver an improved narrative of progress. April: Engagement approach in IC Strategy underway with sessions during May. JFP engagement and stakeholder management approach now in development. August: JFP engagement approach remains in development.	*- Continued and accelerated implementation of the Communications and Engagement Strategy actions plan priorities across stakeholder management, digital, media, internal communications and public involvement. *- Continued formation of the remit of the Public Partnership Committee *- Key role for C&E Team to play in ICB OD programme *- Continued links with IC Strategy development programme *- Continued links with Place Alliances to understand and communicate priorities	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 inesight 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. January: Continuing to seek to align engagement approach with 24/25 planning. Update paper to January PPC meeting. Also requirement to refresh JFP as set out in statute; will require review of associated engagement activity. February: Continuing to seek alignment to 24/25 and priority setting.	4	3	12	4	3	12	3	2	6	Jun-24	SR1 SR2 SR3 SR4 SR5 SR6	Feb-24	Mar-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 NHSEI.	Population Health & Strategic Commissioning Committee	Primary Care	4	3	12	Information cascaded to all practices detailing processes needing to be put in place before 1st November. Signposting to National webinars and hosting of local webinar. Local Information cascaded including contact details for support through NECS CSU. Work with Derbyshire LMC & FAQs circulated including a range of options for practices prior to 1st November including the application of a system code which if applied prior to the 1st of November can block patient access - to no records (practice ready for go live date) /to all records/ to patients were records still need to be reviewed. Linked with JUCD Communications team and patient facing information developed.	The GMS Contract has included Patient access to medical records since 2019, this has not been enforced, NHSEI communicated with systems during September 2022 to inform that this would go live on1st November 2022. Nationally, patients registered with practices using System One and EMIS IT Systems will have full access to their prospective medical records from the 1st of November 2022 (Access to retrospective records will be sought through existing processes). All records where there is a potential for patient harm to occur as a result of viewing the record need to be reviewed before the 1st of November 2022, all records where there is an existing safeguarding concern need to be reviewed There remain a number of uncertainties re; what will be viewable and when including Secondary Care Communications/ Local Authority Communications A survey has been circulated asking for practices to inform which option they have adopted in order to target support to those practices who require support. To continue to communicate updates to general practice. Working with communications – circulate information to support patients and practices.	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/January: 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 Feb 2024 - No further practice feedback has been received and therefore recommend closure of this risk in February 2024.	2	3	6	2	3	6	2	2	4	Feb-24	SR1 SR8 SR9	Feb-24	Mar-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 UHDB as learnings can be used by the wider hospital 13. Jan 24 work launched to deliver a care transfer Hub in Derbyshire, this work will start from Feb 24 to define the vision and approach as well as identify staffing and outcomes 14 Project of work to deliver a true 'trusted assessor' way of working. Requires changes to training and ways of working with agreed framework from health and social care 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. Ambulance Trusts - are 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.	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. Jan : P1 transformation in county commenced, this will deliver more capacity and strength based reviews for pathway 1. Daily flow meetings in place with CHS /CRT/county LA to look at demand and capacity. PDSA review held at UHDB to review discharge process and capture learning and improvement. More sessions planned in January. Workshop on Care transfer hubs held Jan 24 with system stakeholders to describe the shift in delivery and scope out next steps. Workshop on 'trusted assessor' held Jan 16 to outline process to move to truely trusted model of delivery. Recruitment to CRT (DCHS led team delivering P1 capacity) successful and onboarding of new staff starting from Jan to deliver more P1 capacity and enable flow. Oct 23 ASCDF funded additional patient transport vehicles to support with discharge and patient flow. February: Following a recent discussion at the Strategic Discharge Group in relation to the Corporate Risk Register and this risk, a small Working Group has been established to develop the wording, mitigations, risks score, etc. to reflect the current issues/risks. Work is currently being carried out to finalise the wording for this risk and at the next Strategic Discharge Group planned for 8th March, the revised wording will be discussed.	5	4	20	5	4	20	2	5	10	February 2024	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Feb-24	Mar-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.	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. 16/1/24 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. 12/02/24 - The Home Office/ and Serco has now closed two of the 7 hotels - one in the city and one in the county and they are looking to close the other hotels but no timeframe at this stage. This is a positive move of change. The risk remains for the residents in relation to the other hotels and the residents living in a hotel setting for a lengthy period of time and impact on services still remains an issue. Therefore, no change to the risk score.	4	4	16	4	4	16	3	3	9	Feb 24	SR6 SR8 SR9	Feb-24	Mar-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, Digital and Performance 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. January/February 2024: process set up to identify and intervene with GP practices at risk of handing in contracts. Group established co-ordinated by GP Provider Board and supported by the ICB Primary Care / Quality Team	3	4	12	3	4	12	2	3	6	Ongoing	SR1 SR2 SR3 SR4 SR5 SR6 SR8 SR9	Feb-24	Mar-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.	Feb: 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. We have now received some requests for information from the national team as several organisations who provide services to the System have appealed for this funding.	4	4	16	4	4	16				Ongoing	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Feb-24	Mar-24	Keith Griffiths, Chief Financial Officer	Keith Griffiths / Darran Green

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk 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			Residual/ Current Risk			Target Risk			Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
					Probability	Impact	Rating				Probability	Impact	Rating	Probability	Impact	Rating	Probability	Impact	Rating						
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	December - Turnaround lead in place at UHDB to deliver recovery programme (managed through ICB chaired Elective and Cancer Recovery Group) January - Turnaround lead in place at UHDB to deliver recovery programme (managed through ICB chaired Elective and Cancer Recovery Group). Work ongoing supported through JUCD Elective and Cancer Recovery weekly calls. No change expected in referrals from Staffordshire. Current focus is how we develop existing services to meet sustained demand on UHDB capacity and work to develop primary care pathways across DDICB and SSICB. February: The risk is currently being reviewed and the risk description will be revised for March reporting. There is a challenge in re-wording the risk description to ensure all aspects are captured that impact the risk and also the specific challenges and cancer recovery plan.	4	4	16	4	4	16	2	4	8	September 2024	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Feb-24	Mar-24	Prof Dean Howells Chief Nursing Officer	Monica McAlindon Head of Cancer
24 (Former Confidential 08C)	23/24	There is a risk that the ICB is non-compliant with the requirement to commission and have in place a Designated Doctor for looked after children as this is a statutory role.	System Quality Group	Clinical	4	3	12	The Designated Doctor for looked after children for Derby City is a statutory role. DDICB are responsible in ensuring that this role is in place. DDICB fund the post via Derbyshire Healthcare Foundation Trust who we commission to provide the Looked after children service for Derby City. The role equates to 1 pa session a week (4 hours a week) If we are inspected in regard to our looked after children's functions, we would need to declare we have this gap- both OFSTED and CQC inspectors expect that these statutory roles are in place and fulfilling their roles and responsibilities. DHCFT are in the process of going out to advert for a number of community paediatricians. One of these roles will have the role of the Designated Doctor for looked after children – Derby City aligned to the role - 1 PA session a week. The DHCFT Clinical Director and Consultant Community Paediatrician on a short-term basis is addressing any issues that arise with the support of the Designated Nurse for looked after children.	If the ICB or the local authority is inspected around its safeguarding /looked after children provision we would be required to inform the regulators that there is a gap and what are mitigations are to cover this vacancy and its functions until its appointed to. •DHCFT are in the process of preparing for the job advert to go out for Community paediatricians – one of which will include the function of the Designated Dr for looked after children – 1 pa session a week. •DHCFT Clinical Director and Consultant Community Paediatrician to keep the ICB updated on recruitment process via the Designated Nurse for Looked after children. •DHCFT looked after children Named Nurse / Manager to also keep the Designated nurse for looked after children updated with any issues that arise that the ICB need to be made aware of.	•Due to the vacancy in this statutory function – this has been added onto the DDICB risk register. •DHCFT who we commission and hold the funds for this post are in the process of preparing for the job advert to go out for Community paediatricians – one of which will include the function of the Designated Dr for looked after children – 1 pa session a week. •DHCFT Clinical Director and Consultant Community Paediatrician to keep the ICB updated on recruitment process via the Designated Nurse for Looked after children. •DHCFT looked after children Named Nurse / Manager to also keep the Designated nurse for looked after children updated with any issues that arise that the ICB need to be made aware of. 16/01/24 update - post remains vacant. interviews took place in early January 24 but applicant not successful, therefore post will need to be readvertised. Post is being covered as an interim by the Clinical director/ Consultant Paediatrician 12/02/24 The post remains vacant - the interviews that took place recently did not lead to a successful appointment- therefore the post has needed to be readvertised. the post is being covered as an interim period by the Clinical Director / Consultant Paediatrician	3	3	9	3	3	9	2	3	6	March 2024	SR1	Feb-24	Mar-24	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children
25 (Former Confidential 09C)	23/24	There is a risk of significant waiting times for moderate to severe stroke patients for community rehabilitation. This means, patients may have discharges from acute delayed, be seen by non-stroke specialist therapists and require more robust social care intervention.	System Quality Group	Clinical	4	5	20	•Risk matrix in community services is used to triage referrals- this addresses risk and clinical need and is used to prioritise waiting lists •Regular waiting list reviews are conducted in community to ensure patient needs/risk continue to be managed. This is done every 12 weeks to ensure patients are in the right place from a triage decision perspective. •When referral is accepted the service, patients receive condition specific resources which includes signposting to services and wider resource packs. Guidance is given on when to contact services, which is based on the risk matrix. •Staffing resource is redeployed/flexed across the county to manage staffing shortfalls. •Advice clinic has been established to allow non-specialists to bring Stroke and Neuro cases for advice from stroke specialists. •Provider Collaboration Leadership Board (Nov 23) and NHSE (Jan 24) have agreed to provide oversight and assurance to the project.	•Undertake a review of current service provision to better understand the patient level impact of the current service •Explore opportunities alongside the Stroke and Neuro Rehabilitation task and finish group partners for rapid service improvement measures •Develop business case for enhanced funding to move the service in line with regions best practice. August: The Integrated Stroke Delivery Network have identified recommendations for improvement that relate to commissioning, access, service gaps, low staffing levels, psychology provision and life after stroke.	•A plan for a rehabilitation review has been developed •Key system partners have been engaged at Chesterfield Royal hospital, Royal Derbyshire Hospital, Derbyshire Community Health Service, Derbyshire Mental health Foundation Trust and the Stroke Association. •Work is ongoing to extract service level data from the system to describe the current system challenges •Patient experience leads have developed and implemented a plan to engage patients and carers across Derbyshire to understand their experiences of the stroke rehabilitation pathway •Staff engagement sessions are planned to explore opportunities for service development, integrated working and service efficiency. •A paper outlining current service provision will be presented to the Stroke Delivery Board on the 15th may with recommendations to develop a business case for enhanced Clinical Psychology input and to review VCSE provision alongside the core rehabilitation review. •Commenced the data extraction and patient engagement activity. The priority is to understand in greater detail the impact of current service provision on patients. •Escalated issue to the Stroke Delivery Board Nov- PCLB have agreed to provide oversight and assurance of the project. The task and finish group are working on the Case for Change document to support the engagement process. Dec- Revised project plan agreed by providers. Case for change development is ongoing. Jan: Revised project plan agreed by providers. Case for change development is ongoing expected to be completed by mid Feb. Complex pathway improvement project. NHSE Regional team proving assurance. Pathway development and implementation will not be complete until March 25. Feb- No update. Case for Change is ongoing and will be completed this month. NHSE requested to review the document.	4	4	16	4	4	16	2	4	8	July 2024	SR1 SR2 SR4 SR7 SR9	Feb-24	Mar-24	Dr Chris Wainer Chief Medical Officer	Scott Webster Head of Strategic Clinical Conditions and Pathways
26 (Former Confidential 11C)	23/24	There is a risk that the Local Maternity & Neonatal System (LMNS) is unable to undertake perinatal quality surveillance satisfactorily and complete the necessary assurance and oversight of maternity and neonatal services without additional investment and recruitment to increase appropriately trained staff and therefore the resilience of the LMNS PMO team.	System Quality Group	Clinical	4	4	16	•LNMS/Maternity PMO team is in place and is covering the workload however this is a very small team (Head of Transformation x1, Midwife Safety Lead x1, LMNS administrator x1) and capacity needs to be increased to ensure there is cover in the event of staff absence and to improve resilience as the role evolves. •Additional staff required to meet the changing role of the team have been identified however there is no agreement currently to fund and recruit to additional posts. •Funding is in place to recruit to a fixed term Neonatal Project Manager; however, despite interviews taking place, there have been no suitable candidates for recruitment.	•Recruited to the LMNS Programme Administrator which is a part time role. Took up post in June 2023. •Recruitment of a part time Project Manager is in place. This post will be a fixed term post to cover the vacancy of the substantive post holder is on secondment under August 2024. •Leadership support provided by ICB Deputy Chief Nurse and ICB Assistant Director of Nursing and Quality. •In the interim, support provided from Acute Quality Team to assist with aspects of work.	August/September 2023: Status remains the same at present. Funding is in place to recruit to a fixed term Project Manager; however, despite interviews taking place, there have been no suitable candidates for recruitment. The advertisement for the post is currently posted on TRAC and other recruitment sites. Updates on this risk continues to be monitored via the Derbyshire Local Maternity System Board. October update: Following interviews on 20 October 2023, a successful candidate received and accepted an offer for the fixed post (subject to the recruitment process). November/December update: The new member of staff is due to commence in post in January 2024. January: The LMNS Project manager is now in post and the LMNS Board agreed to close the risk at the meeting held on 23.01.24. Propose closure of the risk from the ICB Confidential Corporate Risk Register. February: Closure of this risk approved at System Quality Group meeting held on 6th February.	3	4	12	3	4	12	1	2	2	March 2024	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Feb-24	Mar-24	Prof Dean Howells Chief Nursing Officer	Letitia Harris Assistant Director of Quality Anne Pridgeon Head of Maternity Transformation

Appendix 2 - ICB Risk Register - Movement - February 2024

Risk Reference	Risk Description	Previous Rating (January)			Residual/ Current Risk Rating (February)			Movement - February	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	⟷	Conversations are ongoing between UEC Team and UTC Providers to ensure that business continuity processes are in place to support the system during times of pressure.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager	
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	⟷	There is no change to the risk score due to the pressures in general practice, uncertainty around the GP contract and financial pressures as a result of increases in staff costs that are not covered through the national contract uplifts.	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	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	⟷	Finalisation of ICB Restructure to confirm ICB EPRR Team in place, work continues to be delivered as above albeit hampered by Industrial Action Response.	Helen Dillistone - Chief of Staff	Chris Leach, Head of EPRR	

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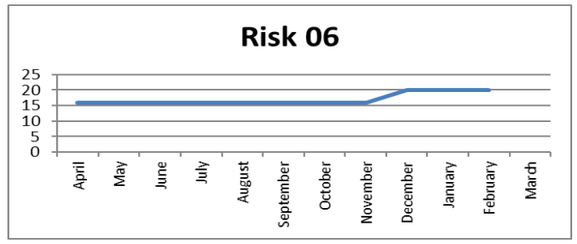
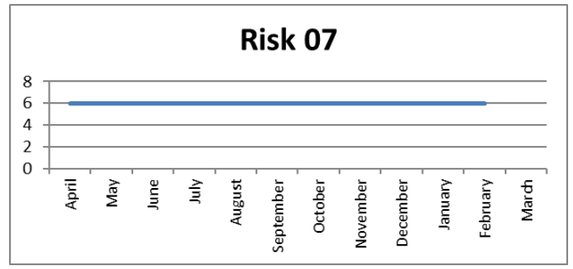
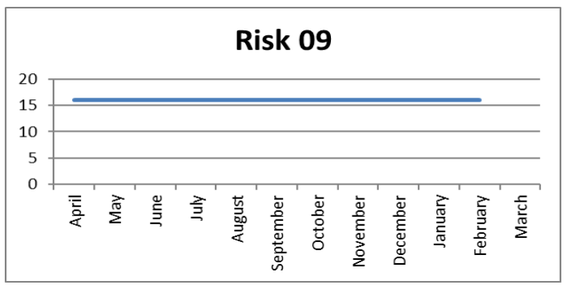
		Probability	Impact	Rating	Probability	Impact	Rating					
06	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.	5	4	20	5	4	20	⟷	Recurrent baselines continue to be worked upon and there is a need to understand how additional recurrent costs above 2022/23 planned levels have increase over the financial year. Early indications are that the recurrent position heading into 2024/25 will have deteriorated further due to the level of non-recurrent benefits supporting the 2023/24 position.	Keith Griffiths, Chief Financial Officer	Darran Green, Acting Operational Director of Finance	
07	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to the former Derby and Derbyshire CCG this data is not held consistently across the sites.	2	3	6	2	3	6	⟷	Review of files to transfer to Scarsdale and leavers for storage continuing. Additional administrative resource identified and planned completion by 31 March 2024.	Helen Dillistone Chief of Staff	James Lunn, Head of People and Organisational Development	
09	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	4	4	16	4	4	16	⟷	At March Quality and Performance Committee, there will be further discussions around the risk, description and challenge regarding the risk score.	Prof Dean Howells Chief Nursing Officer	Letitia Harris Clinical Risk Manager	

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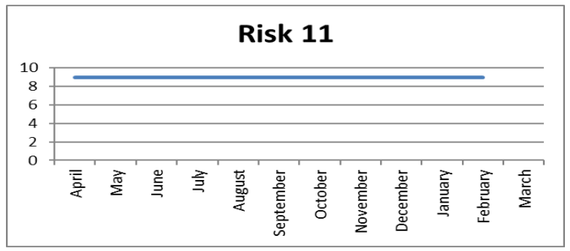
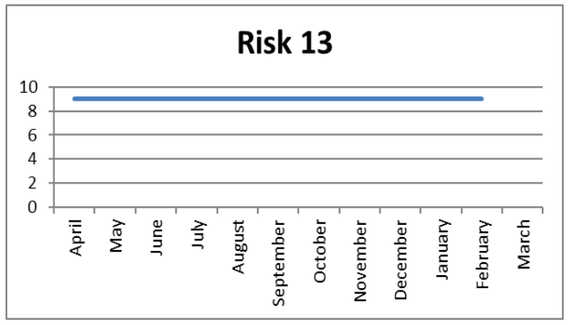
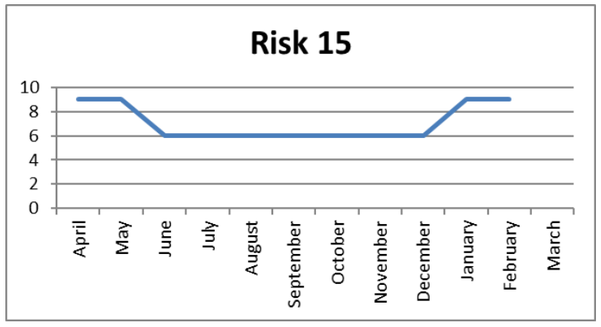
		Probability	Impact	Rating	Probability	Impact	Rating					
11	If the ICB does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	3	3	9	3	3	9	⟷	As part of the NHSE Greener NHS Maturity self assessment, the ICB has been assessed as a Tier 3, maturing organisation. The ICS is still required to deliver a further 50% achievement of 2023/24 priorities. Delivery of this will continue into 2024/25 and beyond. Therefore, we consider the risk score of a high 9 to be appropriate and realistic.	Helen Dillistone Chief of Staff	Suzanne Pickering Head of Governance	
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	⟷	Temporary appointments within the engagement team remain, awaiting understanding of final destination of existing, substantive post holders. Temporary mitigations in place until 31 March.	Helen Dillistone Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement	
15	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	3	3	9	3	3	9	⟷	Risk score increased slightly from 6 in January due to the complexity of services transferring and the lack of clarity as to the operational model. As much of the detail as to how this will work operationally and it is not yet clear what the individual responsibilities of ICBs will be, the score is appropriate at a 9.	Helen Dillistone Chief of Staff	Chrissy Tucker - Director of Corporate Delivery	

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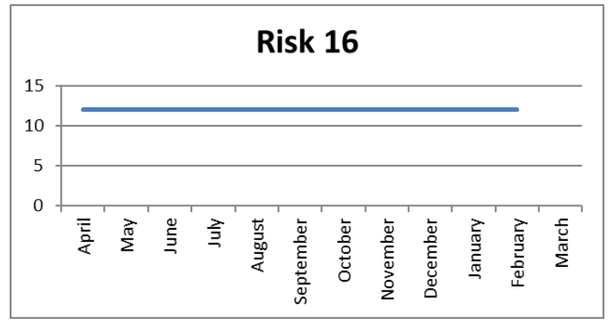
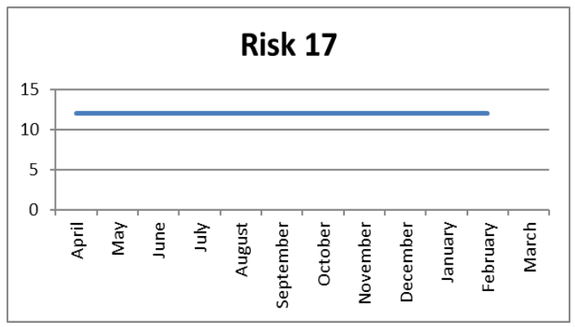
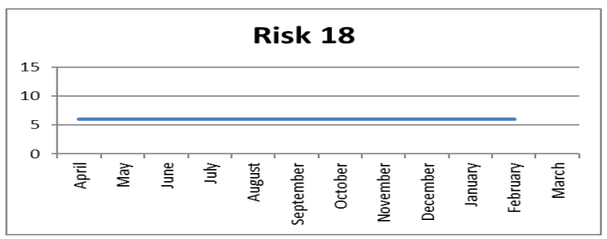
		Probability	Impact	Rating	Probability	Impact	Rating					
16	Risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.	4	3	**12**	4	3	**12**	⟺	ICB to commence filling posts in the new structure with priority status for colleagues 'at risk' of redundancy. HR team to support individual 'at risk' to find suitable alternative employment within the ICB and wider NHS.	Helen Dillistone Chief of Staff	James Lunn, Head of People and Organisational Development	
17	Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.	4	3	**12**	4	3	**12**	⟺	Continuing to seek alignment to 24/25 and priority setting.	Helen Dillistone Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement	
18	There is a risk of patient harm through existing safeguarding concerns due to patients being able to pro-actively view their medical record from 1st November 2022. This is a result of national changes to the GMS contract required by NHSE/I.	2	3	**6**	2	3	**6**	**PROPOSED CLOSURE OF RISK**	No further practice feedback has been received and therefore **recommend closure of this risk.**	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	

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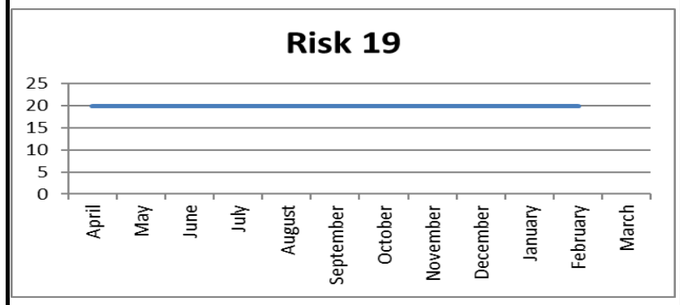
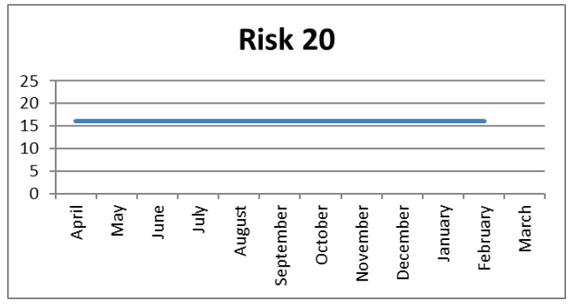
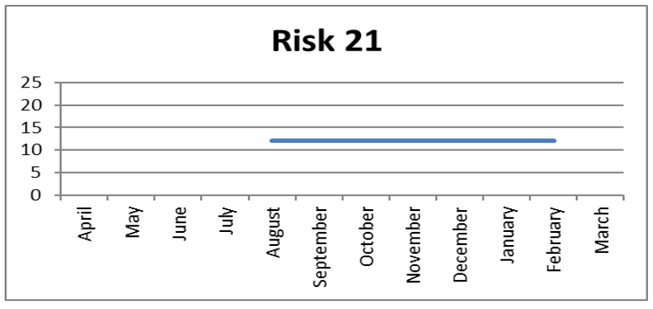
19	Failure to deliver a timely response to patients due to excessive handover delays and transfer of patients to the appropriate care setting from Acute Hospitals. Risk of leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential significant levels of harm.	5	4	**20**	5	4	**20**	⟷	Following a recent discussion at the Strategic Discharge Group in relation to the Corporate Risk Register and this risk, a small Working Group has been established to develop the wording, mitigations, risks score, etc to reflect the current issues/risks.	Dr Chris Weiner Chief Medical Officer	Jo Warburton Dan Webster	
20	Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.	4	4	**16**	4	4	**16**	⟷	The Home Office/ and Serco have now closed two of the seven hotels. The risk remains for the residents in relation to the other hotels and the residents living in a hotel setting for a lengthy period of time and impact on services still remains an issue. Therefore, no change to the risk score.	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children	
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**	⟷	Process set up to identify and intervene with GP practices at risk of handing in contracts. Group established co-ordinated by GP Provider Board and supported by the ICB Primary Care / Quality Team.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Lana Davidson Senior Contract Manager	

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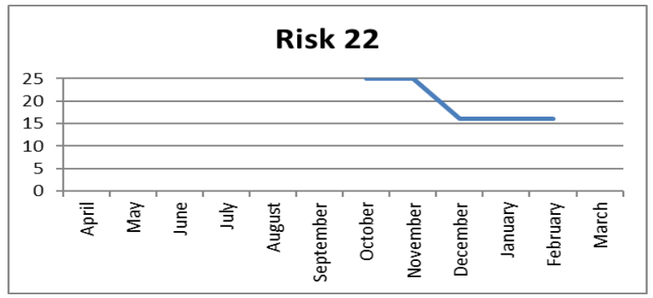
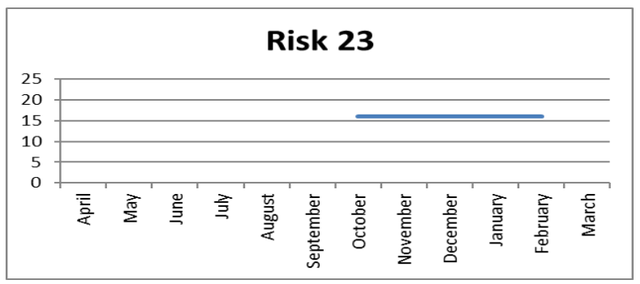
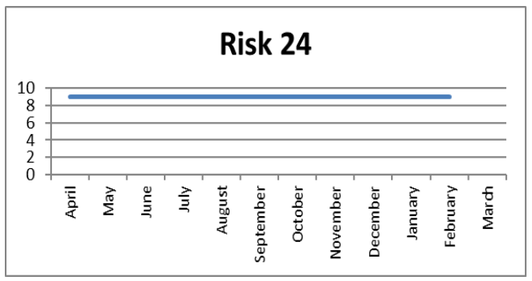
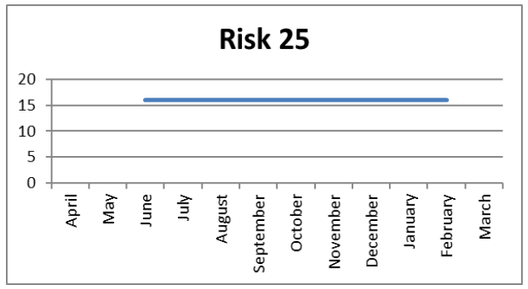
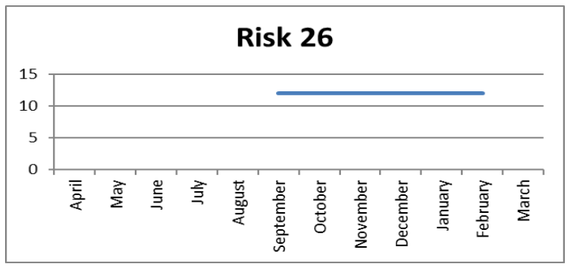
22	National funding for the 23/24 pay award and 22/23 one off payments excluded all staff who were not on NHS payrolls. Consequently staff employed by DHU, NHS subsidiary bodies, in PFI arrangements and Primary care were not eligible. Consequently there is a an increasing risk of legal challenge as well as real, emerging loss of morale for over 4500 staff across the Derbyshire system which could affect recruitment and retention of critical frontline colleagues.	4	4	**16**	4	4	**16**	⟷	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.	Keith Griffiths, Chief Financial Officer	Keith Griffiths / Darran Green	
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**	⟷	There is work underway to re-word the risk description and this will be available for March reporting. There is a challenge in re-wording the risk description to ensure all aspects are captured that impact the risk and also the specific challenges and cancer recovery plan.	Prof Dean Howells Chief Nursing Officer	Monica McAllindon Head of Cancer	
24 *(Former Confidential 08C)*	There is a risk that the ICB is non-compliant with the requirement to commission and have in place a Designated Doctor for looked after children as this is a statutory role.	3	3	**9**	3	3	**9**	⟷	The post remains vacant. The interviews that took place recently did not lead to a successful appointment, therefore the post has needed to be readvertised.	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children	

Risk Reference	Risk Description	Previous Rating (January)			Residual/ Current Risk Rating (February)			Movement - February	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
25 *(Former Confidential 09C)*	There is a risk of significant waiting times for moderate to severe stroke patients for community rehabilitation. This means, patients may have discharges from acute delayed, be seen by non-stroke specialist therapists and require more robust social care intervention.	4	4	**16**	4	4	**16**	⟷	Case for Change development is ongoing and will be completed this month. NHSE have requested to review the document.	Dr Chris Weiner Chief Medical Officer	Scott Webster Head of Strategic Clinical Conditions and Pathways	
26 *(Former Confidential 11C)*	There is a risk that the Local Maternity & Neonatal System (LMNS) is unable to undertake perinatal quality surveillance satisfactorily and complete the necessary assurance and oversight of maternity and neonatal services without additional investment and recruitment to increase appropriately trained staff and therefore the resilience of the LMNS PMO team.	3	4	**12**	3	4	**12**	**PROPOSED CLOSURE OF RISK**	The LMNS Project manager is now in post and the LMNS Board agreed to close the risk at the meeting held on 23.01.24. It is proposed to **close this risk from the ICB Corporate Risk Register.**	Prof Dean Howells Chief Nursing Officer	Letitia Harris Assistant Director of Quality Anne Pridgeon Head of Maternity Transformation	

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: 150

Report Title	Domestic Abuse Pledge							
Author	Michelina Racioppi, Assistant Director for Safeguarding Children/Lead Designated Nurse for Safeguarding Children							
Sponsor (Executive Director)	Chris Clayton, Chief Executive Officer							
Presenter	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☒	Discussion	☒	Assurance	☐	Information	☐
Appendices	Appendix 1 – Domestic Abuse Pledge							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	ICB Executive Team, 13th March 2024							

Recommendations
The ICB Board are recommended to **DISCUSS** and **APPROVE** the ICB's Domestic Abuse Pledge that will sit alongside the ICB's Domestic Abuse Policy and the new ICB Sexual Safety in Healthcare Organisations Charter.
Purpose
The Domestic Abuse Pledge provides key principles on what the ICB is committed to do for its staff, raise awareness in regard to the support services that are available from the ICB and from external agencies that staff can access if required.
Background
The ICB is highly committed to provide a workplace environment where its workforce feels safe, confident, and able to seek advice and support in relation to domestic abuse. In order for the ICB to demonstrate the commitment that we have in supporting the wellbeing of all their staff the domestic abuse pledge has been produced. The ICB Executive Team discussed the pledge at their meeting on the 13th March 2024, and recommend that the Board support and approve this.
Report Summary
The ICB acknowledges that domestic abuse is a serious issue within our society and affects many adult's and children's lives. The ICB have a clear responsibility for all its employees' health, safety and welfare at work and appropriate support needs to be available and offered to its staff. To demonstrate ICB commitment in supporting its staff the Domestic Abuse Pledge has been

produced. This pledge is intended to sit alongside the ICB's Domestic Abuse Policy and the new ICB Sexual Safety in Healthcare Organisations Charter, that is due to be launched.

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**	There is a risk that the system does not create and enable a health and care 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

[To be completed by Finance Team ONLY]

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

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

Not applicable.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable.

NHS
Derby and Derbyshire
Integrated Care Board

Domestic Abuse Pledge

If you are experiencing domestic abuse, our pledge to you is:

YOU WILL BE LISTENED TO

- You will be heard by whoever you choose to tell and be given space and time to talk.
- Your regular one-to-one meeting with your manager also provides a private opportunity to seek support about anything you are experiencing.
- You do not need to wait for a scheduled meeting and can ask your manager for a one-to-one at any point.

YOU WILL BE BELIEVED

- Whoever you choose to tell will respect and believe you, without judgement, and they will take immediate action to support you – putting your safety and welfare first.

YOU WILL HAVE CONTROL

• Your views will always be at the heart of any decision making.

WE WILL SUPPORT YOU

- You can self-refer to Occupational Health for psychological support without needing to go through your manager or telling anyone else or your manager can make a referral for you on your behalf.
- Consideration will be given on reasonable adjustments to your workplace as appropriate. You can access the staff confidential support services for counselling and advice Tel: 0800 028 0199 Health Assured EAP - Digital launch < ICB Intranet (ddicb-nhs.uk)
- If you need time away from work, you will be able to talk to your manager about taking special leave.

YOUR CONFIDENTIALITY WILL BE RESPECTED

- We understand that confidentiality is crucial, and we will work with you to maintain your confidentiality, whilst respecting your wishes. But this must be balanced against the risk to you, your children, and your family.
- If a crime has been disclosed to a member of staff, there is a legal responsibility for this to be shared with the police.
- Information will only be shared on a strict need to know basis.
- Where we have a duty to safeguard a child or an adult and let other agencies know, you will be made aware as appropriate.

WE WILL HELP TO KEEP YOU SAFE

- We recognise that everyone's experience and needs are different, as an employer, we want to help you to feel safe at work and at home. This means we can consider any request you feel may help you to achieve that.

Support services:

If you are experiencing domestic abuse, below is a list of organisations who can assist you:

Derbyshire Domestic Abuse Helpline

Provides a range of support services for men, women or children affected by domestic abuse.

Call 0800 0198 668 (any time). If you're deaf or hard of hearing, use our textphone service 07534 617252.

Derbyshire County Council domestic abuse support
Help for children, young people and families who are affected by domestic abuse or violence, including refuge accommodation.

Crossroads Derbyshire
Local help and advice for women, men, children and young people.

Refuge and National Domestic Abuse Helpline
Refuge is a large domestic abuse organisation for women and children, which runs a 24-hour national helpline.

Women's Aid Domestic Violence Helpline
A national charity working to end domestic abuse against women and children.

Men's Advice Line
Confidential helpline for male victims of domestic abuse.

ManKind Initiative
Confidential helpline for male victims of domestic abuse and domestic violence

SafeLives.org.uk
A UK-wide charity that provides domestic abuse support and guidance for victims, as well as friends and families.

https://galop.org.uk/get-help/helplines/ 0800 999 5428

National Helpline for LGBT+ Victims and survivors of abuse and violence

https://www.sv2.org.uk Tel:01773746115

Support for victims of sexual violence

Policy:

- **For additional information Please refer to the Derby and Derbyshire Integrated Board Domestic Abuse Policy** DDICB Domestic Abuse Policy < ICB Intranet (ddicb-nhs.uk)
- **Derby and Derbyshire Safeguarding children Procedures.** Welcome to the Online Procedures for the Derby and Derbyshire Safeguarding Children Partnership (proceduresonline.com)
- **Derby and Derbyshire Safeguarding Adult Procedures** derby-and-derbyshire-safeguarding-adults-policy-and-procedures.pdf (derbysab.org.uk)

Safeguarding Children and Safeguarding Adults Professionals for NHS Derby and Derbyshire Integrated Care Board:

Michelina Racioppi – Assistant Director, Safeguarding Children: Mobile: 07786 113203

Juanita Murray – Designated Nurse, Safeguarding Children Mobile: 07920 765394

Bill Nicol – Assistant Director, Safeguarding Adults Mobile: 07900 545354

Michelle Grant – Designated Nurse, Safeguarding Adults: Mobile: 07909 097615

Aaron Brown Safeguarding Adults Manager: Mobile:07979511384

Special thanks to Avon and Somerset Constabulary – Reference Domestic abuse pledge -Guidance for victims, colleagues, and survivors.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: 151

Report Title	Delegated Specialised Commissioning Services from NHS England							
Author	Chrissy Tucker, Director of Corporate Delivery							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Dr Chris Clayton, Chief Executive Officer							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 – Delegation Agreement Appendix 2 – Memorandum of Understanding and Collaboration Agreement Appendix 3 – Commissioning Standard Operating Framework Appendix 4 – Service Portfolio Report - Derbyshire							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Audit & Governance Committee, 14th March 2024							

Recommendations
The ICB Board are recommended to **NOTE** the contents of this report and to **AGREE** the sign-off of the attached documentation, with the following to be noted: • NHSE to provide more detail as to how they will work with ICBs and manage these services in partnership; • a full pre-delegation pack has not yet been shared and therefore ICBs need clarity from NHSE ahead of transition in relation to any risks that may be present or might emerge in the 59 services to be transferred, along with a process for resolution of such risks; and • greater clarity is required from NHSE on the role and expectations of the lead ICB. The ICB will work with NHSE to resolve the above during the spring.
Purpose
This paper requests the authorisation to progress to the formal Delegation of the 59 specialised services approved by the NHS England board on the 6 December 2023.

Background

1. Introduction

1.1 Since April 2023, the Midlands ICBs and NHS England have operated under statutory joint working arrangements to commission specified specialised services. This has included 59 Acute Specialised Services identified in the Specialised Commissioning Roadmap (May 2022) as suitable and ready for delegation.

1.2 Following an agreed due diligence process, it is recommended that the 11 Midlands ICBs support formal delegation of the 59 services in April 2024. This is in line with the ICB readiness submission to NHS England though the pre-delegation assessment framework and the subsequent NHS England Board approval in December 2023.

1.3 National policy requires ICBs to work in formal collaboration regarding Specialised Services. This responsibility, it is proposed, will be enacted through the East and West Midlands Joint Committees. However. the decision to move from joint working to formal delegation is a decision for each statutory ICB Board. Given the NHS England Board decision and policy direction, all Boards who do support the recommendation will be enabled to progress.

1.4 All ICBs are expected to receive the delegation of all agreed Specialised Services (Acute, Mental Health and Learning Disabilities, and Vaccinations) by no later than April 2025. The proposed phasing of delegation, with 59 services proceeding in April 2024, provides the Midlands ICBs with the opportunity to build experience in commissioning these services with a developmental safety net of a transitional year. NHS England will provide significant support to ICBs from 2024 to 2025 as they take on these delegated functions.

1.5 The delegation of the 59 Acute specialised services is to individual ICBs, however, the formal Delegation Agreement requires ICBs to collaborate in a multi-ICB partnership. The Delegation Agreement must therefore be supported by a Collaboration Agreement and Commissioning Standard Operating Framework, which includes NHSE as a partner in their continued role in commissioning retained services. The approach supports the requirement to consider the cross-system population needs that support safe and sustainable care in specialised provision.

1.6 The Midlands have developed a joint Memorandum of Understanding as a part of the suite of delegation documents, setting out our collaborative commitment to working together to maximise the benefits of delegations for patients, populations and across complex pathways.

2. Responsibilities and Accountabilities

2.1 The delegation of specialised commissioning does not change the accountability for these services as this remains with NHS England.

2.2 Upon delegation the services become the responsibility of the 11 Midlands ICBs. As noted, the ICBs are required to commit to working together to commission these services. NHS England remains a partner in this process and is responsible for the commissioning of retained specialised services.

3. Benefits of delegation

3.1 The primary purpose of delegation is to benefit the care provided to patients across their care pathways, improve access and reduce inequalities for whole populations. There is a

significant opportunity to ensure that the disconnect between the commissioning of specialised services through NHS England and the local commissioning bodies is removed.

3.2 The clinical leaders across ICBs and NHSE have identified the delegation benefits as follows:

Equity of access for all patients: There is good evidence that this varies across geographies with those further from specialised provision less likely to have access. Delegation provides the opportunity to understand access and consider outcomes and value across pathways.

Whole pathway approach: Joining up the whole pathway is likely to encourage focus on upstream prevention improving overall patient outcomes and reducing pressure on specialised services.
In addition, this ensures any proposed changes in specialised services are planned with interdependent local services; this could include diagnostic services, services that have a key pathway linkage or support services in health care or local authority provision.

Facilitation of whole pathway transformation across ICS footprints as new services are introduced: It will allow implementation of clinical advances as close to home as possible for patients whilst maintaining speciality capacity for when needed most.

3.3 An example of the benefits of delegation is set out below:

Renal Services

The need for **renal dialysis** can be reduced by ICBs focusing on identifying those at risk for developing kidney disease and its progression. New treatments are now available to delay progression which if systematically implemented should reduce population dialysis and transplantation needs.

Currently planning and delivery are separate between primary and tertiary care and more local solutions could be developed. More integrated commissioning of specialised renal services would make innovations easier by:

- The same people and organisation being responsible for commissioning both the specialised (e.g. dialysis) and non- specialised (GP led) parts of the patient pathway ensuring complete clinical join up of pathway.
- Budgets could be pooled which creates more of an incentive to prevent renal progression, promotion of home therapies to reduce transportation costs and prompt referral for renal transplantation.
- Wider service provision could be included more easily e.g. psychological support and welfare support.
- Services can be tailored around the needs of local populations helping to address health inequalities.
- Those who do need specialist services will still be able to access them in line with national standards and policies.

4. Summary of the due diligence process

4.1 The 11 ICBs and NHS England have been working together throughout 2023/24 through formal joint working arrangements. This has enabled ICB specialised services leads to

understand and work alongside NHSE teams, making informed decisions on finance, quality and commissioning and contracting.

4.2 The approach to the transition process for delegation has been led through joint working groups covering finance, governance, clinical quality, strategic commissioning, and planning. This approach was informed by the design principles and operating model set by ICB CEOs.

4.3 The comprehensive national safe delegation checklist, which all regions utilise to provide joint ICB and NHS England assurance on deliverables for safe delegation, has guided the approach to due diligence. In addition, learning from the POD delegation, an additional process was agreed and led in the Midlands including ICB and NHSE leads. The summary due diligence reports have focussed on four key domains and have been received by the East Midlands and West Midlands Joint Committees. The due diligence domains are set out below:

- **Quality** – understanding of the quality issues as the receiving organisations and the agreed framework for how ICBs will operate in 24/25
- **Finance** – Clarity on the absolute risks and issues required for transition. Agreed position on the ICB allocations and methodology and risk share to mitigate the risks for ICBs.
- **Resources** – staff capacity and capability over the transition year (in advance of transfer to ICB hosting in 2024/25) and the ability to meet requirements for delegation as ICBs take on the commissioning role.
- **Benefits and opportunities** – Clarity on the benefits of proceeding with delegation in 24 /25. This assessment must also consider the missed opportunity that may accrue through delay to delegation.

There has been a level assurance met against each of these domains.

4.4 The joint working groups have co-produced several key documents that support the delegation of these services, these include:

(a) **Delegation Agreement:** Nationally mandated document setting out the formal legal requirements of delegation.

(b) **Memorandum of Understanding (MoU) and Collaboration Agreement 2024/25:** The MoU sets out the key principles and commitments to supporting the collaborative working model for the 11 ICBs in the Midlands and NHS England Midlands. The MOU should be read in conjunction with the formal Collaboration Agreement which is a mandated requirement of the delegation process. The Collaboration Agreement, which is between the 11 ICBs and NHS England sets on how ICBs will make joint decisions through delegation of responsibility to the existing Joint Committees in the East and West Midlands, how they will commission the services and the financial framework in which they operate including the operation of a pooled fund between the 11 ICBs to manage financial risks across the Midlands. The agreement also sets out how NHS England will work with the ICBs on services that have been identified as suitable for future delegation but are not yet being delegated. The initial agreement is for one year in which it will be reviewed prior to further service delegation.

(c) **Commissioning Team Agreement and Operating Framework:** This document described the multidisciplinary team (finance, clinical and quality, commissioning, and support teams) who will work on behalf of the 11 ICBs and NHS England. These staff will continue to be employed by NHS England for 24/25. The document describes who the teams are, what they do and how they work.

(d) **Service Portfolio Reports:** These documents have been developed regionally to ensure an appropriate baseline position related to specialised service lines including:

- A clear understanding of the services provided within each individual ICB.
- Organisational memory on quality issues captured, written down and communicated formally to receiving bodies.
- Identification of the top issues/risks along with mitigating actions - captured for handover.

The Service portfolio reports will continue to be developed and subsequently form the detailed functional document to enable commissioning for ICB populations and across multi-ICBs.

5 Future arrangements

5.1 **Decision Making** – On agreement of individual ICBs to accept the delegation of the 59 Specialised Acute service lines, Boards are asked to support the delegation authority for decisions related to these specialised services through to the Joint Committees, established through the Joint Working Agreement in operation in the East and West Midlands. Terms of Reference have been amended from the Joint Working Agreement arrangements to reflect this change. The committees have authority to establish appropriate subsidiary arrangements to support the efficient operation of those services, which will include establishing appropriate delegations to enable day-to-day decision making through sub-groups, details of these subsidiary arrangements are summarised in the Collaboration Agreement and will be formally ratified by the Joint Committees at their first meeting after 1 April 2024.

5.2 **Finance Subgroup** – A Joint Finance and Contracting Subgroup reporting to the Committees that will oversee the financial framework.

- The ICBs will establish and maintain a mutually agreed pooled fund arrangement for in-year financial management, with a defined contribution based on the allocation received for the 59 delegated specialised services which will be transferred to the Host ICB, (Birmingham & Solihull ICB) on behalf of the Midlands. Some detail of the management of this is articulated in detail in the Collaboration Agreement, but the finer details are still being discussed. This arrangement is for 2024/25 only and it is not anticipated that this will create a financial risk due to the level of uncommitted contingency being held. A separate arrangement for 2025/26 and beyond will be developed in 2024/25.
- NHS England will commit to continue to regularly review the overall financial position and risks with ICBs and ensure the retained services and 59 acute delegated services are reviewed together.

5.3 **Quality Subgroup** – Quality will be overseen by the Specialised Commissioning Quality Group. The group will provide a forum for routinely and systematically bringing together partners from across ICSs and the region to share insight and intelligence in relation to quality concerns, to identify opportunities for improvement and to develop regional responses as required. The focus of the discussions will be on intelligence, learning, issues, and risks that are recurrent and/ or have an impact wider than individual ICSs.

5.4 **Midlands Specialised Services Commissioning Subgroup** – A multi-disciplinary group that oversees the design, development, planning, transformation, improvement, and reduction of inequalities for the effective delivery of services.

5.5 During 2024/25 the ICBs and NHS England will continue to develop and share expertise through a clearly defined joint workplan to including quality, finance commissioning and planning.

5.6 In line the agreed governance framework ICBs should add the following to their SFIs 'Delegated Specialised Commissioning - Decisions will be made in line with the Arrangements agreed by the East/West Midlands Joint Commissioning Committee which has Delegated Authority to set approval limits in line with those arrangements.'

Report Summary

Recommendation

In summary ICBs have been jointly working with NHS England throughout 23/24 to commission acute specialised services and gain an understanding of the risks and issues.

It is proposed that Midlands ICBs work together and receive an initial delegation of 59 Acute Specialised in 2024/25. This will enable ICBs to have the benefit of learning and developing their approach in a phased manner before the full delegation of further specialised services (including Mental Health and Learning Disabilities) and immunisation and vaccination services in 2025/26.

The ICB is asked to approve the following:

- The delegation of the defined set of 59 specialised acute services to the ICB on the 1 April 2024.
- To agree the Memorandum of Understanding and Collaboration Agreement between the ICBs in the Midlands and NHS England to manage the delegated services.
- To agree the variation of the Joint Working Agreement between the East Midlands ICBs to delegate responsibility for the decision making on Specialised Commissioning to the Joint Committee of the ICBs
- To agree the required changes to the ICB's Scheme of Reservation and Delegation and Standing Financial Instructions to reflect the arrangements for delegation.

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**	There is a risk that the system does not create and enable a health and care 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.	☐

This paper supports Risk 15 on the ICB's risk register: *The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI.*

Financial impact on the ICB or wider Integrated Care System		
[To be completed by Finance Team ONLY]		
Yes ☒	No☐	N/A☐
Details/Findings A Joint Finance and Contracting Subgroup reporting to the Committees that will oversee the financial framework.		**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

Dated 2024

(1) **NHS ENGLAND**

- and -

(2) **NHS DERBY AND DERBYSHIRE ICB INTEGRATED CARE BOARD**

Delegation Agreement between NHS England and NHS Derby and Derbyshire ICB in relation to Specialised Commissioning Functions

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DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. PARTICULARS

1.1 This Agreement records the particulars of the agreement made between NHS England and the Integrated Care Board (ICB) named below.

Integrated Care Board	NHS Derby and Derbyshire ICB
Area	Derbyshire and Derby City
Date of Agreement	[Date]
ICB Representative	Helen Dillistone, Chief of Staff
ICB Email Address for Notices	Council House, Corporation Street, Derby, DE1 2FS
NHS England Representative	Dale Bywater, Regional Director (Midlands)
NHS England Email Address for Notices	england.midlandscorporate@nhs.net

1.2 This Agreement comprises:

1.2.1 the Particulars (Clause 1);

1.2.2 the Terms and Conditions (Clauses 2 to 32);

1.2.3 the Schedules; and

1.2.4 the Mandated Guidance

Signed by **NHS England**

DALE BYWATER

REGIONAL DIRECTOR - MIDLANDS

(for and on behalf of NHS England)

Signed by **NHS Derby and Derbyshire Integrated Care Board**

Dr Chris Clayton

Chief Executive

for and on behalf of NHS Derby and Derbyshire Integrated Care Board

TERMS AND CONDITIONS

2. **INTERPRETATION**

2.1 This Agreement is to be interpreted in accordance with SCHEDULE 1 *(Definitions and Interpretation)*.

2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.2.1 the Developmental Arrangements;

2.2.2 the Particulars and Terms and Conditions (Clauses 1 to 32);

2.2.3 Mandated Guidance;

2.2.4 all Schedules excluding Developmental Arrangements and Local Terms; and

2.2.5 Local Terms.

2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.

2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. **BACKGROUND**

3.1 NHS England has statutory functions (duties and powers) conferred on it by legislation to make arrangements for the provision of prescribed services known as Specialised Services. These services support people with a range of rare and complex conditions. They are currently set out in the Prescribed Specialised Services Manual. The legislative basis for identifying these Specialised Services is Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996.

3.2 The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.

3.3 Pursuant to section 65Z5 of the NHS Act, NHS England is able to delegate responsibility for carrying out its Commissioning Functions to an ICB. NHS England will remain accountable to Parliament for ensuring that statutory requirements to commission all Specialised Services, and duties set out in the mandate, are being met.

3.4 By this Agreement, NHS England delegates the functions of commissioning certain Specialised Services (the “Delegated Functions”) to the ICB under section 65Z5 of the NHS Act.

3.5 This Agreement also sets out the elements of commissioning those Specialised Services for which NHS England will continue to have responsibility (the “Reserved Functions”).

3.6 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the ICB.

3.7 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB. It also sets out each Party's responsibilities and the measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. **TERM**

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with Clause 27 *(Termination)* below.

5. **PRINCIPLES**

5.1 In complying with the terms of this Agreement, NHS England and the ICB must:

5.1.1 at all times have regard to the Triple Aim;

5.1.2 at all times act in good faith and with integrity towards each other;

5.1.3 consider how they can meet their legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

5.1.4 consider how in performing their obligations they can address health inequalities;

5.1.5 at all times exercise functions effectively, efficiently and economically;

5.1.6 act in a timely manner;

5.1.7 share information and Best Practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost; and

5.1.8 have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

6. **DELEGATION**

6.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for its Population, as further described in this Agreement ("Delegation").

6.2 The Delegated Functions are the functions described as being delegated to the ICB as have been identified and included within Schedule 3 to this Agreement but excluding the Reserved Functions set out within Schedule 4.

6.3 The Delegation in respect of each Delegated Function has effect from the Effective Date of Delegation.

6.4 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.5 Unless expressly provided for in this Agreement, the ICB is not authorised by this Agreement to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions.

6.6 NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could, in relation to the Delegated Functions, cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.7 The terms of Clauses 6.5 and 6.6 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.2 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.2.1 the terms of this Agreement;

7.2.2 Mandated Guidance;

7.2.3 any Contractual Notices;

7.2.4 the Local Terms;

7.2.5 any Developmental Arrangements;

7.2.6 all applicable Law and Guidance;

7.2.7 the ICB's constitution;

7.2.8 the requirements of any assurance arrangements made by NHS England; and

7.2.9 Good Practice.

7.3 The ICB must perform the Delegated Functions in such a manner:

7.3.1 so as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Reserved Functions and to enable NHS England to fulfil its Reserved Functions; and

7.3.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions; and

7.3.3 so as to ensure that the ICB complies with its statutory duties and requirements including those duties set out in Section 14Z32 to Section 14Z44 and the NICE Regulations.

7.4 In exercising the Delegated Functions, the ICB must comply with all Mandated Guidance as set out in this Agreement or as otherwise may be issued by NHS England

from time to time including, but not limited to, ensuring compliance with National Standards and following National Specifications.

7.5 Where Developmental Arrangements conflict with any other term of this Agreement, the Developmental Arrangements shall take precedence until such time as NHS England agrees to the removal or amendment of the relevant Developmental Arrangements in accordance with Clause 26 (*Variations*).

7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.

7.7 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Specialised Service Provider that is a party to a Contract. NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

7.8 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.

7.9 Subject to the provisions of this Agreement, the ICB may determine the arrangements for the exercise of the Delegated Functions.

8. REQUIREMENT FOR ICB COLLABORATION ARRANGEMENT

8.1 Subject to the provisions of Clause 12 *(Further Arrangements)*, the ICB must establish appropriate ICB Collaboration Arrangements with other ICBs in order to ensure that the commissioning of the Delegated Services can take place across an appropriate geographical footprint for the nature of each particular Delegated Service with consideration of population size, provider landscape and patient flow. Such ICB arrangements in respect of the Delegated Functions must be approved in advance by NHS England.

8.2 The ICB must establish, as part of or separate to the arrangements set out in Clause 8.1, an agreement that sets out the arrangements in respect of the Commissioning Team as required by Clause 13.

8.3 The ICB must participate in discussions, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view with the other ICBs within the ICB Collaboration Arrangement. The members of the ICB Collaboration Arrangement shall have a collective responsibility for the operation of the ICB Collaboration Arrangement.

8.4 The ICB shall ensure that any ICB Collaboration Arrangement is documented and such documentation must include (but is not limited to) the following:

8.4.1 membership which is limited solely to ICBs unless otherwise approved by NHS England;

8.4.2 clear governance arrangements including reporting lines to the ICBs' Boards;

8.4.3 provisions for independent scrutiny of decision making;

8.4.4 the Delegated Functions or elements thereof which are the subject of the arrangements;

8.4.5 the Delegated Services which are subject to the arrangements;

8.4.6 financial arrangements and any pooled fund arrangements;

8.4.7 data sharing arrangements including evidence of a Data Protection Impact Assessment;

8.4.8 terms of reference for decision making; and

8.4.9 limits on onward delegation.

8.5 The ICB must not terminate an ICB Collaboration Arrangement in respect of the Delegated Functions without the prior written approval of NHS England.

9. **PERFORMANCE OF THE RESERVED FUNCTIONS AND COMMISSIONING SUPPORT ARRANGEMENTS**

9.1 NHS England will remain responsible for the performance of the Reserved Functions.

9.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to Clause 26 (*Variations*) of this Agreement.

9.3 Where it considers appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

9.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. If an ICB identifies such a conflict or inconsistency, it will inform NHS England as soon as is reasonably practicable.

9.5 The Parties acknowledge that they may agree for the ICB to provide Administrative and Management Services to NHS England in relation to certain Reserved Functions and Retained Services in order to assist in the efficient and effective exercise of such functions. Any such Commissioning Team Arrangements shall be set out in writing.

9.6 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Retained Services and Reserved Functions, NHS England shall retain statutory responsibility for, and be accountable for, the commissioning of the Retained Services.

9.7 The Parties acknowledge that they may agree for NHS England to provide Administrative and Management Services to ICBs in relation to certain Delegated Functions and Delegated Services in order to assist in the efficient and effective exercise of such Delegated Functions. Any such Administrative and Management Services shall be set out in writing.

9.8 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Delegated Services, the ICB shall retain delegated responsibility for the commissioning of the Delegated Services.

10. **FINANCE**

10.1 Without prejudice to any other provision in this Agreement, the ICB must comply with the Finance Guidance and any such financial processes as required by NHS England

for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

10.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.

10.3 Subject to Clause 10.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

10.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions; and

10.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's Functions other than the Delegated Functions.

10.4 The ICB's expenditure on the Delegated Functions must be sufficient to:

10.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently;

10.4.2 meet all liabilities arising under or in connection with all Contracts in so far as they relate to the exercise of the Delegated Functions;

10.4.3 appropriately commission the Delegated Services in accordance with Mandatory Guidance, National Specifications, National Standards and Guidance; and

10.4.4 meet national commitments from time to time on expenditure on specific Delegated Functions.

10.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

10.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation, adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance or otherwise;

10.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act;

10.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under Clause 17 (*Claims and Litigation)*;

10.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions or funds transferred (or that should have been transferred) to the ICB in respect of Administrative and Management Services; and

10.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

10.6 NHS England acknowledges that the intention of Clause 10.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change

the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

10.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

10.8 NHS England may in respect of the Delegated Funds:

10.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;

10.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

10.9 The Schedules to this Agreement may identify further financial provisions in respect of the exercise of the Delegated Functions.

10.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.

10.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or such other process as notified to the ICB from time to time.

10.12 Without prejudice to any other obligation upon the ICB, for the purposes of the Delegated Functions the ICB agrees that it must use its resources in accordance with:

10.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts);

10.12.2 any NHS payment scheme published by NHS England;

10.12.3 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

10.12.4 any Capital Investment Guidance;

10.12.5 the HM Treasury Guidance *Managing Public Money* (dated September 2022) as replaced or updated from time to time; and

10.12.6 any other Guidance published by NHS England with respect to the financial management of Delegated Functions.

10.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:

10.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions;

10.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Pooled Funds

10.14 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund(s) in respect of any part of the Delegated Funds with:

10.14.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;

10.14.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or

10.14.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and

10.15 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act. Where the ICB has decided to enter into arrangements under Clause 10.14 the agreement must be in writing and must specify:

10.15.1 the agreed aims and outcomes of the arrangements;

10.15.2 the payments to be made by each partner and how those payments may be varied;

10.15.3 the specific Delegated Functions which are the subject of the arrangements;

10.15.4 the Delegated Services which are subject to the arrangements;

10.15.5 the duration of the arrangements and provision for the review or variation or termination of the arrangements;

10.15.6 the arrangements in place for governance of the pooled fund; and

10.15.7 the arrangements in place for assuring, oversight and monitoring of the ICB's exercise of the functions referred to in 10.15.3.

10.16 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

11. INFORMATION, PLANNING AND REPORTING

11.1 The ICB must provide to NHS England:

11.1.1 such information or explanations in relation to the exercise of the Delegated Functions; as required by NHS England from time to time; and

11.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

11.2 The provisions of this Clause 11 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

11.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

11.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

11.5 The ICB must maintain a risk register in respect of its exercise of the Delegated Functions and periodically review its content. The risk register must follow such format as may be notified by NHS England to the ICB from time to time.

12. FURTHER ARRANGEMENTS

12.1 In addition to any ICB Collaboration Arrangement agreed in accordance with Clause 8 (*ICB Collaboration Arrangements*) the ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act ("Further Arrangements").

12.2 The ICB may only make Further Arrangements with another person (a "Sub-Delegate") with the prior written approval of NHS England.

12.3 The approval of any Further Arrangements may:

12.3.1 include approval of the terms of the proposed Further Arrangements; and

12.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

12.4 All Further Arrangements must be made in writing.

The ICB must not terminate Further Arrangements without the prior written approval of NHS England.

12.5 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

12.6 The terms of this Clause 12 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

12.7 Where Further Arrangements are made, and unless NHS England has otherwise given specific prior written agreement, any obligations or duties on the part of the ICB under this Agreement that are relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with such obligations or duties and support the ICB in doing so.

13. STAFFING, WORKFORCE AND COMMISSIONING TEAMS

13.1 Where there is an arrangement for NHS England to provide Administrative and Management Services to the ICB, the ICB shall provide full co-operation with NHS England and enter into any necessary arrangements with NHS England and, where appropriate, other ICBs in respect of the Specialised Services Staff.

13.2 The ICB shall, if and where required by NHS England, enter into appropriate arrangements with NHS England in respect of the transfer of Specialised Services Staff.

13.3 The ICB shall, where appropriate, enter into an agreement with other ICBs, in order to establish arrangements in respect of the Commissioning Team Where appropriate, this

agreement may be included as part of the ICB Collaboration Arrangement entered into in accordance with Clause 8.

14. **BREACH**

14.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

14.1.1 exercise its rights under this Agreement; and

14.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.

14.2 Without prejudice to Clause 14.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

14.2.1 waive its rights in relation to such non-compliance in accordance with Clause 14.3;

14.2.2 ratify any decision in accordance with Clause 6.5;

14.2.3 substitute a decision in accordance with Clause 6.6;

14.2.4 amend Developmental Arrangements or impose new Developmental Arrangements;

14.2.5 revoke the whole or part of the Delegation and terminate this Agreement in accordance with Clause 27 *(Termination)* below;

14.2.6 exercise the Escalation Rights in accordance with Clause 155 *(Escalation Rights)*; and/or

14.2.7 exercise its rights under common law.

14.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by Clause 14.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

14.4 If:

14.4.1 the ICB does not comply with this Agreement;

14.4.2 the ICB considers that it may not be able to comply with this Agreement;

14.4.3 NHS England notifies the ICB that it considers the ICB has not complied with this Agreement; or

14.4.4 NHS England notifies the ICB that it considers that the ICB may not be able to comply with this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB identifies that it may not be able to comply with this Agreement) setting out:

14.4.5 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and

14.4.6 a plan for how the ICB proposes to remedy the non-compliance.

15. **ESCALATION RIGHTS**

15.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

15.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) Operational Days of NHS England becoming aware of the non-compliance; and

15.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) Operational Days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

15.2 If NHS England does not comply with this Agreement, the ICB may require a suitably senior representative of NHS England to attend a review meeting within ten (10) Operational Days of the ICB making NHS England aware of the non-compliance.

15.3 Nothing in Clause 15 *(Escalation Rights)* will affect NHS England's right to substitute a decision in accordance with Clause 6.76, revoke the Delegation or terminate this Agreement in accordance with Clause 27 *(Termination)* below.

16. LIABILITY AND INDEMNITY

16.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to Clause 16.3).

16.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

16.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement. In respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to Clause 10.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

16.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.

16.5 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

17. CLAIMS AND LITIGATION

17.1 Nothing in this Clause 17 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

17.2 Except in the circumstances set out in Clause **Error! Reference source not found.**17.5 and subject always to compliance with this Clause 17 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

17.3 The ICB must:

17.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and the pro-active management of Claims;

17.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

17.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

17.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and

17.3.5 at the request of NHS England, take such actions or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

17.4 Subject to Clauses 17.3 and 17.5 the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

17.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:

17.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke Clause 17.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and

17.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim; and

17.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to Clause 10.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

17.6 The ICB and NHS England shall notify each other as soon as reasonably practicable of becoming aware of any Claim Losses.

17.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS

England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to Clause 10.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to Clause 10.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to Clause 10.5.3.

18. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

18.1 The Parties must ensure that all Personal Data processed by or on behalf of them while carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

18.2 The ICB must respond to any information governance breach in accordance with Information Governance Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

18.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.

18.4 NHS England may, from time to time, issue a data sharing protocol or update a protocol previously issued relating to the data sharing in relation to the Delegated Functions and/or Reserved Functions. The ICB shall comply with such data sharing protocols.

18.5 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

18.6 Each Party may be required by statute to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

18.6.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

18.6.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested; and

18.6.3 subject only to Clause 17 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

18.7 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the handling and responding to of FOIA or EIR requests in

relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

18.8 Delegated **Services**

NHS England delegates to the ICB the statutory function for commissioning the Specialised Services set out in this Schedule 2 (*Delegated Services*) subject to the reservations set out in Schedule 4 (*Retained Functions*) and the provisions of any Developmental Arrangements set out in Schedule 9.

The following Specialised Services will be delegated to the ICB on 1 April 2024:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology (adults)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass(complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		24Y	Skin cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
113	Specialist haematology services for children	23H	Specialist haematology services for children
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 3: Delegated Functions

1 Introduction

1.1 Subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:

1.1.1 decisions in relation to the commissioning and management of Delegated Services;

1.1.2 planning Delegated Services for the Population, including carrying out needs assessments;

1.1.3 undertaking reviews of Delegated Services in respect of the Population;

1.1.4 supporting the management of the Specialised Commissioning Budget;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Delegated Services with other health and social care bodies in respect of the Population where appropriate; and

1.1.6 such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions.

1.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

2 General Obligations

2.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.

2.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (*Requirement for ICB Collaboration Arrangement*).

2.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

3 Assurance and Oversight

3.1 The ICB must at all times operate in accordance with:

3.1.1 the Oversight Framework published by NHS England;

3.1.2 any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements; and

3.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

3.2 The ICB must:

3.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes;

3.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes;

3.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards;

3.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

4 Attendance at governance meetings

4.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.

4.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

4.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

5 Clinical Leadership and Clinical Reference Groups

5.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

5.2 The ICB shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.

6 Clinical Networks

6.1 The ICB shall participate in the planning, governance and oversight of the Relevant Clinical Networks, including involvement in agreeing the annual plan for each Relevant Clinical Network. The ICB shall seek to align the network priorities with system priorities and to ensure that the annual plan for the Relevant Clinical Network reflects local needs and priorities.

6.2 The ICB will be involved in the development and agreement of a single annual plan for the Relevant Clinical Network.

6.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.

6.4 The ICB shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.

6.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.

6.6 The ICB shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.

6.7 Where a Relevant Clinical Network identifies any concern, the ICB shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.

6.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

7 Complaints

7.1 The ICB shall provide full co-operation with NHS England in relation to any complaints received in respect of the Delegated Services which shall retain the function of complaints management in respect of the Delegated Services.

7.2 The ICB shall provide the relevant individuals at NHS England with appropriate access to data held by the ICB necessary to carry out the complaints function.

7.3 At such time as agreed between the ICB and NHS England, the management of complaints function in respect of the Delegated Services shall be delegated to the ICB and the following provisions shall apply:

7.3.1 NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

7.3.2 The ICB shall provide information relating to key performance indicators ("KPIs") as requested by NHS England. These KPIs shall include information reporting on the following:

7.3.2.1 acknowledgements provided within three (3) Operational Days;

7.3.2.2 responses provided within forty (40) Operational Days;

7.3.2.3 response not provided within six (6) months;

7.3.2.4 open cases with the Parliamentary and Health Services Ombudsman and providing information on any fully or partly upheld complaints; and

7.3.2.5 overall activity by volume (not as a KPI).

7.3.3 The ICB shall co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.

7.3.4 The ICB shall take part in any peer review process put in place in respect of the complaints function.

7.4 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement.

8 Commissioning and optimisation of High Cost Drugs

8.1 The ICB must ensure the effective and efficient commissioning of High Cost Drugs for Delegated Services.

8.2 Where necessary the ICB must collaborate with NHS England in respect of the payment arrangements for High Cost Drugs.

8.3 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.

8.4 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs. This includes supporting the Specialised Service Provider pharmacy services and each Party in the development access to medicine strategies, and minimising barriers that may exacerbate health inequalities.

8.5 The ICB must ensure:

8.5.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies;

8.5.2 effective introduction of new medicines;

8.5.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs;

8.5.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs;

8.5.5 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored; and

8.5.6 consistency of prescribing and unwarranted prescribing variation are addressed.

8.6 The ICB must have in place appropriate monitoring mechanisms, including prescribing analysis, to support the financial management of High Cost Drugs.

8.7 The ICB must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.

8.8 The ICB must provide support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks.

9 Contracting

9.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:

9.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts;

9.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England; and

9.1.3 management of Specialised Services Contracts.

9.2 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

10 Data Management and Analytics

10.1 The ICB shall:

10.1.1 lead on standardised collection, processing, and sharing of data for Delegated Services in line with broader NHS England, Department of Health and Social Care and government data strategies;

10.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services;

10.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics;

10.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement;

10.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement;

10.1.6 ensure data and analytics teams within ICBs and NHS England work collaboratively on jointly agreed programmes of work focusing on provision of pathway analytics;

10.2 The ICB must ensure that the data reporting and analytical frameworks, as set out in Mandated Guidance or as otherwise required by NHS England, are in place to support the commissioning of the Delegated Services.

11 Finance

11.1 The provisions of Clause 10 (*Finance*) of this Agreement set out the financial requirements in respect of the Delegated Functions.

12 Freedom of Information and Parliamentary Requests

12.1 The ICB shall lead on the handling, management and response to all Freedom of Information and parliamentary correspondence relating to Delegated Services.

13 Incident Response and Management

13.1 The ICB shall:

13.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level;

13.1.2 support national and regional incident management relating to Specialised Services; and

13.1.3 ensure surge events and actions relating to Specialised Services are included in ICB escalation plans.

13.2 In the event that an incident is identified that has an impact on the Delegated Services (such as potential failure of a Specialised Services Provider), the ICB shall fully support the implementation of any requirements set by NHS England around the management of such incident and shall provide full co-operation to NHS England to enable a co-ordinated national approach to incident management. NHS England retains the right to take decisions at a national level where it determines this is necessary for the proper management and resolution of any such incident and the ICB shall be bound by any such decision.

14 Individual Funding Requests

14.1 The ICB shall provide any support required by NHS England in respect of determining an Individual Funding Request and shall implement the decision of the Individual Funding Request panel.

15 Innovation and New Treatments

15.1 The ICB shall support local implementation of innovative treatments for Delegated Services.

16 Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

16.1 The ICB shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative arrangements as part of the wider pathway delivery.

17 Provider Selection and Procurement

17.1 The ICB shall:

17.1.1 run appropriate local provider selection and procurement processes for Delegated Services;

17.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services;

17.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape; and

17.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.

17.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.

17.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

17.3.1 made in the best interest of patients, taxpayers and the Population;

17.3.2 robust and defensible, with conflicts of interests appropriately managed;

17.3.3 made transparently; and

17.3.4 compliant with relevant Guidance and legislation.

18 Quality

18.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:

18.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services;

18.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs;

18.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved;

18.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent;

18.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary;

18.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback; and

18.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

18.2 The ICB must establish a plan to ensure that the quality of the Delegated Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.

18.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.

18.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.

18.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

18.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

19 Service Planning and Strategic Priorities

19.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.

19.2 In planning, commissioning and managing the Delegated Services, the ICB must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

19.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.

19.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

20 National Standards, National Specifications and Clinical Commissioning Policies

20.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.

20.2 The ICB shall facilitate engagement with local communities on National Specification development.

20.3 The ICB must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Delegated Service.

20.4 The ICB must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.

20.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

20.6 Where the ICB has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the ICB shall consider the action to take to address this in line with the Assurance Processes.

21 Transformation

21.1 The ICB shall:

21.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services;

21.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services;

21.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan;

21.1.4 support NHS England with agreed transformational programmes for Retained Services;

21.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation;

21.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised; and

21.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

SCHEDULE 4: Reserved Functions

Introduction

1. Reserved Functions in Relation to the Delegated Services

1.1. In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Delegated Functions, are Reserved Functions.

1.2. This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Delegated Functions.

1.3. The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

1.4. The following functions and related activities shall continue to be exercised by NHS England.

2. Retained Services

2.1. NHS England shall commission the Retained Services set out in Schedule 5.

3. Reserved Specialised Service Functions

3.1. NHS England shall carry out the functions set out in this Schedule 4 in respect of the Delegated Services.

Reserved Functions

4. Assurance and Oversight

4.1. NHS England shall:

4.1.1. have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients;

4.1.2. design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes;

4.1.3. help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate);

4.1.4. ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately;

4.1.5. ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery; and

4.1.6. host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a national level, including identification, review and management of appropriate cross-ICB risks.

5. Attendance at governance meetings

5.1. NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at NCG.

5.2. NHS England shall:

5.2.1. ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums;

5.2.2. ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings; and

5.2.3. co-ordinate, and support key national governance groups.

6. Clinical Leadership and Clinical Reference Groups

6.1. NHS England shall be responsible for the following:

6.1.1. developing local leadership and support for the ICB relating to Specialised Services;

6.1.2. providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services;

6.1.3. providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges; and enabling access to clinical trials for new treatments and medicines.

6.2. NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:

6.2.1. Clinical Commissioning Policies;

6.2.2. National Specifications, including National Standards for each of the Specialised Services.

7. Clinical Networks

7.1. Unless otherwise agreed between the Parties, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.

7.2. NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.

7.3. NHS England shall be responsible for:

7.3.1. developing national policy for the Relevant Clinical Networks;

7.3.2. developing and approving the specifications for the Relevant Clinical Networks;

7.3.3. maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services;

7.3.4. convening or supporting national networks of the Relevant Clinical Networks;

7.3.5. agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities;

7.3.6. managing Relevant Clinical Networks jointly with the ICB; and

7.3.7. agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

8. Complaints

8.1. NHS England shall manage all complaints in respect of the Delegated Services at the date of this Agreement and until such time as it agrees the delegation of complaints to the ICB.

8.2. NHS England shall manage all complaints in respect of the Reserved Services.

9. Commissioning and optimisation of High Cost Drugs

9.1. In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:

9.1.1. comply as appropriate with the centralised process for the reimbursement of Specialised Services High Cost Drugs and, where appropriate, ensuring that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally;

9.1.2. support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities;

9.1.3. provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements;

9.1.4. seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation;

9.1.5. provide input into national procurement, homecare and commercial processes;

9.1.6. provide expert medicines advice and input into immunoglobin assessment panels and support to the national Programmes of Care and Clinical Reference Groups;

9.1.7. provide expert medicines advice and input into the Individual Funding Request process for Delegated Services; and

9.1.8. collaborate with commissioners of health and justice services to ensure detained people can access High Cost Drugs using the NHS England or ICB commissioning policies in line with community patient access, including who prescribes and supplies the medicine.

10. Contracting

10.1. NHS England shall retain the following obligations in relation to contracting for Delegated Services:

10.1.1. ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives);

10.1.2. provide advice for ICBs on schedules to support the Delegated Services;

10.1.3. set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

10.1.4. provide and distribute contracting support tools and templates to the ICB.

10.2. In respect of the Retained Services, NHS England shall:

10.2.1. where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s); and

10.2.2. where appropriate, construct model template schedules for Retained Services and issue to ICBs.

11. Data Management and Analytics

11.1. NHS England shall:

11.1.1. support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools;

11.1.2. support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services;

11.1.3. ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies;

11.1.4. lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services;

11.1.5. work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services;

11.1.6. provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised Commissioning team, Programmes of Care and Clinical Reference Groups; and

11.1.7. provide access to data and analytic subject matter expertise to support the ICB when considering local service planning, needs assessment and transformation.

12. Finance

12.1. The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.

13. Freedom of Information and Parliamentary Requests

13.1. NHS England shall:

13.1.1. lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services; and

13.1.2. co-ordinate a response when a single national response is required in respect of Delegated Services.

14. Incident Response and Management

14.1. NHS England shall:

14.1.1. provide guidance and support to the ICB in the event of a complex incident;

14.1.2. lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted;

14.1.3. lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB; and

14.1.4. respond to specific service interruptions where appropriate; for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

15. Individual Funding Requests

15.1. NHS England shall be responsible for:

15.1.1. leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services;

15.1.2. taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services; and

15.1.3. providing expertise for IFR decisions, including but not limited to pharmacy, public health, nursing and medical and quality.

16. Innovation and New Treatments

16.1. NHS England shall support the local implementation of innovative treatments for Delegated Services.

16.2. NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.

16.3. NHS England shall provide national leadership for innovative treatments with significant service impacts including liaison with NICE.

17. Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

17.1. NHS England shall commission and design NHS-led Provider Collaborative arrangements for mental health, learning disability and autism services. Where it considers appropriate, NHS England shall seek the input of the ICB in relation to relevant Provider Collaborative arrangements.

18. Provider Selection and Procurement

18.1. In relation to procurement, NHS England shall be responsible for:

18.1.1. setting standards and agreeing frameworks and processes for provider selections and procurements for Specialised Services;

18.1.2. monitoring and providing advice, guidance and expertise on the overall provider market in relation to Specialised Services; and

18.1.3. where appropriate, running provider selection and procurement processes for Specialised Services.

19. Quality

19.1. In respect of quality, NHS England shall:

19.1.1. work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required;

19.1.2. work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary;

19.1.3. work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance;

19.1.4. facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues;

19.1.5. provide guidance on quality and clinical governance matters and benchmark available data;

19.1.6. support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary;

19.1.7. report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required;

19.1.8. facilitate and support the national quality governance infrastructure (for example, the QGG); and

19.1.9. identify and act upon issues and concerns that cross multiple ICBs, coordinating response and management as necessary.

20. National Standards, National Specifications and Clinical Commissioning Policies

20.1. NHS England shall carry out:

20.1.1. development, engagement and approval of National Standards for Specialised Services (including National Specifications, Clinical Commissioning Policies, quality and data standards);

20.1.2. production of national commissioning products and tools to support commissioning of Specialised Services;

20.1.3. maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters; and

20.1.4. determination of content for national clinical registries.

21. Transformation

21.1. NHS England shall be responsible for:

21.1.1. co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary;

21.1.2. supporting the ICB to implement national policy and guidance across its Populations for Retained Services;

21.1.3. supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services;

21.1.4. providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, or are national priorities for the NHS, including supporting delivery of commitments in the NHS Long Term Plan;

21.1.5. co-production and co-design of transformation programmes with the ICB and wider stakeholders; and

21.1.6. providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5: Retained Services

NHS England shall retain the function of commissioning the Specialised Services that are not Delegated Services and as more particularly set out by NHS England and made available from time to time.

18.9 6 (*Further Information Governance and Sharing* Provisions) makes further provision about information sharing, information governance and the Data Sharing Agreement.

19. IT INTER-OPERABILITY

19.1 The Parties will work together to ensure that all relevant IT systems they operate in respect of the Delegated Functions and Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

19.2 The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

20. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

20.1 The ICB must ensure that, in delivering the Delegated Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

20.2 Without prejudice to the general obligations set out in Clause 20.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

21. PROHIBITED ACTS AND COUNTER-FRAUD

21.1 The ICB must not commit any Prohibited Act.

21.2 If the ICB or its Staff commits any Prohibited Act in relation to this Agreement with or without the knowledge of NHS England, NHS England will be entitled:

21.2.1 to revoke the Delegation;

21.2.2 to recover from the ICB the amount or value of any gift, consideration or commission concerned; and

21.2.3 to recover from the ICB any loss or expense sustained in consequence of the carrying out of the Prohibited Act.

21.3 The ICB must put in place and maintain appropriate arrangements, including without limitation, Staff training, to address counter-fraud issues, having regard to any relevant Guidance, including from the NHS Counter Fraud Authority.

21.4 If requested by NHS England or the NHS Counter Fraud Authority, the ICB must allow a person duly authorised to act on behalf of the NHS Counter Fraud Authority or on behalf of NHS England to review, in line with the appropriate standards, any counter-fraud arrangements put in place by the ICB.

21.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in Clause 21.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

21.6 The ICB must, on becoming aware of:

21.6.1 any suspected or actual bribery, corruption or fraud involving public funds; or

21.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources;

promptly report the matter to NHS England and to the NHS Counter Fraud Authority.

21.7 On the request of NHS England or NHS Counter Fraud Authority, the ICB must allow the NHS Counter Fraud Authority or any person appointed by NHS England, as soon as it is reasonably practicable and in any event not later than five (5) Operational Days following the date of the request, access to:

21.7.1 all property, premises, information (including records and data) owned or controlled by the ICB; and

21.7.2 all Staff who may have information to provide.

relevant to the detection and investigation of cases of bribery, fraud or corruption, or security incidents or security breaches directly or indirectly in connection with this Agreement.

22. CONFIDENTIAL INFORMATION OF THE PARTIES

22.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Party and the receiving Party has no right to use it.

22.2 Subject to Clauses 22.3 to 22.5, the receiving Party agrees:

22.2.1 to use the disclosing Party's Confidential Information only in connection with the receiving Party's performance under this Agreement;

22.2.2 not to disclose the disclosing Party's Confidential Information to any third party or to use it to the detriment of the disclosing Party; and

22.2.3 to maintain the confidentiality of the disclosing Party's Confidential Information.

22.3 The receiving Party may disclose the disclosing Party's Confidential Information:

22.3.1 in connection with any dispute resolution procedure under Clause 25;

22.3.2 in connection with any litigation between the Parties;

22.3.3 to comply with the Law;

22.3.4 to any appropriate Regulatory or Supervisory Body;

22.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under Clause 22.2;

22.3.6 to NHS bodies for the purposes of carrying out their functions;

22.3.7 as permitted under or as may be required to give effect to Clause 21 (*Prohibited Acts and Counter-Fraud*); and

22.3.8 as permitted under any other express arrangement or other provision of this Agreement.

22.4 The obligations in Clauses 22.1 and 22.2 will not apply to any Confidential Information which:

22.4.1 is in, or comes into, the public domain other than by breach of this Agreement;

22.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or

22.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

22.5 This Clause 22 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

22.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this Clause 22 by the receiving Party, and in addition to any right to damages the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this Clause 22.

22.7 This Clause 222 will survive the termination of this Agreement for any reason for a period of five (5) years.

22.8 This Clause 22 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

23. INTELLECTUAL PROPERTY

23.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

23.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

23.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any Intellectual Property Rights ("IPR") attaches to Best Practice) grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

24. NOTICES

24.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars or as otherwise notified by one Party to another as the appropriate address for this Clause 24.1.

24.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

25. DISPUTES

25.1 This clause does not affect NHS England's right to exercise its functions for the purposes of assessing and addressing the performance of the ICB.

25.2 If a Dispute arises out of, or in connection with, this Agreement then the Parties must follow the procedure set out in this clause:

25.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("Dispute Notice"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

25.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) Operational Days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

25.2.3 if the people referred to in Clause 25.2.2 are for any reason unable to resolve the Dispute within twenty (20) Operational Days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' ("ADR) notice") to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR. The mediation will start no later than ten (10) Operational Days after the date of the ADR notice.

25.3 If the Dispute is not resolved within thirty (30) Operational Days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) Operational Dys, or the mediation terminates before the expiration of the period of thirty (30) Operational Days, the Dispute must be referred to the NHS England Board, who shall resolve the matter and whose decision shall be binding upon the Parties.

26. VARIATIONS

26.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

26.2 NHS England may vary this Agreement without the ICB's consent where:

26.2.1 it is reasonably satisfied that the variation is necessary in order to comply with Legislation, NHS England's statutory duties, or any requirements or direction given by the Secretary of State;

26.2.2 where variation is as a result of amendment to or additional Mandated Guidance;

26.2.3 it is satisfied that any Developmental Arrangements are no longer required;

26.2.4 it reasonably considers that Developmental Arrangements are required under Clause 14 (*Breach*); or

26.2.5 it is satisfied that such amendment or Developmental Arrangement is required in order to ensure the effective commissioning of the Delegated Services or other Specialised Services.

26.3 Where NHS England wishes to vary the Agreement in accordance with Clause 26.2 it must notice in writing to the ICB of the wording of the proposed variation and the date on which that variation is to take effect which must, unless it is not reasonably practicable, be a date which falls at least thirty (30) Operational Days after the date on which the notice under that clause is given to the ICB.

26.4 For the avoidance of doubt, NHS England may issue or update Mandated Guidance at any point during the term of the Agreement.

26.5 Either Party ("the Proposing Party") may notify the other Party (the "Receiving Party") of a Variation Proposal in respect of this Agreement including, but not limited to the following:

26.5.1 a request by the ICB to add, vary or remove any Developmental Arrangement; or

26.5.2 a request by NHS England to include additional Specialised Services or NHS England Functions within the Delegation; and

the Proposing Party will identify whether the proposed variation may have the impact of changing the scope of the Delegated Functions or Reserved Functions so that NHS England can establish the requisite level of approval required.

26.6 The Variation Proposal will set out the variation proposed and the date on which the Proposing Party requests the variation to take effect.

26.7 When a Variation Proposal is issued in accordance with 26.6, the Receiving Party must respond within thirty (30) Operational Days following the date that it is issued by serving notice confirming either:

26.7.1 that it accepts the Variation Proposal; or

26.7.2 that it refuses to accept the Variation Proposal and setting out reasonable grounds for that refusal.

26.8 If the Receiving Party accepts the Variation Proposal issued in accordance with Clause 26.5, the Receiving Party agrees to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

26.9 If the Receiving Party refuses to accept a Variation Proposal submitted in accordance with 26.5 to 26.7, or to take such steps as are required to give effect to the variation, then the provisions of Clause 15 (*Escalation Rights*) shall apply.

26.10 When varying the Agreement in accordance with Clause 26, the Parties must consider the impact of the proposed variation on any ICB Collaboration Arrangements and any Further Arrangements.

27. TERMINATION

27.1 The ICB may:

27.1.1 notify NHS England that it requires NHS England to revoke the Delegation; and

27.1.2 terminate this Agreement;

with effect from the end of 31 March in any calendar year, provided that:

27.1.3 on or before 30 September of the previous calendar year, the ICB sends written notice to NHS England of its requirement that NHS England revoke the Delegation and its intention to terminate this Agreement; and

27.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at Clause 27.1.3 above to discuss

arrangements for termination and transition of the Delegated Functions to a successor commissioner in accordance with Clause 28.2; and

27.1.5 the ICB confirms satisfactory arrangements for terminating any ICB Collaboration Arrangements or Further Agreements in whole or part as required including agreed succession arrangements for Commissioning Teams,

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

27.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case Clause 27.4 will apply.

27.3 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

27.3.1 the ICB acts outside of the scope of its delegated authority;

27.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement;

27.3.3 the ICB persistently commits non-material breaches of this Agreement;

27.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply;

27.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB;

27.3.6 failure to agree to a variation in accordance with Clause 26 *(Variations)*;

27.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or

27.3.8 the ICB merges with another ICB or other body.

27.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this Clause 277 *(Termination)*) except that the provisions referred to in Clause 299 (*Provisions Surviving Termination*) will continue in full force and effect.

27.5 Without prejudice to Clause 14.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this Clause 27 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

27.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

28. CONSEQUENCE OF TERMINATION

28.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have

accrued before the date of that termination or which later accrue in respect of the term of this Agreement. For the avoidance of doubt, the ICB shall be responsible for any Claims or other costs or liabilities incurred in the exercise of the Delegated Functions during the period of this Agreement unless expressly agreed otherwise by NHS England.

28.2 Subject to Clause 28.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and, if appropriate, any successor delegate will:

28.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of the Staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

28.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with Clause 28.2.1; and

28.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

28.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

28.3.1 co-operate with NHS England and any successor delegate to ensure continuity and a smooth transfer of the Delegated Functions; and

28.3.2 at the reasonable request of NHS England:

28.3.2.1 promptly provide all reasonable assistance and information to the extent necessary for an efficient assumption of the Delegated Functions by a successor delegate;

28.3.2.2 deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions; and

28.3.2.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

28.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

29. PROVISIONS SURVIVING TERMINATION

29.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in Clause 29.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

29.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

29.2.1 Clause 10 (*Finance*);

29.2.2 Clause 13 (*Staffing, Workforce and Commissioning Teams*);

29.2.3 Clause 16 *(Liability and Indemnity*);

29.2.4 Clause 17 (*Claims and Litigation*);

29.2.5 Clause 18 (*Data Protection, Freedom of Information and Transparency*);

29.2.6 Clause 25 (*Disputes*);

29.2.7 Clause 27 (*Termination*);

29.2.8 Schedule 6 (*Further Information Governance and Sharing Provisions*).

30. COSTS

30.1 Each Party is responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

31. SEVERABILITY

31.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

32. GENERAL

32.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

32.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

32.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1: Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

8. Use of the masculine includes the feminine and all other genders.

9. Use of the term “including” or “includes” will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

“Administrative and Management Services”	means administrative and management support provided in accordance with Clause 9.5 or 9.7;
“Agreement”	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance;
“Agreement Representatives”	means the ICB Representative and the NHS England Representative as set out in the Particulars or such person identified to the other Party from time to time as the relevant representative;
“Annual Allocation”	means the funds allocated to the ICB annually under section 223G of the NHS Act;
“Area”	means the geographical area covered by the ICB;
“Assurance Processes”	has the definition given in paragraph 3.1 of Schedule 3;
“Best Practice”	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in

	the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;
"Capital Investment Guidance"	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology; and - the revenue consequences for commissioners or third parties making such investment;
"CEDR"	means the Centre for Effective Dispute Resolution;
"Claims"	means, for or in relation to the Delegated Functions (i) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (ii) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
"Claim Losses"	means all Losses arising in relation to any Claim;
"Clinical Commissioning Policies"	means a nationally determined clinical policy setting out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
"Clinical Reference Groups"	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
"Collaborative Commissioning Agreement"	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commissioning Functions"	means the respective statutory functions of the Parties in arranging for the provision of services as part of the health service;
"Commissioning Team"	means those Specialised Services Staff that support the commissioning of Delegated Services immediately prior to this Agreement and, at the point that Staff transfer from NHS England to an identified ICB, it shall mean those NHS England Staff and such other Staff appointed by that ICB to carry out a role in respect of commissioning the Delegated Services;

Commissioning Team Arrangements	means the arrangements through which the services of a Commissioning Team are made available to another NHS body for the purposes of commissioning the Delegated Services;
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to an FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
Contracts	means any contract or arrangement in respect of the commissioning of any of the Delegated Services;
"Contracting Standard Operating Procedure"	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Delegated Services;
"Contractual Notice"	means a contractual notice issued by NHS England to the ICB, from time to time and relating to allocation of contracts for the purposes of the Delegated Functions;
"CQC"	means the Care Quality Commission;
"Data Controller"	shall have the same meaning as set out in the UK GDPR;
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Impact Assessment"	means an assessment to identify and minimise the data protection risks in relation to any data sharing proposals;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the UK GDPR;
"Data Protection Legislation"	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and

	the Privacy and Electronic Communications (EC Directive) Regulations 2003;
"Data Sharing Agreement"	means a data sharing agreement which should be in substantially the same form as a Data Sharing Agreement template approved by NHS England;
"Data Subject"	shall have the same meaning as set out in the UK GDPR;
"Delegated Commissioning Group (DCG)"	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;
"Delegated Functions"	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
"Delegated Funds"	means the funds defined in Clause 10.2;
"Delegated Services"	means the services set out in Schedule 2 of this Agreement and which may be updated from time to time by NHS England;
"Delegation"	means the delegation of the Delegated Functions from NHS England to the ICB as described at Clause 6.1;
"Developmental Arrangements"	means the arrangements set out in Schedule 9 as amended or replaced;
"Dispute"	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
"Effective Date of Delegation"	means for the Specialised Services set out in Schedule 2, the date set out in Schedule 2 as the date delegation will take effect in respect of that particular Specialised Service and for any future delegations means the date agreed by the parties as the date that the delegation will take effect;
"EIR"	means the Environmental Information Regulations 2004;
"Escalation Rights"	means the escalation rights as defined in Clause 15 *(Escalation Rights)*;
"Finance Guidance"	means the guidance, rules and operating procedures produced by NHS England that relate to these delegated arrangements, including but not limited to the following: - Commissioning Change Management Business Rules; - Contracting Standard Operating Procedure; - Cashflow Standard Operating Procedure; - Finance and Accounting Standard Operating Procedure; - Service Level Framework Guidance;

"Financial Year"	shall bear the same meaning as in section 275 of the NHS Act;
"FOIA"	means the Freedom of Information Act 2000;
"Further Arrangements"	means arrangements for the exercise of Delegated Functions as defined at Clause 12;
"Good Practice"	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
"Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance;
"High Cost Drugs"	means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list;
"Host ICB"	means the ICB that employs the Commissioning Team as part of the Commissioning Team Arrangements;
"ICB"	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
"ICB Collaboration Arrangement"	means an arrangement entered into by the ICB and at least one other ICB under which the parties agree joint working arrangements in respect of the exercise of the Delegated Functions;
"ICB Deliverables"	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications;
"ICB Functions"	the Commissioning Functions of the ICB;
"Information Governance Guidance for Serious Incidents"	means the checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation' (2015) as may be amended or replaced;
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);

"IPR"	means intellectual property rights and includes inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
"Law"	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
"Local Terms"	means the terms set out in Schedule 8 *(Local Terms)* and/or such other Schedule or part thereof as designated as Local Terms;
"Losses"	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
"Managing Conflicts of Interest in the NHS"	the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ ;
"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with Clause 7.35 which at the Effective Date of Delegation shall include the Mandated Guidance set out in Schedule 7;
"National Commissioning Group (NCG)"	means the advisory forum in respect of the Retained Services currently known as the National Commissioning Group for Specialised, Health and Justice and Armed Forces Services;
"National Standards"	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHS England in respect of Specialised Services;
"Need to Know"	has the meaning set out in paragraph 1.2 of Schedule 6 (*Further Information Governance and Sharing Provisions)*;
"NICE Regulations"	means the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 as amended or replaced;
"NHS Act"	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 and other legislation from time to time);

"NHS Counter Fraud Authority"	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
"NHS Digital Data Security and Protection Toolkit"	means the toolkit published by NHS Digital and available on the NHS Digital website at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit ;
"NHS England"	means the body established by section 1H of the NHS Act;
"NHS England Deliverables"	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications;
"NHS England Functions"	means all functions of NHS England as set out in legislation excluding any functions that have been expressly delegated;
"Non-Personal Data"	means data which is not Personal Data;
"Operational Days"	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
"**Oversight Framework**"	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England;
"Party/Parties"	means a party or both parties to this Agreement;
"Patient Safety Incident Response Framework"	means the framework published by NHS England and made available on the NHS England website at: https://www.england.nhs.uk/patient-safety/incident-response-framework/ ;
"Personal Data"	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
"Population"	means the individuals for whom the ICB has responsibility in respect of commissioning the Delegated Services;
"Prescribed Specialised Services Manual"	means the document which may be amended or replaced from time to time which is currently known as the prescribed specialised services manual which describes how NHS England and ICBs commission specialised services and sets out the identification rules which describe how NHS England and ICBs identify Specialised Services activity within data flows;
"Provider Collaborative"	means a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services;

"Provider Collaborative Guidance"	means the guidance published by NHS England in respect of Provider Collaboratives;
"Prohibited Act"	means the ICB: (i) offering, giving, or agreeing to give NHS England (or an of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and (ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or (iii) committing an offence under the Bribery Act 2010;
"Regional Quality Group"	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) the National Institute for Health and Care Excellence; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;

"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Relevant Information"	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
"Reserved Functions"	means statutory functions of NHS England that it has not delegated to the ICB including but not limited to those set out in the Schedules to this Agreement;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out in Schedule 5;
"Secretary of State"	means the Secretary of State for Health and Social Care;
"Shared Care Arrangements"	means arrangements put in place to support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;
"Single Point of Contact"	means the member of Staff appointed by each relevant Party in accordance with Paragraph 9.6 of Schedule 6;
"Special Category Personal Data"	shall have the same meaning as in UK GDPR;
"Specialised Commissioning Budget"	means the budget identified by NHS England for the purpose of exercising the Delegated Functions;
"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act and Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;
"Specialised Services Contract"	means a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	means a provider party to a Specialised Services Contract;
"Specialised Services Staff"	means the Staff of roles identified as carrying out the Delegated Services Functions immediately prior to the date of this Agreement;

"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph **Error! Reference source not found.** of Schedule 6 *(Further Information Governance and Sharing Provisions)* to this Agreement;
"Staff or Staffing"	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"Sub-Delegate"	shall have the meaning in Clause 12.2;
"System Quality Group"	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
"Triple Aim"	means the duty to have regard to wider effect of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
"Variation Proposal"	means a written proposal for a variation to the Agreement, which complies with the requirements of Clause 26.5.

SCHEDULE 2: Delegated Services

Delegated Services

NHS England delegates to the ICB the statutory function for commissioning the Specialised Services set out in this Schedule 2 (*Delegated Services*) subject to the reservations set out in Schedule 4 (*Retained Functions*) and the provisions of any Developmental Arrangements set out in Schedule 9.

The following Specialised Services will be delegated to the ICB on 1 April 2024:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology (adults)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass(complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		24Y	Skin cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 3: Delegated Functions

22 Introduction

22.1 Subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:

22.1.1 decisions in relation to the commissioning and management of Delegated Services;

22.1.2 planning Delegated Services for the Population, including carrying out needs assessments;

22.1.3 undertaking reviews of Delegated Services in respect of the Population;

22.1.4 supporting the management of the Specialised Commissioning Budget;

22.1.5 co-ordinating a common approach to the commissioning and delivery of Delegated Services with other health and social care bodies in respect of the Population where appropriate; and

22.1.6 such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions.

22.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

23 General Obligations

23.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.

23.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (*Requirement for ICB Collaboration Arrangement*).

23.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

24 Assurance and Oversight

24.1 The ICB must at all times operate in accordance with:

24.1.1 the Oversight Framework published by NHS England;

24.1.2 any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements; and

24.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

24.2 The ICB must:

24.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes;

24.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes;

24.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards;

24.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

25 Attendance at governance meetings

25.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.

25.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

25.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

26 Clinical Leadership and Clinical Reference Groups

26.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

26.2 The ICB shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.

27 Clinical Networks

27.1 The ICB shall participate in the planning, governance and oversight of the Relevant Clinical Networks, including involvement in agreeing the annual plan for each Relevant Clinical Network. The ICB shall seek to align the network priorities with system priorities and to ensure that the annual plan for the Relevant Clinical Network reflects local needs and priorities.

27.2 The ICB will be involved in the development and agreement of a single annual plan for the Relevant Clinical Network.

27.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.

27.4 The ICB shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.

27.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.

27.6 The ICB shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.

27.7 Where a Relevant Clinical Network identifies any concern, the ICB shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.

27.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

28 Complaints

28.1 The ICB shall provide full co-operation with NHS England in relation to any complaints received in respect of the Delegated Services which shall retain the function of complaints management in respect of the Delegated Services.

28.2 The ICB shall provide the relevant individuals at NHS England with appropriate access to data held by the ICB necessary to carry out the complaints function.

28.3 At such time as agreed between the ICB and NHS England, the management of complaints function in respect of the Delegated Services shall be delegated to the ICB and the following provisions shall apply:

28.3.1 NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

28.3.2 The ICB shall provide information relating to key performance indicators ("KPIs") as requested by NHS England. These KPIs shall include information reporting on the following:

28.3.2.1 acknowledgements provided within three (3) Operational Days;

28.3.2.2 responses provided within forty (40) Operational Days;

28.3.2.3 response not provided within six (6) months;

28.3.2.4 open cases with the Parliamentary and Health Services Ombudsman and providing information on any fully or partly upheld complaints; and

28.3.2.5 overall activity by volume (not as a KPI).

28.3.3 The ICB shall co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.

28.3.4 The ICB shall take part in any peer review process put in place in respect of the complaints function.

28.4 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement.

29 Commissioning and optimisation of High Cost Drugs

29.1 The ICB must ensure the effective and efficient commissioning of High Cost Drugs for Delegated Services.

29.2 Where necessary the ICB must collaborate with NHS England in respect of the payment arrangements for High Cost Drugs.

29.3 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.

29.4 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs. This includes supporting the Specialised Service Provider pharmacy services and each Party in the development access to medicine strategies, and minimising barriers that may exacerbate health inequalities.

29.5 The ICB must ensure:

29.5.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies;

29.5.2 effective introduction of new medicines;

29.5.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs;

29.5.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs;

29.5.5 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored; and

29.5.6 consistency of prescribing and unwarranted prescribing variation are addressed.

29.6 The ICB must have in place appropriate monitoring mechanisms, including prescribing analysis, to support the financial management of High Cost Drugs.

29.7 The ICB must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.

29.8 The ICB must provide support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks.

30 Contracting

30.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:

30.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts;

30.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England; and

30.1.3 management of Specialised Services Contracts.

30.2 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

31 Data Management and Analytics

31.1 The ICB shall:

31.1.1 lead on standardised collection, processing, and sharing of data for Delegated Services in line with broader NHS England, Department of Health and Social Care and government data strategies;

31.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services;

31.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics;

31.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement;

31.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement;

31.1.6 ensure data and analytics teams within ICBs and NHS England work collaboratively on jointly agreed programmes of work focusing on provision of pathway analytics;

31.2 The ICB must ensure that the data reporting and analytical frameworks, as set out in Mandated Guidance or as otherwise required by NHS England, are in place to support the commissioning of the Delegated Services.

32 Finance

32.1 The provisions of Clause 10 (*Finance*) of this Agreement set out the financial requirements in respect of the Delegated Functions.

33 Freedom of Information and Parliamentary Requests

33.1 The ICB shall lead on the handling, management and response to all Freedom of Information and parliamentary correspondence relating to Delegated Services.

34 Incident Response and Management

34.1 The ICB shall:

34.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level;

34.1.2 support national and regional incident management relating to Specialised Services; and

34.1.3 ensure surge events and actions relating to Specialised Services are included in ICB escalation plans.

34.2 In the event that an incident is identified that has an impact on the Delegated Services (such as potential failure of a Specialised Services Provider), the ICB shall fully support the implementation of any requirements set by NHS England around the management of such incident and shall provide full co-operation to NHS England to enable a co-ordinated national approach to incident management. NHS England retains the right to take decisions at a national level where it determines this is necessary for the proper management and resolution of any such incident and the ICB shall be bound by any such decision.

35 Individual Funding Requests

35.1 The ICB shall provide any support required by NHS England in respect of determining an Individual Funding Request and shall implement the decision of the Individual Funding Request panel.

36 Innovation and New Treatments

36.1 The ICB shall support local implementation of innovative treatments for Delegated Services.

37 Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

37.1 The ICB shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative arrangements as part of the wider pathway delivery.

38 Provider Selection and Procurement

38.1 The ICB shall:

38.1.1 run appropriate local provider selection and procurement processes for Delegated Services;

38.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services;

38.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape; and

38.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.

38.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.

38.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

38.3.1 made in the best interest of patients, taxpayers and the Population;

38.3.2 robust and defensible, with conflicts of interests appropriately managed;

38.3.3 made transparently; and

38.3.4 compliant with relevant Guidance and legislation.

39 Quality

39.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:

39.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services;

39.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs;

39.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved;

39.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent;

39.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary;

39.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback; and

39.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

39.2 The ICB must establish a plan to ensure that the quality of the Delegated Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.

39.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.

39.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.

39.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

39.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

40 Service Planning and Strategic Priorities

40.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.

40.2 In planning, commissioning and managing the Delegated Services, the ICB must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

40.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.

40.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

41 National Standards, National Specifications and Clinical Commissioning Policies

41.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.

41.2 The ICB shall facilitate engagement with local communities on National Specification development.

41.3 The ICB must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Delegated Service.

41.4 The ICB must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.

41.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

41.6 Where the ICB has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the ICB shall consider the action to take to address this in line with the Assurance Processes.

42 Transformation

42.1 The ICB shall:

42.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services;

42.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services;

42.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan;

42.1.4 support NHS England with agreed transformational programmes for Retained Services;

42.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation;

42.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised; and

42.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

SCHEDULE 4: Reserved Functions

Introduction

22. Reserved Functions in Relation to the Delegated Services

22.1. In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Delegated Functions, are Reserved Functions.

22.2. This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Delegated Functions.

22.3. The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

22.4. The following functions and related activities shall continue to be exercised by NHS England.

23. Retained Services

23.1. NHS England shall commission the Retained Services set out in Schedule 5.

24. Reserved Specialised Service Functions

24.1. NHS England shall carry out the functions set out in this Schedule 4 in respect of the Delegated Services.

Reserved Functions

25. Assurance and Oversight

25.1. NHS England shall:

25.1.1. have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients;

25.1.2. design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes;

25.1.3. help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate);

25.1.4. ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately;

25.1.5. ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery; and

25.1.6. host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a

national level, including identification, review and management of appropriate cross-ICB risks.

26. Attendance at governance meetings

26.1. NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at NCG.

26.2. NHS England shall:

26.2.1. ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums;

26.2.2. ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings; and

26.2.3. co-ordinate, and support key national governance groups.

27. Clinical Leadership and Clinical Reference Groups

27.1. NHS England shall be responsible for the following:

27.1.1. developing local leadership and support for the ICB relating to Specialised Services;

27.1.2. providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services;

27.1.3. providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges; and enabling access to clinical trials for new treatments and medicines.

27.2. NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:

27.2.1. Clinical Commissioning Policies;

27.2.2. National Specifications, including National Standards for each of the Specialised Services.

28. Clinical Networks

28.1. Unless otherwise agreed between the Parties, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.

28.2. NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.

28.3. NHS England shall be responsible for:

28.3.1. developing national policy for the Relevant Clinical Networks;

28.3.2. developing and approving the specifications for the Relevant Clinical Networks;

28.3.3. maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services;

28.3.4. convening or supporting national networks of the Relevant Clinical Networks;

28.3.5. agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities;

28.3.6. managing Relevant Clinical Networks jointly with the ICB; and

28.3.7. agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

29. Complaints

29.1. NHS England shall manage all complaints in respect of the Delegated Services at the date of this Agreement and until such time as it agrees the delegation of complaints to the ICB.

29.2. NHS England shall manage all complaints in respect of the Reserved Services.

30. Commissioning and optimisation of High Cost Drugs

30.1. In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:

30.1.1. comply as appropriate with the centralised process for the reimbursement of Specialised Services High Cost Drugs and, where appropriate, ensuring that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally;

30.1.2. support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities;

30.1.3. provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements;

30.1.4. seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation;

30.1.5. provide input into national procurement, homecare and commercial processes;

30.1.6. provide expert medicines advice and input into immunoglobin assessment panels and support to the national Programmes of Care and Clinical Reference Groups;

30.1.7. provide expert medicines advice and input into the Individual Funding Request process for Delegated Services; and

30.1.8. collaborate with commissioners of health and justice services to ensure detained people can access High Cost Drugs using the NHS England or ICB commissioning policies in line with community patient access, including who prescribes and supplies the medicine.

31. Contracting

31.1. NHS England shall retain the following obligations in relation to contracting for Delegated Services:

31.1.1. ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives);

31.1.2. provide advice for ICBs on schedules to support the Delegated Services;

31.1.3. set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

31.1.4. provide and distribute contracting support tools and templates to the ICB.

31.2. In respect of the Retained Services, NHS England shall:

31.2.1. where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s); and

31.2.2. where appropriate, construct model template schedules for Retained Services and issue to ICBs.

32. Data Management and Analytics

32.1. NHS England shall:

32.1.1. support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools;

32.1.2. support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services;

32.1.3. ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies;

32.1.4. lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services;

32.1.5. work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services;

32.1.6. provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised Commissioning team, Programmes of Care and Clinical Reference Groups; and

32.1.7. provide access to data and analytic subject matter expertise to support the ICB when considering local service planning, needs assessment and transformation.

33. Finance

33.1. The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.

34. Freedom of Information and Parliamentary Requests

34.1. NHS England shall:

34.1.1. lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services; and

34.1.2. co-ordinate a response when a single national response is required in respect of Delegated Services.

35. Incident Response and Management

35.1. NHS England shall:

35.1.1. provide guidance and support to the ICB in the event of a complex incident;

35.1.2. lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted;

35.1.3. lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB; and

35.1.4. respond to specific service interruptions where appropriate; for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

36. Individual Funding Requests

36.1. NHS England shall be responsible for:

36.1.1. leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services;

36.1.2. taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services; and

36.1.3. providing expertise for IFR decisions, including but not limited to pharmacy, public health, nursing and medical and quality.

37. Innovation and New Treatments

37.1. NHS England shall support the local implementation of innovative treatments for Delegated Services.

37.2. NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.

37.3. NHS England shall provide national leadership for innovative treatments with significant service impacts including liaison with NICE.

38. Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

38.1. NHS England shall commission and design NHS-led Provider Collaborative arrangements for mental health, learning disability and autism services. Where it considers appropriate, NHS England shall seek the input of the ICB in relation to relevant Provider Collaborative arrangements.

39. Provider Selection and Procurement

39.1. In relation to procurement, NHS England shall be responsible for:

39.1.1. setting standards and agreeing frameworks and processes for provider selections and procurements for Specialised Services;

39.1.2. monitoring and providing advice, guidance and expertise on the overall provider market in relation to Specialised Services; and

39.1.3. where appropriate, running provider selection and procurement processes for Specialised Services.

40. Quality

40.1. In respect of quality, NHS England shall:

40.1.1. work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required;

40.1.2. work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary;

40.1.3. work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance;

40.1.4. facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues;

40.1.5. provide guidance on quality and clinical governance matters and benchmark available data;

40.1.6. support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary;

40.1.7. report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required;

40.1.8. facilitate and support the national quality governance infrastructure (for example, the QGG); and

40.1.9. identify and act upon issues and concerns that cross multiple ICBs, coordinating response and management as necessary.

41. National Standards, National Specifications and Clinical Commissioning Policies

41.1. NHS England shall carry out:

41.1.1. development, engagement and approval of National Standards for Specialised Services (including National Specifications, Clinical Commissioning Policies, quality and data standards);

41.1.2. production of national commissioning products and tools to support commissioning of Specialised Services;

41.1.3. maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters; and

41.1.4. determination of content for national clinical registries.

42. Transformation

42.1. NHS England shall be responsible for:

42.1.1. co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary;

42.1.2. supporting the ICB to implement national policy and guidance across its Populations for Retained Services;

42.1.3. supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services;

42.1.4. providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, or are national priorities for the NHS, including supporting delivery of commitments in the NHS Long Term Plan;

42.1.5. co-production and co-design of transformation programmes with the ICB and wider stakeholders; and

42.1.6. providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5: Retained Services

NHS England shall retain the function of commissioning the Specialised Services that are not Delegated Services and as more particularly set out by NHS England and made available from time to time.

SCHEDULE 6: Further Information Governance And Sharing Provisions

PART 1

1. Introduction

1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Parties on a Need To Know basis, in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.2. References in this Schedule *(Further Information Governance and Sharing Provisions)* to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3. This Schedule and the Data Sharing Agreements entered under this Schedule are designed to:

1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Parties;

1.3.2. describe the purposes for which the Parties have agreed to share Relevant Information;

1.3.3. set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;

1.3.4. describe roles and structures to support the exchange of Relevant Information between the Parties;

1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;

1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8. apply to the activities of the Parties' Staff; and

1.3.9. describe how complaints relating to Personal Data sharing between the Parties will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Delegated Functions and NHS England's Reserved Functions.

2.2. Each Party must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Parties must obtain data in order to achieve the Specified Purpose. Where necessary specific

and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant legislation and Guidance.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Delegated Services.

4. Lawful basis for sharing

4.1. The Parties shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Parties shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

5.1. Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2. Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Parties' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Parties.

5.4. Neither Party shall subcontract any processing of the Relevant Information without the prior consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

5.5. The Parties shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6. Any particular restrictions on use of certain Relevant Information should be included in a Personal Data Agreement.

6. Ensuring fairness to the Data Subject

6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Parties will take the following measures as reasonably required:

6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and

6.1.4. giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

6.2. Each Party shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.

6.3. The Parties shall reasonably co-operate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

6.4. Further provision in relation to specific data flows may be included in a Personal Data Agreement between the Parties.

7. Governance: Staff

7.1. The Parties must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.

7.2. The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Parties' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018), the employing Parties must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

7.3. The Parties shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data. The Parties shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

7.4. Each Party shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.5. The Parties shall ensure that:

7.5.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information;

7.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and

7.5.3. specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8. Governance: Protection of Personal Data

8.1. At all times, the Parties shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2. Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Parties. The Parties shall co-operate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.

8.4. If any Party becomes aware of:

8.4.1. any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

8.4.2. any security vulnerability or breach in respect of the Relevant Information,

it shall promptly, within 48 hours, notify the other Parties. The Parties shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5. In processing any Relevant Information further to this Agreement, the Parties shall process the Personal Data and Special Category Personal Data only:

8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body; and

8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6. The Parties shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection

Legislation, and in particular to protect Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1. take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and

8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data and Special Category Personal Data which is to be protected.

8.7. In particular, each Party shall:

8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;

8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

8.7.3. obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;

8.7.4. permit any other party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

8.8. The Parties shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8.9. The Parties shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.10. The Parties' Single Points of Contact set out in paragraph **Error! Reference source not found.** will be the persons who, in the first instance, will have oversight of third party security measures.

9. Governance: Transmission of Information between the Parties

9.1. This paragraph supplements paragraph 8 of this Schedule.

9.2. Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as

the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record and/or data is identified.

9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered into in accordance with this Schedule.

9.5. Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

9.6. The Parties' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

10. Governance: Quality of Information

10.1. The Parties will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11. Governance: Retention and Disposal of Shared Information

11.1. A non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

11.2. Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3. If a Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Parties in writing of that retention, giving details of the documents or materials that it must retain.

11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

11.5. The Parties shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6. The Parties shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7. Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8. Electronic records will be considered for deletion once the relevant retention period has ended.

11.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

12.1. The Parties shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the ICB. Complaints about information sharing shall be routed through each Parties' own complaints procedure unless otherwise provided for in the Agreement or determined by the ICB.

12.3. The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4. Basic details of the Agreement shall be included in the appropriate log under each Party's publication scheme.

13. Governance: Single Points of Contact

13.1. The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

14.1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 7: Mandated Guidance

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- Information Governance Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable Guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable Guidance relating to the use of data and data sets for reporting.
- Guidance relating to the processes for making and handling individual funding requests, including:
    - Commissioning policy: Individual funding requests;
    - Standard operating procedures: Individual funding requests.

Workforce

- Guidance on the Employment Commitment.

Finance

- Guidance on NHS System Capital Envelopes.
- Managing Public Money (HM Treasury).

Specialised Services Mandated Guidance

- Commissioning Change Management Business Rules.
- Cashflow Standard Operating Procedure.
- Finance and Accounting Standard Operating Procedure.
- Provider Collaborative Guidance.
- Clinical Commissioning Policies.
- National Specifications.
- National Standards.
- The Prescribed Specialised Services Manual

SCHEDULE 8: Local Terms

None – local terms are described as part of the Collaboration Agreement and Operating Framework which includes a pooled budget established by the ICBs

General

Where there is a Dispute as to the content of this Schedule, the Parties should follow the Disputes procedure set out at Clause 25.

Following signature of the Agreement, this Schedule can be amended by the Parties using the Variations procedure at Clause 26.

NHS England can amend this Schedule without the ICB's consent by using the variation procedure set out in Clause 26.2 but the expectation is that variations should be by consent.

SCHEDULE 9: Developmental Arrangements

None

SCHEDULE 10: Administrative and Management Services

blank

Appendix 2

Memorandum of Understanding
&
Collaboration Agreement
For the Delegation of Acute Specialised Services
2024-2025

Memorandum of Understanding (MoU)
Delegation of Acute Specialised Services
2024-2025

1.0 Introduction

This Memorandum of Understanding (MoU) sets out the key principles and commitments to supporting the collaborative working model for the 11 ICBs in the Midlands and NHSE Midlands.

The MOU covers the year 2024-25 and is referred to as the transitional year. In this year 59 Acute Specialised Service Lines will be formally delegated (Subject to Board Approval). The MOU should be read in conjunction with the formal Collaboration Agreement which is a mandated requirement of the delegation process.

The Midlands are committed to working together to achieve best outcomes promoting pathway integration and parity of access to drive improvements in population health.

Our aim in this transitional year is to set out the practical ways in which we will work together to mitigate any potential risks and issues and to develop a strong operating model for the future.

2.0 Principles

This MOU is a statement based on principles of co-operation between all organisations including:

- To build strong relationships and an environment based on trust and collaboration.
- To seek to continually improve whole pathways of care and to design and implement effective and efficient integration.
- To share information and best practice and work together to identify solutions, eliminate duplication of effort, mitigate risks, and promote value.
- To have regard to each other's needs and views
- To work within the intentions set out within the Delegation Agreement.
- To commit to continue to work together during 2024/25 to build on the foundation from statutory joint working and learn lessons from previous delegation.

3.0 Responsibilities and Accountabilities

The delegation of specialised commissioning does not change the accountability of the services lines and functions remaining with NHS England.

Upon delegation the services become the responsibility of the 11 Midlands ICBs who are required to commit to working together to commission these services. NHSE remains a partner in this process and is also responsible for the commissioning of retained specialised services.

ICB responsibilities for the delegated services are as follows:

- All delivery is conducted in the name of the ICB, and legal liabilities are the ICBs.
- Decisions in relation to the commissioning and management of the delegated services
- Planning delegated services for the population, including carrying out needs assessments
- Undertaking reviews of delegated services in respect of the population
- Supporting the management of the specialised commissioning budget for delegated services

- Co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate

NHSE accountabilities and responsibilities for the delegated services are as follows:

- Remains politically accountable to the Secretary of State and parliament, although not directly legally responsible for any shortcomings or delivery failures.
- Has continued responsibilities to support the ICBs in their delegated responsibilities providing guidance and expertise.
- NHSE could be subject to judicial review and challenge.

Joint consideration will be given to the development of a future concordat to underpin future joint working arrangements from 2025/26.

4.0 Pre delegation assurance requirements

A robust programme of work has been underway (jointly managed between NHSE and the ICBs) throughout the year to oversee the delegation of services from April 2024.
Over and above, this work it was agreed that additional due diligence requirements would be enacted to ensure ICBs have all the necessary assurance to allow them to sign off at ICB Boards in March 2024. These include the following:

- **Sender /Receiver Summary report -** One of the key documents to be produced will be a summary of the safe delegation checklist report completed by NHSE (as the sender organisation) approved by the joint working groups summarising the following:
    - Performance – activity /waiting lists against trajectory /improvement plans.
    - Contracts – outstanding issues/disputes
    - Procurements
    - Operational work programme
    - Risk register and mitigations
    - Corporate – complaints /litigations/FoIs
    - Finance – investment /cases
    - Responsibilities around high-cost drugs and devices

- **Service Profiles** – including assessment of quality and fragile services by ICB. This report will be available prior to Board sign off and updated for April 2024.
- **Finance** – Risk managed through a Pooled Fund approach between ICBs in 2024/25, working closely with NHSE to manage the overall financial position of specialised services recognising differential growth between retained and delegated services.
- **Quality Assurance Framework** – outlines the transitional arrangements for quality assurance responsibilities.
- **Benefits of delegation** – set out the practical examples of the benefits of delegation for patients.

Note: current ICB performance analysis already includes specialised activity data

5.0 Working arrangements of the teams /functions in 2024/25

The Specialised Services Standard Operating Framework sets out who the Midlands Specialised Commissioning team are and how they will operate.
This team is committed to the following:

- Agreeing individual joint priorities recognising the breadth of commissioning responsibility for delegated and retained functions. The Director posts will have a single set of priorities on behalf of the 11 ICBs and NHSE.

- Delivering an agreed work plan for the actions agreed for delegated services and retained services.
- Improving specialised services health inequalities through delivering recommendations in the health inequalities strategy.

The team will progress:

- New approaches to working with ICB colleagues to ensure a shared leadership model and learning to enable expertise in specialised services, and system expertise to be combined to improve outcomes.
- Full engagement in joint development opportunities to ensure that the experience across Programmes of Care is maximised and opportunities to drive value are realised.
- Explore ways to further support the staff through the transitional year to maintain the workforce.
- Develop new ways of working during the transition year to reflect the changing environment.

In the transitional year, executive and operational leadership for the Operating Framework will be through:

- A Specialised Services Executive Group (including the East and West ICB CEO Strategic Leads for Specialised Commissioning and the NHSE Regional Director of Commissioning Integration
- A multi-professional Specialised Services Senior Leadership Team function including input from Midlands Specialised Commissioning and East and West ICB professional executive leads.

Recognising 2024/25 as a transitional year prior to delegation of further services, the Operating Model Working Group (OMG) will be responsible for the joint planning for this next phase of delegation, with assurance and escalation through the joint Delegation and Transfer Programme Board and direction from the ICB CEOs/NHSE development sessions.

Decision making will be through ICB Boards and the NHSE Regional Support Group. Connectivity between the current and future agendas will be ensured through the Specialised Executive Group and reports to the Joint Committees.

6.0 Finance and Governance

Formal governance will be through the East and West Midlands Joint Committees who will formally stand-up a sub-group of the committees, these being:

- Midlands Acute Specialised Services Group – Commissioning including Planning Development, Transformation, and Reducing Inequalities
- Finance and Contracting Group – Financial Management and Financial Planning
- Specialised Commissioning Quality Group – Quality Oversight and Assurance

In addition, advisory groups including, the Collaborative Clinical Executive Group will provide clinically lead transformation and improvement advice guidance and recommendations for pathway re-design.

To ensure the integrated planning and decision making around the needs of the Midlands populations, these forums will consider NHSE Midlands retained functions as well as delegated functions; however, decision making for retained functions will be through the Midlands Commissioning Group and / or National Commissioning Group, as appropriate.
The Director of Specialised Commissioning will represent the perspectives of the East and West Midlands Joint Committees at the national NHSE Delegated Commissioning Group.

Finance
During the transitional year it is recognised that the management of financial risks across all ICBs will be mitigated through working with NHSE through several routes:

- Pooled fund arrangements

The ICBs will establish and maintain a mutually agreed pooled fund arrangement for in-year financial management, with a defined contribution based on the allocation received for the 59 delegated specialised services being transferred to the Host ICB, (Birmingham & Solihull ICB) on behalf of the Midlands. The detail of the management of this will be articulated in detail within the Collaboration Agreement.

- Joint contractual meetings

There will be close working relationships across NHSE/ICBs with the aim to have a single contractual meeting with providers to understand the whole position.

The specialised services contracts are operated on a block basis – for the elements of the contracts covered by the block, commissioners will have no financial exposure to activity variance. In 24/25 Elective activity is managed through the Elective Recovery Fund which will be managed on the same basis as 2023/24 with contract values and allocations being adjusted for activity variances. There will be no financial risk to commissioners associated with the application of ERF.

There are a small number of variable services (linked to Best Practice Tariffs) within the contract, these being:

- Chemotherapy
- Diagnostic Imaging
- Nuclear Medicine
- PRT-CT
- Molecular Radiotherapy
- Renal Transplant

These services are paid on a cost per case basis. Opening baselines for variable services will be based on 2023/24 outturn with growth applied based on historic activity.

There remains a potential risk at an ICB and regional level of variance against contract and budget for these services. A contingency of 0.5% will be held in the Pooled budget to manage in year financial risk to mitigate the impact of variable service financial risks.
NHSE will commit to continue to regularly review in partnership with ICBs the overall financial position and risks and ensure the retained /59 acute services are reviewed together.

Data protection – to support and enable the appropriate sharing of information and data to facilitate joint working a DPIA will be approved and signed by each ICB in March 2024 which will be supported by and included in a dedicated schedule within the Collaboration Agreement

Complaints and FoI – All complaints received (on average circa 5-7 per annum across the whole Specialised portfolio including retained services) are managed by the Head of Services with input from subject matter experts with clinical and quality review. Complaints will continue to be managed in this way for ICB and NHSE during 2024/25, with reports to the Tier 2 subgroups. Both the FoI and complaints process will be detailed in the Commissioning Team Agreement and Operating Framework for 2024/25.

The Midlands Specialised Commissioning Team will operate on behalf of all the 11 ICBs and NHSE. It is recognised that relationships and new ways of working will take time to develop but there is a commitment to increasing focus towards and with systems, ensuring increasing shared ownership, access to subject matter expertise and, wherever possible. reducing points of contact for systems and providers. Any changes and/or recruitment will be jointly agreed and coordinated through the joint leadership team.

The Specialised Services Networks are a Midlands resource, whose work plans, reflecting operational and strategic priorities, will be agreed through the Collaborative Clinical Executive and MASCG on behalf of the Joint Committees. The funding/resources for these networks remains with NHSE and will not be delegated to ICBs in 2024/25.
The Specialised Clinical Services Strategy will inform the 2025/26 specialised services operational plan and the priorities for transformational activity. It is currently being jointly developed and is scheduled for completion by the end of Qtr. 2. The Clinical Services Strategy will be agreed through formal governance and subject to final approval by the Joint Committees.

7.0 Development plan

It is recognised that over and above the due diligence requirements put in place to support the delegation process we will commit to putting in place a development plan for 2024/25.

This will clearly set out the key deliverables agreed between ICBs and NHSE to further develop a robust operating model.
The development plan will be initiated and developed through executive and operational working sessions planned from April 2024.

This will be developed further.

Priority Objectives	Commitments to date	Joint SROs
Culture / OD – team development	Develop joint OD plans Collaborative recruitment	Karen Helliwell, Sarah Prema, Alison Kemp
Clinical Strategy	Clinical Networks Agreed clinical strategy and action plan Clinical benefits and outcomes	Clara Day. Nilesh Sanganee, Colette Marshall
Contracting	Integrated performance reporting Integrated commissioning intentions for 2025/26 Integrated contracting a	Ali Kemp, East and West rep leads to be confirmed
Finance	Analysis of impact of differential local pricing in spec com contracts. Reconciliation of Trust cost base between core and specialised services. Impact of needs-based allocations and convergence from 2025/26.	Madi Parmer, Jon Cooke, East CFO To be confirmed

8.0 Assurance

A national assurance framework has been developed and published that provides an approach to assurance that will minimise significant additional contacts and maximise existing NHSE assurance arrangements. ICBs will be requested to self-assess aspects of delivery of specialised provision. The collaborative agreement however sets out how integrated working will be delivered in 2024/25 and ensure that risk is jointly understood, and mitigation is managed through agreed governance.

9.0 Review process during 2024/25

This MoU and Collaboration Agreement will be subject to quarterly review within the ICB CEO Time Out Sessions and reported to Joint Committees.
A formal review will be coproduced and progressed in Q3/402024/25 in preparation for revised agreements, including further delegations, in advance of 2025/26.
There is a commitment to a formal post transactions review in 2026/27

END

Midlands Specialised Services Collaboration Agreement 2024/25

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THIS AGREEMENT is made on the first day of April 2024

BETWEEN:

(1) **NHS Lincolnshire Integrated Care Board** of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and

(2) **NHS Nottingham & Nottinghamshire Integrated Care Board** of Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA ("Nottingham & Nottinghamshire ICB"); and

(3) **NHS Leicester, Leicestershire & Rutland Integrated Care** Board of Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB ("Leicester, Leicestershire & Rutland ICB"); and

(4) **NHS Northamptonshire Integrated Care Board** of Francis Crick House, 6 Summerhouse Road, Northampton, Northamptonshire, NN3 6BF ("Northamptonshire ICB"); and

(5) **NHS Derby & Derbyshire Integrated Care Board** of Cardinal Square, 10 Nottingham Road, Derby, Derbyshire, DE1 3QT ("Derby & Derbyshire ICB"). **NHS Lincolnshire Integrated Care Board** of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and

(6) **NHS Birmingham & Solihull Integrated Care Board** of First Floor, Wesleyan, Colmore Circus, Birmingham, B4 6AR ("Birmingham & Solihull ICB"); and

(7) **NHS Black Country Integrated Care Board** of Civic Centre, St Peters Square, Wolverhampton WV1 1SD ("Black Country ICB"); and

(8) **NHS Herefordshire & Worcestershire Integrated Care Board** of Kirkham House, John Comyn Drive, Perdiswell, Worcester, WR3 7NS ("Herefordshire & Worcestershire ICB"); and

(9) **NHS Coventry & Warwickshire Integrated Care Board** of Westgate House, Market St, Warwick CV34 4DE ("Coventry & Warwickshire ICB"); and

(10) **NHS Shropshire, Telford & Wrekin Integrated Care Board** of Halesfield 6, Halesfield, Telford, TF7 4BF ("Shropshire, Telford & Wrekin ICB"); and

(11) **NHS Staffordshire & Stoke-on-Trent Integrated Care Board** of Winton House, Stoke Road, Stoke-on-Trent ST4 2RW ("Staffordshire & Stoke-on-Trent ICB"); and

(12) **NHS England** of Quarry House, Quarry Hill, Leeds, LS2 7UE (acting under the name NHS England) (**"NHS England"**).

each a "Partner" and together the "Partners".

Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB, Birmingham & Solihull ICB, Black Country ICB, Herefordshire & Worcestershire ICB, Coventry & Warwickshire ICB, Shropshire, Telford & Wrekin ICB and Staffordshire & Stoke-on-Trent ICB are together referred to in this Agreement as the "ICBs", and "ICB" shall mean any of them.

BACKGROUND

(A) NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.

(B) The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.

(C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs can establish and maintain joint arrangements in respect of the discharge of their Commissioning Functions.

(D) Under the Delegation Agreement made pursuant to section 65Z5, NHS England has delegated the Delegated Functions to each of the ICBs. NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.

(E) It is agreed that to exercise the Delegated Functions in the most efficient and effective manner, some of the Delegated Services are best commissioned collaboratively between multiple ICBs.

(F) This Agreement sets out the arrangements that will apply between the ICBs and NHS England in relation to the collaborative commissioning of Specialised Services for the ICBs' Populations.

NOW IT IS HEREBY AGREED as follows:

1. **COMMENCEMENT AND DURATION**

1.1 This Agreement has effect from the date of this Agreement and will remain in force unless terminated in accordance with Clause 23 (*Termination & Default)* below.

2. **PRINCIPLES AND AIMS**

2.1 The Partners acknowledge that, in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act and must:

2.1.1 consider how it can meet its legal duties to involve patients and the public in shaping the provision of Services, including by working with local communities, under-represented groups, and those with protected characteristics for the purposes of the Equality Act 2010;

2.1.2 consider how, in performing its obligations, it can address health inequalities;

2.1.3 at all times exercise functions effectively, efficiently, and economically; and

2.1.4 act always in good faith towards each other.

2.2 The Partners agree:

2.2.1 that successfully implementing this Agreement will require strong relationships and an environment based on trust and collaboration;

2.2.2 to seek to continually improve whole pathways of care including Specialised Services and to design and implement effective and efficient integration;

2.2.3 to act in a timely manner;

2.2.4 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks, and reduce cost;

2.2.5 to act at all times, ensure the Partners comply with the requirements of the Delegation Agreements including Mandated Guidance;

2.2.6 to act at all times in accordance with the scope of their statutory powers; and

2.2.7 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Services and, as far as is reasonably practicable, take such needs and views into account.

2.3 The Partners' aims are:

2.3.1 to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through

designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim;

3. SCOPE OF THE ARRANGEMENTS

3.1 This Agreement sets out the Joint Working Arrangements through which the Partners will work together to commission Services. This may include one or more of the following commissioning mechanisms (the "Flexibilities") although this list is not exhaustive:

3.1.1 Lead Commissioning Arrangements: where agreed Commissioning Functions are delegated to a lead Partner (Lead Partner);

3.1.2 Aligned Commissioning Arrangements: where there is no further delegation of the Commissioning Functions. However, the Partners agree mechanisms to co-operate in the commissioning of identified Services;

3.1.3 Joint Commissioning Arrangements: where the Partners exercise agreed Commissioning Functions jointly;

3.1.4 the establishment of one or more Joint Committees;

3.1.5 the establishment of one or more Commissioning Teams;

3.1.6 the establishment of one or more Pooled Funds;

3.1.7 the use of one or more Non-Pooled Fund.

3.2 At the Commencement Date the Partners agree that the following Joint Working Arrangements shall be in place:

3.2.1 Delegation by NHS England of the Delegated Functions to each individual ICB in accordance with the relevant Delegation Agreement.

3.2.2 Establishment of the following Joint Working Arrangements:

- Establishment of a Commissioning Team in accordance with Clause 5.1 through which agreed Delegated Services may be commissioned [as set out in the Commissioning Team Agreement and Standard Operating Framework];
- Delegation of responsibilities by the ICBs to the two Joint Committees for the East and West Midlands established under existing multi-ICB Joint Working Agreements;
- Approval of the three schemes for the commissioning of delegated specialised services for the East and West Midlands multi-ICBs and for the collaborative commissioning of retained services as set out in Schedule 3;
- Establishment of financial risk share and pooled budget arrangement as set out in Schedule 4.

4. FUNCTIONS

4.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the commissioning of health services in accordance with the terms of this Agreement.

4.2 This Agreement shall include such Commissioning Functions as shall be agreed from time to time by the Partners and set out in the relevant Scheme Specifications.

4.3 The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in Schedule 3.

4.4 Where the Partners add a new Individual Scheme to this Agreement, a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner in accordance with the variation procedure set out in Clause 13 (*Variations*).

4.5 The Partners shall work in co-operation and shall endeavour to ensure that all Services are commissioned with all due skill, care and attention irrespective of the Joint Working Arrangements utilised.

4.6 Where there are Lead Commissioning Arrangements in respect of any Individual Scheme, unless the Scheme Specification otherwise provides, the Lead Partner shall:

4.6.1 exercise the Functions of each Partner as identified in the relevant Scheme Specification;

4.6.2 endeavour to ensure that all Commissioning Functions included in the relevant Individual Scheme are funded as agreed by each Partner in respect of each Financial Year;

4.6.3 comply with all relevant legal duties and Guidance of all Partners in relation to the Services being commissioned;

4.6.4 perform all commissioning obligations with all due skill, care and attention;

4.6.5 undertake performance management and contract monitoring of all service contracts including (without limitation) the use of contract notices where Services fail to deliver contracted requirements;

4.6.6 make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and

4.6.7 keep the other Partner(s) regularly informed of the effectiveness of the Joint Working Arrangements including any forecasted Overspend or Underspend where there is a Pooled Fund or Non-Pooled Fund.

5. COMMISSIONING TEAM

5.1 The Partners agree to establish a Commissioning Team(s) as set out in Schedule 6 (*Commissioning Team Arrangements*).

6. STAFFING

6.1 The staffing arrangements in respect of each Individual Scheme shall be as set out in the relevant Scheme Specification and/or the Commissioning Team Agreement and Standard Operating Framework.

7. JOINT COMMITTEE

7.1 Where Partners intend to form a Joint Committee then the arrangements for the Joint Committee shall be as set out in Schedule 2 (*Governance Arrangements*); and the relevant Joint Committee Terms of Reference.

8. GOVERNANCE

8.1 Overall strategic oversight of partnership working between the Partners shall be as set out in Schedule 2 (*Governance Arrangements*).

8.2 Each Partner has internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

8.3 The Governance Arrangements shall set out how the Partners shall provide overall oversight and approval of Individual Schemes and variations to those Individual Schemes.

8.4 Each Scheme Specification shall confirm the Governance Arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to each partner.

9. POOLED FUNDS, NON-POOLED FUNDS AND RISK SHARING

9.1 The Partners may establish Pooled Funds, Non-Pooled Funds and agree Risk Sharing in accordance with Schedule 4 (*Financial Arrangements*).

10. REVIEW

10.1 Save where the Partners agree alternative arrangements (including alternative frequencies) the Partners shall undertake an Annual Review of the operation of this Agreement, any Pooled Fund and Non-Pooled Fund and the provision of the Services within three (3) months of the end of each Financial Year.

10.2 Annual Reviews shall be conducted in good faith.

11. COMPLAINTS

11.1 Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

11.2 A report summarising complaints, actions and lessons learnt will be provided to the East and West Board annually.

12. FINANCES

12.1 The financial arrangements shall be as agreed between the Partners in the relevant Scheme Specification and Schedule 4 (*Financial Arrangements*).

12.2 Unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners, each Partner shall bear its own costs as they are incurred.

13. VARIATION

13.1 The Partners acknowledge that the scope of the Collaboration Arrangements may be reviewed and amended from time to time.

13.2 This Agreement may be varied by the agreement of the Partners at any time in writing in accordance with the Partners' internal decision-making processes.

13.3 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

13.4 Where the Partners agree that there will be:

13.4.1 a new Pooled Fund;

13.4.2 a new Individual Scheme; or

13.4.3 an amendment to a current Individual Scheme,

the Partners shall agree the new or amended Individual Scheme in accordance with the Governance Arrangements and, in respect of amendments, the Scheme Specification. Each new or amended Individual Scheme must be signed by each of the Partners. A request to vary an Individual Scheme, which may include (without limitation) a change in the level of Financial Contributions or other matters set out in the relevant Scheme Specification, may be made by any Partner but will require agreement from all the Partners. The notice period for any variation unless otherwise agreed by the Partners shall be three (3) months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

13.5 Partners may propose additional schemes to be added to this agreement via the Joint Committees.

13.6 The following approach shall, unless otherwise agreed, be followed by the Partners:

13.6.1 on receipt of a request from one Partner to vary the Agreement including (without limitation) the introduction of a new Individual Scheme or amendments to an existing Individual Scheme, the Partners will first undertake an impact assessment and identify the likely impact of the variation including those Individual Schemes and Service Contracts likely to be affected;

13.6.2 the Partners will agree any action to be taken because of the proposed variation. This shall include consideration of:

13.5.2.1 governance and decision-making arrangements;

13.5.2.2 oversight and assurance arrangements;

13.5.2.3 contracting arrangements; and/or

13.5.2.4 whether the proposed variation could have an impact on a Commissioning Team and/or any Staff;

13.6.3 wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and

13.6.4 should this not be possible, and one Partner is left financially disadvantaged because of the proposed variation, then the financial risk will, unless otherwise agreed, be apportioned according to the financial risk share arrangement detailed in Schedule 4.

14. DATA PROTECTION

14.1 The Partners must ensure that all Personal Data processed by or on behalf of them while carrying out the Joint Working Arrangements is processed in accordance with the relevant Partner's obligations under Data Protection Legislation and Data Guidance, and the Partners must assist each other as necessary to enable each other to comply with these obligations.

14.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a need-to-know basis. If any Partner:

14.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted, or unusable; or

14.2.2 becomes aware of any security breach,

in respect of the Relevant Information, it shall promptly notify the relevant Partners and NHS England. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.

14.3 In processing any Relevant Information further to this Agreement, each Partner shall at all times comply with their own policies and any NHS England policies and guidance on the handling of data.

14.4 Any information governance breach must be responded to in accordance with the Information Governance Guidance for Serious Incidents. If any Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant Partner must fully inform the other Partners of the information governance breach. This clause does not require the relevant Partner to provide information which identifies any individual affected by the information governance breach were doing so would breach Data Protection Legislation.

14.5 Whether or not a Partner is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Partners acknowledge that a Partner may act as both a Data Controller and a Data Processor.

14.6 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of

Law, including the Data Protection Legislation in respect of any Personal Data.

14.7 Other than in compliance with judicial, administrative, governmental, or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any third parties save as agreed by the Partners in writing.

14.8 Schedule 5 *(Further Information Governance and Sharing Provisions)* makes further provision about information sharing and information governance.

15. IT INTER-OPERABILITY

15.1 The Partners will work together to ensure that all relevant IT systems operated by the Partners in respect of the Joint Working Arrangements are inter-operable and that data may be transferred between systems securely, easily and efficiently.

15.2 The Partners will each use reasonable endeavours to help develop initiatives to further this aim.

16. FURTHER ARRANGEMENTS

16.1 The Partners must give due consideration to whether any of the Commissioning Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

17. FREEDOM OF INFORMATION

17.1 Each Partner acknowledges that the others are a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

17.2 Each Partner may be statutorily required to disclose further information about the Agreement and the FOIA or EIA Information in response to a specific request under FOIA or EIR, in which case:

17.2.1 each Partner shall provide the other Partners with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

17.2.2 each Partner shall consult the other Partners as relevant regarding the possible application of exemptions in relation to the FOIA or EIA Information requested; and

17.2.3 each Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the Partner to whom the request is addressed.

17.3 The commissioning team will respond to all FOIA requests on behalf of Partners as part of the administrative responsibility set out in Schedule 6 (Commissioning Team Agreement and Standard Operating Framework).

18. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

18.1 The Partners must ensure that, in delivering the Joint Working Arrangements, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

18.2 Each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Joint Working Arrangements. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.

19. CONFIDENTIALITY

19.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Partner and the receiving Partner has no right to use it.

19.2 Subject to Clause 19.3, the receiving Partner agrees:

19.2.1 to use the disclosing Partner's Confidential Information only in connection with the receiving Partner's performance under this Agreement;

19.2.2 not to disclose the disclosing Partner's Confidential Information to any third party or to use it to the detriment of the disclosing Partner; and

19.2.3 to maintain the confidentiality of the disclosing Partner's Confidential Information.

19.3 The receiving Partner may disclose the disclosing Partner's Confidential Information:

19.3.1 in connection with any Dispute Resolution Procedure;

19.3.2 to comply with the Law;

19.3.3 to any appropriate Regulatory or Supervisory Body;

19.3.4 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Partner's duty under Clause 19.2;

19.3.5 to NHS bodies for the purposes of carrying out their functions; and

19.3.6 as permitted under any other express arrangement or other provision of this Agreement.

19.4 The obligations in Clause 19 will not apply to any Confidential Information which:

19.4.1 is in or comes into the public domain other than by breach of this Agreement;

19.4.2 the receiving Partner can show by its records was in its possession before it received it from the disclosing Partner; or

19.4.3 the receiving Partner can prove it obtained or was able to obtain from a source other than the disclosing Partner without breaching any obligation of confidence.

19.5 This Clause 19 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.

19.6 This Clause 19 will survive the termination of this Agreement for any reason for a period of five (5) years.

19.7 This Clause 19 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

20. LIABILITIES

20.1 Subject to Clause 20.2, and 20.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement (including a Loss arising under an Individual Scheme) as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement then the Other Partner shall be liable to the First Partner for that Loss.

20.2 Clause 20.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner. Clause 20.1 shall not apply in respect of Loss where an alternative arrangement has been agreed by the Partners and set out in the relevant Scheme Specification.

20.3 If any third party makes a Claim or intimates an intention to make a Claim against any Partner, which may reasonably be considered as likely to give rise to liability under this Clause 20, the Partner that may have a Claim against the Other Partner will:

20.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant Claim;

20.3.2 not make any admission of liability, agreement, or compromise in relation to the relevant Claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed); and

20.3.3 give the Other Partner and its professional advisers reasonable access to its premises and Staff and to any relevant assets, accounts, documents and records within its power or control so as to enable the Other Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant Claim.

20.4 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a Claim against the other pursuant to this Agreement.

20.5 Unless expressly agreed otherwise, nothing in this Agreement shall affect:

20.5.1 the liability of NHS England to any person in respect of NHS England's Commissioning Functions; or

20.5.2 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.

20.6 Each ICB must:

20.6.1 comply with any requirements set out in the Delegation Agreement in respect of Claims and any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims;

20.6.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify the other Partners and send each relevant Partner all copies of such correspondence; and

20.6.3 co-operate fully with each relevant Partner in relation to such Claim and the conduct of such Claim.

21. DISPUTE RESOLUTION

21.1 Where any dispute arises between the ICBs in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute.

21.2 Where any dispute is not resolved under Clause 21.1 on an informal basis, any Authorised Officer may convene a special meeting of the Partners to attempt to resolve the dispute.

22. BREACHES OF THE AGREEMENT

22.1 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 21 (*Dispute Resolution*).

22.2 Without prejudice to Clause 22.1, if any Partner does not comply with the terms of this Agreement (including if any Partner exceeds its authority under this Agreement), the other Partners may at their discretion agree to:

22.2.1 waive their rights in relation to such non-compliance;

22.2.2 ratify any decision;

22.2.3 terminate this Agreement in accordance with Clause 23 *(Termination and Default)* below; or

22.2.4 exercise the Dispute Resolution Procedure in accordance with Clause 21 *(Dispute Resolution).*

23. TERMINATION AND DEFAULT

23.1 If an ICB wishes to end its participation in this Agreement, the relevant ICB must provide at least six (6) months' notice to the other Partners of its intention to end its participation in this Agreement and must have given prior notification to NHS England. Such notification shall only take effect from the end of 31 March in any calendar year and shall only take effect where alternative arrangements for the provision of the Delegated Services and effective exercise of the Delegated Functions are in place for the period immediately following termination.

23.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that each Partner is assured that the relevant Services will continue to be appropriately commissioned.

23.3 The ICBs will work together to ensure that there are suitable alternative arrangements in place in relation to the Services.

24. CONSEQUENCES OF TERMINATION

24.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:

24.1.1 the Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the Partners and third parties, to minimise costs and liabilities of each Partner in doing so;

24.1.2 where there are Commissioning Team arrangements in place the Partners shall discuss and agree arrangements for the Staff and any financial arrangements;

24.1.3 where a Partner has entered a Service Contract in exercise of the Functions of any other Partner which continues after the termination of this Agreement, all Partners shall continue to provide necessary funding in accordance with the agreed contribution for that Service prior to termination and will enter all appropriate legal documentation required in respect of this;

24.1.4 where there are Lead Commissioning Arrangements in place, the Lead Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the Service Contract) where the other Partner requests the same in writing provided that the Lead Partner shall not be required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.5 where there are Joint Commissioning Arrangements in place, the Partners shall co-operate with each other as reasonably necessary to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place any Partner in breach of the Service Contract) where a Partner requests the same in writing provided that no Partner shall be

required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.6 where a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions and provided that the Service Contract allows, the other Partner may request that the Lead Partner assigns the Service Contract in whole or part upon the same terms as the original contract; and

24.1.7 termination of this Agreement shall have no effect on the liability, rights or remedies of any Partner already accrued, prior to the date upon which such termination takes effect.

24.2 The provisions of Clauses 14 (*Data Protection*), 1717 (*Freedom of Information*), 19 (*Confidentiality*), 20 (*Liabilities*) and 24 (*Consequences of Termination*) shall survive termination or expiry of this Agreement.

25. PUBLICITY

25.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement, the Joint Working Arrangements or any Services provided under the Joint Working Arrangements.

26. EXCLUSION OF PARTNERSHIP OR AGENCY

26.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners.

26.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

27. THIRD PARTY RIGHTS

27.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

28. NOTICES

28.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

28.2 Notices by email will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

29. ASSIGNMENT AND SUBCONTRACTING

29.1 This Agreement, and any rights and conditions contained in it, may not be assigned or transferred by a Partner, without the prior written consent of the other Partners, except to any statutory successor to the relevant Commissioning Function.

30. SEVERABILITY

30.1 If any term, condition, or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

31. WAIVER

31.1 No failure or delay by a Partner to exercise any right or remedy provided under this Agreement or by Law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

32. STATUS

32.1 The Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

33. ENTIRE AGREEMENT

33.1 This Agreement constitutes the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

34. GOVERNING LAW AND JURISDICTION

34.1 Subject to the provisions of Clause 21 (*Dispute Resolution*) and Clause 32 (*Status*), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

35. FAIR DEALINGS

35.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of any Partner and that, if in the course of the performance of this Agreement, unfairness to any Partner does or may result, then the Relevant Partner(s) shall use reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

36. COUNTERPARTS

36.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the Commencement Date

SIGNED by John Turner .....

for and on behalf of NHS Lincolnshire Integrated Care Board (Signature)

.....

(Date)

SIGNED by Amanda Sullivan .....

for and on behalf of NHS Nottingham & Nottinghamshire Integrated Care Board (Signature)

.....

(Date)

SIGNED by Dr Caroline Trevithick .....

for and on behalf of NHS Leicester, Leicestershire & Rutland Integrated Care Board (Signature)

.....

(Date)

SIGNED by Toby Sanders .....

for and on behalf of NHS Northamptonshire Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Chris Clayton .....

for and on behalf of NHS Derby & Derbyshire Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Philip Johns .....

for and on behalf of NHS Coventry & Warwickshire Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Mark Axcell .....

for and on behalf of NHS Black Country Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Simon Trickett .....

for and on behalf of NHS Herefordshire & Worcestershire Integrated Care Board

(Signature)

.....

(Date)

SIGNED by David Melbourne .....

for and on behalf of NHS Birmingham & Solihull Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Peter Axon .....

for and on behalf of NHS Staffordshire & Stoke-on-Trent Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Simon Whitehouse .....

for and on behalf of NHS Shropshire, Telford & Wrekin Integrated Care Board (Signature)

.....

(Date)

SIGNED by Roz Lindridge .....

For and on behalf of NHS England (Signature)

.....

(Date

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

1. In this Agreement, unless the context otherwise requires, the following words and expressions shall have the following meanings:

“Agreement"	means this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
“Aligned Commissioning Arrangements”	means the arrangements by which the Partners agree to commission a Service in a co-ordinated and collaborative manner. For the avoidance of doubt, an aligned commissioning arrangement does not involve the delegation of any functions between ICBs;
“Annual Review”	means the annual review of the arrangements under this Agreement by the Partners;
“Area”	means the geographical area covered by the ICBs;
"Authorised Officer"	the individual(s) appointed as Authorised Officer in accordance with the agreed Terms of Reference;
“Claim”	means for or in relation to the Commissioning Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal, or the Secretary of State, any governmental, regulatory, or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
“Clinical Commissioning Policies”	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure, or intervention for patients with a condition requiring a specialised service;
“Clinical Reference Groups”	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
“Collaborative Commissioning Agreement”	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commencement Date"	[means 1 April 2024];
"Commissioning Functions"	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
“Commissioning Team”	means a staffing arrangement for commissioning agreed Services through an integrated team structure. This can be either set up using: . Lead Commissioning (one Partner hosts the Unit as Lead and all functions are delegated to that Partner); or . Joint Commissioning or Aligned Commissioning (one Partner may host but no functions are delegated). The Partners will need to agree whether decisions are taken via a Joint Commissioning

arrangement such as a Joint Committee or whether each Partner is required to take decisions;

"Confidential Information"	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or Joint Working Arrangements made pursuant to it and: i. which comprises Personal Data or which relates to any patient or his treatment or medical history; ii. the release of which is likely to prejudice the commercial interests of a Partner; or iii. which is a trade secret;
"Contracting Standard Operating Procedure"	means any contracting standard operating procedure produced by NHS England in respect of the Delegated Specialised Services;
"Data Controller"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Sharing Agreement"	means any data sharing agreement entered in accordance with Schedule 5 (*Further Information Governance and Sharing Provisions*);
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy, or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency, and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of Personal Data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Security and Protection Toolkit"	means the toolkit at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit or as amended or replaced from time to time
"**Delegated Commissioning Group**" **"DCG"**	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;

“Delegation Agreement(s)”	means the Delegation Agreements under which NHS England delegate specific NHS England Specialised Services Commissioning Functions to each ICB;
“Delegated Functions”	means the Specialised Services Commissioning Functions of NHS England delegated to each ICB under a Delegation Agreement;
“Delegated Services”	means those Specialised Services commissioned in exercise of the Delegated Functions;
"Dispute Resolution Procedure"	the procedure set out in Clause 21 (*Dispute Resolution*);
“EIR”	means the Environmental Information Regulations 2004;
“Finance Guidance”	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following: • Commissioning Change Management Business Rules; • Contracting Standard Operating Procedure; • Cashflow Standard Operating Procedure; • Finance and Accounting Standard Operating Procedure; • Service Level Framework Guidance;
“Flexibilities”	Mean the flexibilities that the Partners may use to work in a co-ordinated manner as set out at Clause 3 (*Scope of the Arrangements*);
“Financial Contribution”	means the financial contributions agreed by each Partner in respect of an Individual Scheme in any Financial Year;
“Financial Year”	means each financial year running from 1 April in any year to 31 March in the following calendar year;
"FOIA"	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
"FOIA or EIR Information"	has the meaning given under section 84 of FOIA or the meaning given for “environmental information” under the EIR as applicable;
“Good Practice”	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
“Governance Arrangements”	means the governance arrangements in respect of the Arrangements agreed by the Partners and as set out in Schedule 2 (*Governance Arrangements*);
“Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Partners have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body;
“High-Cost Drugs”	means medicines not reimbursed though national prices and identified on the NHS England high-cost drugs list;

"ICB Reserved Functions"	Where there is any delegation of an ICB's Commissioning Functions or further delegation of Delegated Functions, those functions that remain reserved to each ICB;
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Individual Scheme"	means an arrangement in relation to how the ICBs will work together using one or more of the Flexibilities which has been agreed by the Partners to be included within this Agreement as part of the Joint Working Arrangements;
"Joint Committee"	means the joint committee(s) established by the partners that perform functions under this Agreement on the terms set out in their Terms of Reference;
"Joint Functions"	any Functions that are delegated to a Joint Committee;
"Joint Commissioning"	means Partners agreeing to jointly exercise agreed Commissioning Functions on behalf of each other in exercise of the functions of each Partner part of that Individual Scheme. This may, for example, be through agreeing to enter into the same contract or by use of a Joint Committee;
"Joint Working Arrangements"	means the Flexibilities that the Partners have agreed to use to work in a co-ordinated manner which, at the Commencement Date, are as set out in Clause 3;
"Law"	means: i. any statute or proclamation or any delegated or subordinate legislation; i. any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and i. any judgment of a relevant court of law which is a binding precedent in England;
"Lead Commissioning Arrangements"	means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of another Partner or Partners in exercise of the Commissioning Functions of the ICB Partners;
"Lead Partner"	means the Partner responsible for commissioning under a Lead Commissioning Arrangement;
"Loss"	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
"Managing Conflicts of Interest in the NHS"	means the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ or such publication that amends or replaces that publication;

"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of Delegated Functions and issued by NHS England from time to time as mandatory;
"National Standards"	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHS England in respect of Specialised Services;
"Need to Know"	has the meaning set out in Schedule 5 *(Further Information Governance and Sharing Provisions)*;
"NHS Act"	the National Health Service Act 2006;
"NHS England Functions"	NHS England's Commissioning Functions exercisable under or by virtue of the NHS Act;
"NHS England Reserved Functions"	those aspects of the Specialised Commissioning Functions for which NHS England retains commissioning responsibility;
"Non-Personal Data"	means data which is not Personal Data;
"Non-Pooled Funds"	means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification;
"Operational Days"	means a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
"Partners"	means the parties to this Agreement;
"Personal Data"	has the meaning set out in the Data Protection Legislation;
"Pooled Funds"	means any pooled fund established and maintained by the Partners as a pooled fund;
"Population"	means the population for which an ICB or all the ICBs have the responsibility for commissioning health services;
"Provider Collaborative"	means a group of Providers who have agreed to work together to improve the care pathway for one or more Services;
"Provider Collaborative Arrangements"	means the arrangements entered in respect of a Provider Collaborative;
"Provider Collaborative Guidance"	means any guidance published by NHS England in respect of Provider Collaboratives;
"Regional Quality Group"	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify, and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards, or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: i. CQC;

ii. NHS England;

iii. the Department of Health and Social Care;

iv. NICE;

v. Healthwatch England and Local Healthwatch;

vi. the General Medical Council;

vii. the General Dental Council;

viii. the General Optical Council;

ix. the General Pharmaceutical Council;

x. the Healthcare Safety Investigation Branch; and

xi. the Information Commissioner;

"Relevant Information"	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
"Reserved Functions"	means NHS England Reserved Functions or ICB Reserved Functions;
"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out the Delegation Agreement;
"Risk Sharing"	means an agreed arrangement for risk and benefit sharing between the Partners;
"Scheme Specification"	means a specification setting out the Joint Working Arrangements in respect of an Individual Scheme agreed by the Partners to be commissioned under this Agreement;
"Services"	means such health services as agreed from time to time by the Partners as commissioned under the Joint Working Arrangements and more specifically defined in each Scheme Specification;
"Service Contract"	means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of Services in accordance with the relevant Individual Scheme
"Single Point of Contact"	the member of Staff appointed by each relevant Partner in accordance with Paragraph 13 of Schedule 5 *(Further Information Governance and Sharing Provisions)*
"Special Category Personal Data"	has the meaning set out in the Data Protection Legislation;
"Specialised Commissioning Budget"	means the budget identified by NHS England in respect of each ICB for the purpose of exercising the Delegated Functions;

"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Working Arrangements as specified in Schedule 5 *(Further Information Governance and Sharing Provisions)* to this Agreement;
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;
"Specialised Services Contract"	means a contract for the provision of Specialised Services entered in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	means a provider party to a Specialised Services Contract;
"Staff"	means the Partners' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"Standard Operating Framework"	means the agreement(s) that sets out the arrangements for a Commissioning Team;
"Terms of Reference"	means the Terms of Reference for the Joint Committee agreed between the Partners at the first meeting of the Joint Committee;
"Triple Aim"	means the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to: i. the health and well-being of the people of England; ii. the quality of services provided to individuals by the NHS; iii. efficiency and sustainability in relation to the use of resources by the NHS;
"Underspend"	means any expenditure from a Pooled Fund or Non-Pooled Fund in a Financial Year which is less than the value of the agreed contributions by the Partners for that Financial Year;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018.

2. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

3. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are Clauses in this Agreement.

4. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.

5. References to a person or body shall not be restricted to natural persons and shall include a company, corporation, or organisation.

6. Words importing the singular number only shall include the plural.

7. Use of the masculine includes the feminine and all other genders.

8. Where anything in this Agreement requires the mutual agreement of the Partners, then unless the context otherwise provides, such agreement must be in writing.

9. Any reference to the Partners shall include their respective statutory successors, employees and agents.

10. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

11. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2: GOVERNANCE ARRANGEMENTS

1. Joint Committees

1.1. The overall oversight and governance arrangements for these collaborative working arrangements will be discharged through the Joint Committees established by the ICBs through Joint Working Agreements between NHS Lincolnshire Integrated Care Board, NHS Nottingham and Nottinghamshire Integrated Care Board, NHS Leicester, Leicestershire and Rutland Integrated Care Board, NHS Northamptonshire Integrated Care Board and NHS Derby and Derbyshire Integrated Care Board (the "East Midlands ICBs") and NHS Birmingham and Solihull Integrated Care Board, NHS Black Country Integrated Care Board, NHS Coventry and Warwickshire Integrated Care Board, NHS Herefordshire and Worcestershire Integrated Care Board, NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire and Stoke-on-Trent Integrated Care Board (the "West Midlands ICBs")

1.2. The Terms of Reference and other detailed arrangements that support the operation of the Joint Committees are detailed in the Joint Working Agreements between the East and West ICBs. They set out that the two Joint Committees will have delegated authority on behalf of the East and West ICBs respectively to discharge the functions delegated to the ICBs by NHS England in respect of Specialised Services, including establishing appropriate subsidiary arrangements to enable effective decision-making and detailed oversight of performance, finance, and quality.

1.3. In recognition that effective collaboration may require aligned decisions from all the partners, the Joint Committees may consider meeting 'in common' where this is appropriate and will ensure that decisions by either the East or West Joint Committee that impact on the other are made having taken relevant views from the other committee into account.

1.4. The NHS England regional team will continue to work jointly with the Joint Committees on the commissioning of retained specialised services. This will include, where appropriate, discharging its authority (through accountable directors) in consultation with the Joint Committees.

1.5. The subsidiary arrangements established by the Joint Committees will include appropriate schemes of reservation and delegation in place to enable Sub-Groups of the Joint Committees and/or members of staff employed by Joint Commissioning Team to have the authority to make decisions. These arrangements will be developed in collaboration with NHS England to support effective working on both the delegated and retained services.

2. Joint Subgroups

2.1. There will be three joint subgroups established by the partners to support these arrangements, these being:

- **Midlands Acute Specialised Commissioning Group (MASCG)**
- **Specialised Commissioning Quality Group**
- **Finance and Contracting Group**

2.2. Subsidiary arrangements established by the Joint Committees will include providing delegated authority to **Midlands Acute Specialised Commissioning Group (MASCG)** a Joint Sub-Group established by all the partners to make decisions on both the delegated and retained services.

2.3. The role of MASCG will be to support the partners and the Joint Committees in ensuring that the delivery of the delegated and retained services is effective, efficient, and economical and in line with each partner's statutory responsibilities.

2.4. MASCG will report and make recommendations to the Joint Committees in respect of delegated services and to Midlands Commissioning Group in respect of the retained services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1 of this schedule) and the relevant schemes of reservation and delegation and standing financial instructions for delegated and retained services.

2.5. Each of the partners will appoint a member of MASCG who is authorised to act as part of the group and participate in collective decision making on behalf of their organisation. MASCG will also ensure that its decisions are taken with the advice of suitable subject matter experts.

2.6. **Specialised Commissioning Quality Group –** This group, chaired by the Regional Medical Director for Commissioning (RMDC) will provide a forum to share and discuss potential and known issues which impact on the quality and safety of Acute Specialised Commissioned services in the Midlands region and agree any remedial action.

2.7. The purpose of the Specialised Commissioning Quality Group is to provide a forum for routinely and systematically bringing together partners from across ICSs and the region to share insight and intelligence in relation to quality concerns, to identify opportunities for improvement and to develop regional responses as required. The focus of the discussions will be on intelligence, learning, issues and risks that are recurrent and/ or have an impact wider than individual ICSs.

2.9 **Finance and Contracting Subgroup** – will have responsibility to oversee the management of the pooled fund on behalf of the Joint Committees.

2.10 The purpose of the Finance and Contracting Subgroup is to provide robust joint financial management of the pooled fund on behalf of the ICBs in line with the terms set out in schedule 4 of this agreement.

Subgroups reporting to East and West Joint Committees

3. Clinical Governance

3.1. The ICBs will access the clinical, pharmaceutical, and quality governance functions provided by the Midlands Commissioning Multidisciplinary Team via the

Commissioning Team Arrangements and Standard Operating Framework.

3.2. Clinical engagement and leadership will be secured at multiple tiers across the Midlands region and will draw upon established clinical networks including those formally commissioned plus the informal networks that have been recognised over time.

3.3. The Specialised Services Operational Delivery Networks (ODNs) will continue to be formally commissioned by NHS England. NHS England will retain the financial responsibility for the ODNs and will continue to play a key role in supporting understanding of clinical quality for the relevant services.

3.4. At a senior clinical level, the Collaborative Clinical Executive Forum (CCEF), a regional forum of Acute Provider and ICB Chief Medical Officers (CMOs), will continue to meet regularly and engage with the Midlands Commissioning Team. Advice offered via that forum will feed into the decision -making process via the Midlands Acute Specialised Commissioning Group (MASCG) and into the Joint Committees.

3.5. The Commissiong Team will retain Medical Director, Pharmacy and Nursing roles which will provide a vital conduit to local systems and the national clinical leadership architecture.

3.6. Governance and decision-making for high-cost drugs assurance will be via Joint Committees and their sub-groups, with links to the Regional Pharmacy Leadership Board. The pharmacy team for High Costs Drugs will work across ICBs and NHS England informed by other senior pharmacists across the region e.g., HCD pharmacists, regional cancer pharmacists,

3.7. High-cost tariff excluded drugs will continue to be reimbursed through a national process by NHS England irrespective of whether they are used for delegated services, meaning that ICBs will not bear the financial risk of new specialised drugs growth.

4. Quality Governance

4.1. Key quality concerns requiring escalation relating to the Joint Services will be reported monthly to the Joint Committees by the Specialised Commissioning Quality Group. Furthermore, key quality concerns for specialised services will continue to be reported to and discussed at the NHSE led Regional Quality Group, of which all ICBs are members. These groups will ensure key quality concerns are fed back into systems to inform conversations at a local level.

4.2. Key quality concerns involving specialised services will also be reported into Midlands Acute Specialised Commissioning Group (MASCG) of which all 11 Midlands ICBs are members and have representation. Specialised Commissioning Quality Group will provide a forum for delegated decision making, including on quality matters.

4.3. To be proactive on identification of areas for quality improvement, a Quality Surveillance and Improvement Programme (QSIP) has been established to support implementation of the NHSE Midlands Acute Specialised Commissioning Quality Surveillance & Improvement Framework (QSIF). The QSIP aims to provide strategic direction and support implementation of the Quality Surveillance and Improvement Framework QSIF and will agree priorities for the Programme in addition to evaluating risks related to the Programme and to devise and implement mitigations and remedial action. The QSIF involves triangulating intelligence and data from several sources (e.g., CQC reports, specialised services dashboards, national audit etc) to monitor the

quality of each service. This work is overseen by the QSIP Programme Board, has ICB representation, is chaired by the RMDC and reports to MASCG.

4.4. The Joint Committees will also agree a comprehensive Quality Assurance Framework which will provide a high-level description of the proposed overarching governance arrangements including for quality assurance in the Midlands region in terms of how decisions are made; outline reporting flows; where assurances will be sought, and the structures put in place to ensure that NHSE and ICB's act within their powers and discharge their responsibilities correctly and appropriately.

5. Financial Governance

5.1 The Financial governance arrangements in Schedule 4 shall apply to the Collaborative Arrangements.

5.7 **Risk Management Arrangements** - In line with their overall role to provide strategic decision-making, leadership, and oversight for the joint services the Joint Committee will establish a monitoring and management in relation to risk and issue management and escalation, and co-ordinating the approach to intervention with providers where there are quality or contractual issues. This will include feeding back to individual ICBs for consideration of any impact on their own risk management arrangements.

5.8 A formal risk register will be maintained by the Midlands Commissioning Team and reported monthly through the Midlands Acute Specialised Commissioning Group to ensure ICBs are aware of any risks they may impact their systems.

6. Assurance arrangements

6.1. The Joint Committees will be responsible for ensuring that the ICBs are able to meet their obligations under the NHSE Oversight and Assurance Framework in relation to the delegation of specialised services which, requires that the ICBs must at all times operate in accordance with:

(a) the Oversight and Assurance Framework published by NHS England;

(b) any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements; and

(c) any other relevant NHS oversight and assurance guidance;

collectively known as the "Assurance Processes".

And that the ICBs must:

(a) Develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes.

(b) Oversee the provision of Delegated Services and the outcomes being delivered for their patients and Populations in accordance with the Assurance Processes.

(c) Assure Providers are meeting, or have an improvement plan in place to meet, National Standards.

(d) Provide any information and comply with specific actions in relation to the Delegated Specialised Services, as required by NHS England,

including metrics and detailed reporting in accordance with the Terms of Reference.

Appendix 1 – MASCG Terms of Reference

Document name:		Midlands Acute Specialised Commissioning (MASC) Group/ Terms of Reference	
Senior Responsible Owner (SRO):		Alison Kemp	
Lead:		Jon Currington	
Author:		Mel Harris, Peter McKenzie	
Version	1.5	**Date:**	[Publish Date]

Document management

Revision history

Version	Date	Summary of changes
0.1	28/02/23	Initial template
0.2	08/03/23	Incorporating JC/MD edits
1.0	02/08/23	Updated by JC to include financial limits as requested by Joint Committees and non-material amendments for clarity and consistency.
1.1	30/01/24	Amendments to align with ICB Collaboration Agreement for 2024/25
1.2	02/02/24	JM review and update
1.3	05/02/24	JM review and Update
1.4	06/02/24	PMcK review and update including JC Feedback
1.5	21/02/24	Version for approval in Collaboration Agreement

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Matt Day		Regional Director Specialised Commissioning and Health and Justice		0.2
Formal Midlands Acute Specialised Commissioning Group	Approved		17/03/23	0.2
Delegation Governance Working Group				0.2
East Midlands Joint Committee	Approved		20/06/23	0.3
West Midlands Joint Committee	Approved		14/07/23	0.3
Midlands Commissioning Group				0.3

Related documents

Title	Owner	Location
ICB Collaboration Agreement for Specialised Services	NHSE & 11 Midlands ICBs	
East Midlands Joint Committee Terms of Reference	NHSE & 5 EM ICBs	
West Midlands Joint Committee Terms of Reference	NHSE & 6 WM ICBs	

Document control

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Midlands Acute Specialised Commissioning Group (MASCG) Terms of Reference 2024/25	
Introduction and purpose	From April 2024, NHS England delegated responsibility to the eleven Integrated Care Boards ("the ICBs") in the Midlands region for commissioning 59 Prescribed Specialised Services (the "delegated services"). To discharge these duties the ICBs and NHS England have developed a collaboration agreement that sets out that the individual ICBs will delegate responsibilities to the existing East and West Joint Committees (JC) established under the Joint Working Agreements between the ICBs. The two JCs are defined as Tier I Bodies and their responsibilities for the delegated services are set out in their Terms of Reference. NHS England will continue to be responsible for other Prescribed Specialised services, including 29 services designated as suitable but not yet ready for delegation to the ICBs (the "retained services") and will seek input from the ICBs into the commissioning of Retained Specialised Services. NHS England will continue to have budgetary responsibility and holds accountability and responsibility for high-cost drugs within specialised services. NHSE and ICBs will collaborate in the commissioning of high-cost drugs via joint working arrangements. The Collaboration Agreement sets out that the ICBs and NHSE will establish the Midlands Acute Specialised Commissioning Group (MASCG) as a Joint Sub-group to support the JCs and NHSE in the effective and efficient commissioning of both the delegated and retained services. MASCG will have delegated decision-making authority from both JCs and NHS England and will provide joint oversight for the commissioning of all Prescribed Acute Specialised Services for the population of the Midlands.
The Terms of Reference	These Terms of Reference are intended to support effective collaboration between NHS England and ICBs acting through MASCG. They set out the roles, responsibilities, membership, decision-making powers, and reporting arrangements of the MASCG in accordance with the Collaboration Agreement. The MASCG will operate under the limitations of the delegated authority given to it by the East and West Joint Committees (for the delegated services) and NHS England Standing Financial Instructions (SFI) (for the retained service) . This will include authority to make decisions of a value up to £2.5 Million for contract variations and extensions for directly commissioned healthcare services and up to £2.5 million for clinical

	and non-clinical business cases. Values above this will be referred upwards to the JCs and/or authorised decision makers in NHS England as appropriate.
Role of the Group	The role of the MASCG is to support the JCs and NHS England in discharging their duties with respect to prescribed specialised services safely, effectively, efficiently and economically. The MASCG will achieve this through: • Determining the appropriate structure of the MASCG; ▪ Making decisions in relation to the planning and commissioning of delegated and retained specialised services and working collaboratively on any associated commissioning or statutory functions, for the population within the scope of the agreed authority for the group; ▪ Making recommendations to the Joint Committees and NHS England as appropriate in relation to decisions required for delegated and retained specialised services that fall outside the scope of the agreed authority for the group; ▪ Making recommendations on the population-based financial allocation and financial plans for delegated and retained Specialised Services to the Joint Committees and NHS England as appropriate; ▪ Oversight and assurance of all specialised services, either directly or through Tier 3 sub-groups, in relation to quality, operational and financial performance, including co-ordinating risk and issue management and escalation, and developing the approach to intervention with specialised services providers where there are quality or contractual issues and escalating these issues to the Joint Committees and NHS England when required; ▪ Identifying and setting strategic priorities and undertaking ongoing assessment and review of joint specialised services within the remit of the Group and consistent with national, regional and ICS plans, including tackling unequal outcomes and access; ▪ Supporting the development of partnership and integration arrangements with other health and care bodies in relation to all specilaised services including Provider Collaboratives and the Cancer Alliances, and working closely across regional footprints, where there are cross-border patient flows to providers; ▪ Engaging effectively with stakeholders, including patients and the public, and involving them in decision-making; ▪ Obtaining appropriate clinical advice and leadership, including through Clinical Reference Groups and relevant Clinical Networks;

	▪ Linking in with the NHS England National team in order to implement policies, initiatives and service specifications; ▪ Supporting longer-term planning for both delegated and retained services; and ▪ Discussing any matter which any member of the Group believes to be of such importance that it should be brought to the attention of the Group. The Group must adhere to these Terms of Reference but may otherwise regulate its own procedures.
Accountability and reporting	The MASCG is a joint sub-group, established in line with the Collaboration Agreement between the eleven Midlands ICBs and NHS England and is formally accountable to the JCs for delegated services and to the NHS England Midlands Commissioning Group (MCG) for retained services. It will report to the Joint Committees and the MCG after each meeting and make recommendations and escalate issues when required.
Membership	The core membership of the MASCG will comprise one representative of each of the eleven ICBs, nominated by the respective Chief Executive Officer with authority to participate in the collective decision-making of the Group on behalf of their organisation and the Regional Director of Specialised Commissioning, NHS England Midlands. A named substitute may be nominated to attend if a core member of the MASCG is unavailable or unable to attend or because they are conflicted. Core members must ensure that their substitute is fully authorised to act on their behalf. The MASCG will be supported by the NHS England Midlands Acute Specialised Commissioning (MASC) Team including: • Chief Medical Officer for Commissioning • Head of Acute Specialised Commissioning • Deputy Director of Nursing and Quality • Heads of Finance • Regional Pharmacy Lead • Consultants in Public Health • Head of Business Intelligence • Head of Planning • Acute Commissioning Leads Subject matter experts will also support the MASCG from core ICB functions including the offices of the Chief Medical Officers, Chief Nursing Officers and Chief Finance Officers. During 2024/25 (until transfer of staff) this will include nominated ICB Quality and Finance leads on behalf of all the ICBs of the West (6) and the East (5) whose role will be to provide a liaison between MASCG and the Finance and

	Quality sub-groups established to support Joint Commissioning arrangements. The ICBs will agree who will attend the Group, which Include members of the Clinical Collaboration Forum from these functions, and they will be invited on a standing basis. Individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the MASC Group's work at the discretion of the Chair. A list of the members will be made available.
Chair	MASCG will be co-chaired by the Regional Director, Specialised Commissioning, NHS England Midlands and an ICB representative elected from the core membership. The co-chairs will arrange cover in their absence.
Meetings	MASCG shall meet monthly with arrangements to meet face-to-face and virtually. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the MASCG shall prepare a of meetings and work programme for the forthcoming year.
Quorum	The MASCG shall be quorate if the Chair, or their nominated deputy is present together with representation from the ICBs from the Joint Committee that any decisions on the agenda relate to. In urgent circumstances, consideration will be given by the Chair to make decisions which significantly impact an ICB or ICBs not present subject to confirmation of support of the relevant ICB or ICBs outside of the meeting. These situations, together with the outcome will be formally recorded in the minutes.
Decisions and voting arrangements	The decision-making arrangements for the Group will be in line with the delegated authority provided to it by the Joint Committees and NHS England. Items for decision will clearly indicate the source of the authority for the decision which will determine which members will be eligible to participate in the decision-making for that item: - • For items on behalf of the East Midlands Joint Committee this will be the core representatives from Derby and Derbyshire, Leicester, Leicestershire and Rutland, Lincolnshire, Nottingham and Nottinghamshire and Northamptonshire ICBs; • For items on behalf of the West Midlands Joint Committee this will be the Core representatives from Birmingham and Solihull, Black Country, Coventry and Warwickshire, Herefordshire and Worcestershire, Shropshire Telford and Wrekin and Staffordshire and Stoke-on-Trent ICBs;

	• For items on behalf of NHS England this will be the Regional Director Specialised Commissioning and Health and Justice in consultation with the other core members. Items for decision that impact more than one group of eligible members will be decided by all those eligible members. MASCG shall aim to make decisions by consensus of the eligible core membership wherever possible. Where this is not possible the Chair will check whether all the information is available to make a decision or if there are alternative options that may offer an acceptable solution. The core members must ensure that matters requiring a decision are anticipated, and that sufficient time is allowed prior to Group meetings for discussions and negotiations internally and between ICBs and other partners to take place. Where possible papers will be co-developed and jointly sponsored by NHS England and the ICBs. At the discretion of the Chair, where it is not possible to make a decision at the meeting decisions may be deferred to the next meeting or, with appropriate consultation with eligible core members, to take a decision outside of the meeting. Where it has not been possible, despite the best efforts of the core membership, to come to a consensus decision the Chair may decide that a decision may be escalated to the relevant Joint Committee or MCG as appropriate, supported by detail of the issues raised and further steps taken.
Conduct and conflicts of interest	Members of the MASCG will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct, Nolan Principles and relevant organisational policies. Where any core member of the MASCG or the MASC Team or observer has an actual or potential conflict of interest in relation to any matter under consideration by the MASC Group, that individual must declare that interest and take appropriate action to manage the conflict, which could include not participating in the discussion or voting at meetings (or parts of meetings) in which the relevant matter is discussed. The Chair will be responsible for making final decisions on the appropriate management of conflicts of interest.
Confidentiality of proceedings	All members in attendance at a MASCG are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the MASCG.
Publication of notices, minutes and papers	The MASC Multi-Disciplinary Team of NHS England shall provide sufficient resources, administration and secretarial support for the proper organisation and functioning of the Group.

	The co-chair(s) (or in the absence of the co-chairs, the person covering for them) shall see that notice of meetings of the MASCG, together with an agenda listing the business to be conducted and supporting documentation, is issued one week, (seven calendar days), prior to the date of the meeting. The proceedings and decisions taken by the MASCG shall be recorded in minutes, and those minutes circulated in draft form having been reviewed by the person who presided at the meeting within two weeks of the date of the meeting. The MASCG shall approve those minutes at its next meeting.
Review of the Terms of Reference	These Terms of Reference will be in place for the 2024/25 transitional year only. Updated Terms of Reference will be in place to reflect post April 2025 arrangements.

SCHEDULE 3: INDIVIDUAL SCHEMES

Part 1– East Midlands scheme

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE EAST MIDLANDS SCHEME FOR DELEGATED SPECIALISED SERVICES IN 2024/25

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the 59 specialised services delegated to the East Midlands Integrated Care Boards (ICBs) by NHS England on 1st April 2024.

1.2 The Partners' aims are:

(a) to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England has delegated the statutory function for the commissioning of the 59 delegated specialised services to the ICBs. The key powers and duties that the ICBs will be required to carry out in exercise of the delegated functions being, in summary:

(a) decisions in relation to the commissioning and management of the delegated services;

(b) planning delegated services for the population, including carrying out needs assessments;

(c) undertaking reviews of delegated services in respect of the population;

(d) supporting the management of the specialised commissioning budget for delegated services;

(e) co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate; and

(f) such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.2 A list of the delegated services included within the scheme are detailed within schedule 2 of the Delegation Agreement

2.3 The services are being provided to the populations within the East Midlands ICBs geographical footprints.

3 PARTNERS

3.1 The partners of this scheme are NHS England, Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB.

4 THE ARRANGEMENTS

4.1 The Scheme will be overseen by the East Midlands Joint Committee established via a Joint Working Agreement between the ICBs whose role shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified delegated specialised services as agreed by the partners and outlined in Schedule 2 of the ICB Collaboration Agreement.

4.2 Administrative and management functions will be provided to the multi-ICB by the Multidisciplinary Team, hosted in 2024-2025 by NHS England. Details of which are set out in an Commissioning Team Agreement and Standard Operating Framework between all parties.

4.3 Details of the financial arrangements relating to this scheme are contained with Schedule 4 of the ICB Collaboration Agreement.

5 GOVERNANCE ARRANGEMENTS

5.1 The scheme shall be governed by the East Midlands Joint Committee, as set out in Schedule 2 of the ICB Collaboration Agreement.

5.2 The terms of reference of the Joint Committee are set out in the Joint Working Agreement between the ICBs.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

Delegated services will be commissioned from providers on behalf of the ICBs by the Commissioning Team in line with legislative requirements and the NHS planning guidance 2024/25.

6.2 Contracting Arrangements

The list of contracts which are in place across the Midlands in 2023/24 for services due to be delegated in April 24 are contained in Appendix 1. These include;

- 26 x Main NHS Provider contracts
- 2 x Section 75 contracts (in collaboration with Northants & Lincs Local Authorities for HIV)

The scheme will be administered by the Commissioning Team, where;

- Each Midlands provider will have a contract for specialised services where NHSE is the co-ordinating commissioner and a separate contract for core ICB services where the ICB is the co-ordinating commissioner.
- On the specialised services contracts the ICBs will either be associate commissioners or receive service responsibilities via GC12.

6.2.1 The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.
- The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.

- The contracts will be funded in line with the pooled budget arrangements detailed in Schedule 4 of the ICB Collaboration Agreement.

- The contracts will be managed on behalf of the Midlands multi-ICB, by the Commissioning Team.

6.3 **Access**
The scheme will apply to all delegated specialised services provided via contracts with providers.

7. HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8. FINANCIAL GOVERNANCE ARRANGEMENTS

8.1. The financial governance arrangements are set out in Schedule 4 of the ICB Collaboration Agreement.

9. NON FINANCIAL RESOURCES

9.1. The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB Collaboration Agreement.

10. STAFF

10.1. The commissioning team responsible for the operational delivery of specialised commissioning for delegated services will be hosted by NHS England in 2024/25.

10.2. The arrangement through which the commissioning team will provide this support to the ICBs is set out Schedule 6 of the ICB Collaboration Agreement.

11. ASSURANCE AND MONITORING

11.1. The arrangements in relation to assurance and monitoring in relation to this scheme are contained Schedule 4 of the ICB Collaboration Agreement.

12. AUTHORISED OFFICERS

12.1. The authorised officers for this scheme are as follows:

Partner	**Name of Authorised Officer – Tier 1**
Lincolnshire ICB	John Turner
Nottingham & Nottinghamshire ICB	Amanda Sullivan
Leicester, Leicestershire & Rutland ICB	Dr Caroline Trevithick
Northamptonshire ICB	Toby Sanders
Derby & Derbyshire ICB	Dr Chris Clayton

Partner	Name of Authorised Officer – Tier 1
NHS England	Roz Lindridge

13. INTERNAL APPROVALS

13.1. The levels of authority relating to this scheme are described within Schedule 4 of the ICB Collaboration Agreement.

14. REGULATORY REQUIREMENTS

14.1. Details in relation to regulatory requirements in relation to this scheme are contained within the delegation agreement and will be fulfilled on behalf of the ICBs by the Commissioning Team.

15. COMPLAINTS

15.1. Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

15.2. A report summarising complaints, actions and lessons learnt will be provided to the East and West Board annually.

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Part 2 – West Midlands scheme

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE WEST MIDLANDS SCHEME FOR DELEGATED SPECIALISED SERVICES IN 2024/25

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the 59 specialised services delegated to the West Midlands Integrated Care Boards (ICBs) by NHS England on 1st April 2024.

1.2 The Partners' aims are:

(a) to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England delegates to the ICBs the statutory function for the commissioning of the 59 delegated specialised services. The key powers and duties that the ICBs will be required to carry out in exercise of the delegated functions being, in summary:

(a) decisions in relation to the commissioning and management of the delegated services;

(b) planning delegated services for the population, including carrying out needs assessments;

(c) undertaking reviews of delegated services in respect of the population;

(d) supporting the management of the specialised commissioning budget for delegated services;

(e) co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate; and

(f) such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.2 A list of the delegated services included within the scheme are detailed within schedule 2 of the Delegation Agreement

2.3 The services are being provided to the populations within the West Midlands ICBs geographical footprints.

2.4 There are currently no planned changes to the services in 2024/25.

3 PARTNERS

3.1 The partners to this scheme are as recorded in the main Collaboration Agreement.

3.2 The partners of this scheme are NHS England, The Black Country ICB, Staffordshire & Stoke ICB, Shropshire Telford & Wrekin ICB, Coventry and Warwickshire ICB, Herefordshire & Worcestershire ICB and Birmingham & Solihull ICB.

4 THE ARRANGEMENTS

4.1 The Scheme will be overseen by the West Midlands Joint Committee established via a Joint Working Agreement between the ICBs whose role shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified delegated specialised services as agreed by the partners and outlined in Schedule 2 of the ICB Collaboration Agreement.

4.2 Administrative and management functions will be provided to the multi-ICB by the Multidisciplinary Team, hosted in 2024-2025 by NHS England. Details of which are set out in a Commissioning Team Agreement and Standard Operating Framework between all parties.

4.3 Details of the financial arrangements relating to this scheme are contained with Schedule 4 of the ICB Collaboration Agreement.

5 GOVERNANCE ARRANGEMENTS

5.1 The scheme shall be governed by the West Midlands Joint Committee as set out in Schedule 2 of the ICB Collaboration Agreement.

5.2 The terms of reference of the Joint Committee are contained within the Joint Working Agreement between the ICBs.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

Delegated services will be commissioned from providers on behalf of the ICBs by the Commissioning Team in line with legislative requirements and the NHS planning guidance 2024/25.

6.2 Contracting Arrangements

The list of contracts which are in place across the Midlands in 2023/24 for services due to be delegated in April 24 are contained in Appendix 1. These include;

- 26 x Main NHS Provider contracts

The scheme will be administered by the Commissioning Team, where;

- Each Midlands provider will have a contract for specialised services where NHSE is the co-ordinating commissioner and a separate contract for core ICB services where the ICB is the co-ordinating commissioner.
- On the specialised services contracts the ICBs will either be associate commissioners or receive service responsibilities via GC12.

The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.

- The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.

- The contracts will be funded in line with the pooled budget arrangements detailed in Schedule 4 of the ICB Collaboration Agreement.

- The contracts will be managed on behalf of the Midlands multi-ICB, by the Commissioning Team.

6.3 **Access**
The scheme will apply to all delegated specialised services provided via contracts with providers.

7 HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

8.1 The financial governance arrangements are set out in Schedule 4 of the ICB Collaboration Agreement.

9 NON FINANCIAL RESOURCES

9.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB Collaboration Agreement.

10 STAFF

10.1 The commissioning team responsible for the operational delivery of specialised commissioning for delegated services will be hosted by NHS England in 2024/25.

10.2 The arrangement through which the commissioning team will provide this support to the ICBs is set out in Schedule 6 of the ICB Collaboration Agreement.

11 ASSURANCE AND MONITORING

11.1 The arrangements in relation to assurance and monitoring in relation to this scheme are contained Schedule 4 of the ICB Collaboration Agreement.

12 AUTHORISED OFFICERS

12.1 The authorised officers for this scheme are as follows:

Partner	**Name of Authorised Officer – Tier 1**
Coventry & Warwickshire ICB	Philip Johns
The Black Country ICB	Mark Axcell
Herefordshire & Worcestershire ICB	Simon Trickett
Birmingham & Solihull ICB	David Melbourne

Partner	Name of Authorised Officer – Tier 1
Staffordshire and Stoke on Trent ICB	Peter Axon
Shropshire Telford and Wrekin ICB	Simon Whitehouse
NHS England	Roz Lindridge

13 INTERNAL APPROVALS

13.1 The levels of authority relating to this scheme are described within Schedule 4 of the ICB Collaboration Agreement.

14 REGULATORY REQUIREMENTS

14.1 Details in relation to regulatory requirements in relation to this scheme are contained within the delegation agreement and will be fulfilled on behalf of the ICBs by the Commissioning Team.

15 COMPLAINTS

15.1 Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

15.2 A report summarising complaints, actions and lessons learnt will be provided to the East and West Board annually.

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Part 3– Retained Services Scheme

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE SCHEME FOR RETAINED SPECIALISED SERVICES IN 2024/25

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the specialised services for which responsibility is being retained by NHS England in 2024/25 but identified as suitable for future delegation to Integrated Care Boards (ICBs) in the future.

1.2 The Partners' aims are:

(a) to maximise the benefits to patients by working collaboratively on the Retained Functions in preparation for future delegation and integration with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England has identified that the statutory function for the commissioning of the specialised services is suitable for future delegation to the ICBs. Whilst this responsibility is being retained by NHS England for 2024/25 it will involve the ICBs in the of these functions being, in summary:

(a) decisions in relation to the commissioning and management of the services;

(b) planning for the services for the population, including carrying out needs assessments;

(c) undertaking reviews of services in respect of the population;

(d) supporting the management of the specialised commissioning budget for the services;

(e) co-ordinating a common approach to the commissioning and delivery of the services with other health and social care bodies in respect of the population where appropriate; and

2.2 A list of the services included within the scheme are detailed within Appendix 2 of this Schedule.

2.3 The services are being provided to the populations within the Midlands ICBs geographical footprints.

3 PARTNERS

3.1 The partners for joint working within this scheme are NHS England, Birmingham and Solihull ICB, Black Country ICB, Coventry and Warwickshire ICB, Herefordshire and Worcestershire ICB, Shropshire, Telford and Wrekin ICB, Staffordshire and Stoke-on-Trent ICB, Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB

4 THE ARRANGEMENTS

4.1 NHS England will retain responsibility for the delivery of the functions covered by this scheme, working with the ICBs through appropriate consultation with and reporting to the East Midlands Joint Committee and the West Midlands Joint Committee established via a Joint Working Agreements between the ICBs.

4.2 Administrative and management functions will be provided to deliver the scheme by the multi-disciplinary commissioning team, hosted in 2024-2025 by NHS England. Details of which are set out in a commissioning team agreement between all parties.

4.3 Financial arrangements for this scheme will follow NHS England's budgetary and financial arrangements.

5 GOVERNANCE ARRANGEMENTS

5.1 NHS England will continue to hold responsibility for the delivery of the functions covered by the scheme.

5.2 Decision making will be in line with NHS England's Scheme of Reservation and Delegation subject to decisions being taken in consultation with the ICBs and the Joint Committees where appropriate.

5.3 The exercise of NHS England functions in consultation with the Joint Committees will be achieved by NHS England Officers with appropriate delegated authority attending meetings of the East Midlands Joint Committee and West Midlands Joint Committee when exercising that authority.

5.4 NHS England will report on the delivery of the functions under this scheme to the East Midlands and West Midlands Joint Committees.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

6.1.1 Services will be commissioned from providers by the Commissioning Team in line with legislative requirements and the NHS planning guidance 2024/25.

6.2 Contracting Arrangements

6.2.1 The scheme will be administered by the Commissioning Team.

6.2.2 The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.
- The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.
- The contracts will be funded by NHS England.
- The contracts will be managed by the Commissioning Team.

6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

7 HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

8.1 The financial governance arrangements will be in line with NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions.

9 NON-FINANCIAL RESOURCES

9.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB Collaboration Agreement.

10 STAFF

10.1 The commissioning team responsible for the operational delivery of specialised commissioning for the services will be retained by NHS England.

11 ASSURANCE AND MONITORING

11.1 NHS England's requirements in relation to Assurance and Monitoring will apply to this scheme.

12 INTERNAL APPROVALS

12.1 The levels of authority relating to this scheme will follow NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions

13 REGULATORY REQUIREMENTS

13.1 NHS England will retain responsibility for fulfilling the regulatory requirements in relation to this scheme.

14 COMPLAINTS

14.1 Complaints will be managed by the specialised commissioning team within NHSE England in line with the agreed complaints process.

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APPENDIX 1 – LIST OF CONTRACTS HELD WITH PROVIDERS IN 2023/24

Standard Contracts

BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST
DERBYSHIRE COMMUNITY HEALTH SERVICES FOUNDATION TRUST
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
GEORGE ELIOT HOSPITAL NHS TRUST
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST
NORTHAMPTON GENERAL HOSPITAL NHS TRUST
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
THE DUDLEY GROUP NHS FOUNDATION TRUST
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL WOLVERHAMPTON NHS TRUST
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
WALSALL HEALTHCARE NHS TRUST
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

Section 75 Contracts

LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST

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APPENDIX 2 RELEVANT SERVICES

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
4	Adult specialist respiratory services	29E	Management of central airway obstruction
		29V	Complex home ventilation
15	Adult specialist renal services	11T	Renal transplantation
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Blood and marrow transplantation services
		ECP	Extracorporeal photopheresis service
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services
55	Gender dysphoria services (children and adolescents)	22A	Gender identity development service for children and adolescents
56	Gender dysphoria services (adults)	22Z	Gender identity services
		42A	Gender dysphoria: genital surgery (trans feminine)
		42B	Gender dysphoria - genital surgery (trans masculine)
		42C	Gender dysphoria: chest surgery (trans masculine)
		42D	Gender dysphoria - non-surgical services
		42E	Gender dysphoria: other surgical services
58	Specialist adult gynaecological surgery and urinary surgery services for females	04K	Specialised services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse (16 years and above)
		04L	Reconstructive surgery and congenital anomalies of the female genital tract
65	Specialist services for adults with infectious diseases	18T	Tropical Disease
82	Paediatric and perinatal post mortem services	F23	Paediatric and perinatal post mortem services
87	Positron emission tomography-computed tomography services (adults and children)	01P	Positron emission tomography- computed tomography services (PETCT)
89	Primary malignant bone tumours service (adults and adolescents)	01O	Primary malignant bone tumours service (adults and adolescents)
101	Severe intestinal failure service (adults)	12Z	Severe intestinal failure service
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01L	Soft tissue sarcoma
		01X	Penile cancer
111	Clinical genomic services (adults and children)	20G	Genomic laboratory testing services
		20H	Pre-Implantation genetic diagnosis and associated in-vitro fertilisation services
		20Z	Specialist clinical genomics services
		MOL	Molecular diagnostic service
114	Specialist haemoglobinopathy services (adults and children)	38S (DPC)	Sickle cell anaemia -direct patient care
		38T (DPC)	Thalassemia - direct patient care
		38X (HCC)	Haemoglobinopathies coordinating centres (HCCs)
		38X (SHT)	Specialist Haemoglobinopathies Teams (SHTs)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
134	Specialist services to support patients	05C	Specialist augmentative and alternative

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	with complex physical disabilities (excluding wheelchair services) (adults and children)		communication aids
		05E	Specialist environmental controls
137	Spinal cord injury services (adults and children)	06A	Spinal cord injury services (adults and children)
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (Medium and low) - including LD / ASD / WEMS / ABI / DEAF
		22S(b)	Secure and specialised mental health services (adult) (Medium and low) - Excluding LD / ASD / WEMS / ABI / DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) - ASD
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) – LD
		22S(e)	Secure and specialised mental health services (adult) Medium Secure Female WEMS
		22S(f)	Secure and specialised mental health services (adult) (Medium and low) – ABI
		22S(g)	Secure and specialised mental health services (adult) (Medium and low) - DEAF
		YYY	Specialised mental health services exceptional packages of care
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services
32	Children and young people's inpatient mental health service	22C	Tier 4 CAMHS (MSU)
		24E	Tier 4 CAMHS (children's service)
		23K	Tier 4 CAMHS (general adolescent inc eating disorders)
		23L	Tier 4 CAMHS (low secure)
		23O	Tier 4 CAMHS (PICU)
		23U	Tier 4 CAMHS (LD)
		23V	Tier 4 CAMHS (ASD)
98	Specialist secure forensic mental health services for young people	24C	FCAMHS
102	Severe obsessive compulsive disorder and body dysmorphic disorder service (adults and adolescents)	22F	Severe obsessive compulsive disorder and body dysmorphic disorder service
116	Specialist mental health services for Deaf adults	22D	Specialist mental health services for Deaf adults
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services
133	Specialist services for severe personality disorder in adults	22T	Specialist services for severe personality disorder in adults

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SCHEDULE 4: FINANCIAL ARRANGEMENTS

PART A: POOLED FUND MANAGEMENT

1 ESTABLISHMENT OF A POOLED FUND

1.1 The ICBs have agreed to establish and maintain a mutual agreement pooled fund arrangement for in-year financial management of Schemes 1 and 2 of Schedule 3 of this agreement, with a defined contribution based on the allocation received will be transferred to the Host ICB, (Birmingham & Solihull ICB) on behalf of the Midlands.

The monies held in a Pooled Fund may only be expended on the following:

- the Contract Price;
- Third Party Costs where these are set out in the relevant Scheme Specification or as otherwise agreed in advance in writing in accordance with the relevant Scheme Specification;
- Approved expenditure as set out in the relevant Scheme Specification or as otherwise agreed in advance in accordance with the relevant Scheme Specification.
(collectively known as "Permitted Expenditure")

1.2 The Pooled Fund is explicitly for the management of in year expenditure against specialised services contractual commitments. This includes all contractual commitments for the population of Midlands ICBs including any out of Region contractual arrangements.

1.3 The Pooled Fund is not intended to be the route for recurrent commissioning decisions for specialised services. Such decisions would be made through the governance structure established in East and West Midlands.

1.4 The Partners may only depart from the definition of Permitted Expenditure or exceed Pooled Fund budget with the express written agreement of each relevant Partner and in line with approved delegations.

1.5 Birmingham & Solihull ICB on behalf of the Midlands shall be the Partner responsible for:

- Holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;
- Providing the financial administrative systems for the Pooled Fund; and
- The manager of the Pooled Fund (“Pooled Fund Manager”) will be the Director Specialised Commissioning of Finance
- Ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

2. RISK EXPOSURE

2.1. ICB population-based allocations have been developed on the basis of current contractual commitments as demonstrated in the document “ICB Baseline Development”.

2.2. All ICB 2024/25 opening baselines have been updated for 2023/24 variable activity levels and precommitments.

2.3. All ICB 2024/25 opening baselines are in recurrent financial balance and there is no risk exposure from opening contract baselines for 2024/25.

2.4. The specialised services contract is operated on a block basis and there is no financial exposure to activity variance through the block contract.

2.5. Elective activity is managed through the Elective Recovery Fund which will be managed on the same basis as 2023/24 with contract values and allocations being adjusted for activity variances. There will be no financial risk associated with the application of ERF. There are a small number of variable services (linked to Best Practice Tariffs) within the contract, these being:

- Chemotherapy
- Diagnostic Imaging
- Nuclear Medicine
- PRT-CT
- Molecular Radiotherapy
- Renal Transplant

2.6. These services are paid on a cost per case basis. Opening baselines for variable services will be based on 2023/24 outturn with growth applied based on historic activity.

2.7. There remains risk at an ICB and regional level of variance against contract and budget for these services.

2.8. ICBs hold contracts with providers outside the geographical boundary of the Midlands. It is expected that there will be consistency between planning assumptions and contractual growth across regions, but there is a risk that differential application of growth by other NHS England regions will impact on partners to this agreement.

2.9. A contingency of 0.5% will be held to manage in year financial risk to mitigate the impact of variable service financial risks and consequences of cross regional contractual commitments.

2.10. The use of a Pooled Fund will mitigate in year fluctuation at ICB level for variable services within delegated specialised services.

3. POOLED FUND MANAGEMENT

3.1. The Pooled Fund Manager for Pooled Fund shall have the following duties and responsibilities:

- The day-to-day operation and management of the Pooled Fund,
- Ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification,
- Maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund,
- Ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund,
- Reporting to the relevant governance group as required by this Agreement,
- ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement, and
- preparing and submitting reports as required by the relevant Scheme Specification.

3.2. The Partners may agree to the virement of funds between Pooled Funds or amending the allocation of the Pooled Fund between Individual Schemes.

4. FINANCIAL CONTRIBUTIONS

4.1. The pooled fund shall initially operate for the financial year 2024/25. Should the scheme be continued into future years, the Financial Contribution to any Pooled Fund for each subsequent Financial Year of operation shall be subject to review by the Partners.

4.2. Unless otherwise agreed, no provision of this Agreement shall preclude the Partners from making additional contributions to a Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in the budget statement as a separate item.

4.3. ICBs will pay contributions to the Pooled Fund for Specialised Services to the identified Host ICB.

4.4. Contributions will be the equivalent of the allocation for delegated specialised services or an amount specified by the payments schedule calculated by the specialised commissioning team.

Table of contributions to be added once final 2024/25 allocations have been confirmed.

Partner	**Name of CFO**	**Contribution to the Fund**
Coventry & Warwickshire ICB		
The Black Country ICB		
Herefordshire & Worcestershire ICB		
Birmingham & Solihull ICB		
Staffordshire and Stoke on Trent ICB		
Shropshire Telford and Wrekin ICB		
Lincolnshire ICB		
Nottingham & Nottinghamshire ICB		
Leicester, Leicestershire & Rutland ICB		
Northamptonshire ICB		
Derby & Derbyshire ICB		

5. RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPEND

5.1. The Host Partner for the relevant Pooled Fund shall, through the Specialised Commissioning Team Fund Manager, manage expenditure from a Pooled Fund within the Financial Contributions and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

5.2. The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs provided that it has used reasonable endeavours to ensure that the only expenditure from a Pooled Fund has been incurred and it has informed the Partners of any variance.

5.3. In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partners are informed as soon as reasonably possible.

5.4. If expenditure from the Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year, financial resources will be returned to the Partners proportionate to the contributions to the Pooled Fund. Arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions of the Partners.

5.5. Any unmitigated net variance will need to be recognised in the Agreement of Balances exercise completed as part of the month 09 financial reporting process.

5.6. Residual variances (under or overspend), after mitigations and application of contingency, will be allocated to ICBs proportionately to contributions to the Pooled Fund.

6. CAPITAL EXPENDITURE

6.1. Pooled Funds shall not be applied towards any one-off expenditure on goods or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

7. POOLED FUND FINANCIAL GOVERNANCE

7.1. The partners in the Pooled Fund shall make monthly payments of one twelfth of the Pooled Fund contributions by the 5th of the month.

7.2. The Specialised Commissioning Team will manage specialised services through the host ledger managing financial risk across all Partner ICBs.

7.3. All contractual payments including variable adjustments will be managed by the Specialised Commissioning Team through the single joint Specialised Commissioning contract in line with the Contracting Standard Operating Procedure.

7.4. In year financial management will be undertaken at a multi ICB level across eleven ICBs in the Midlands region, mitigating the risk of variation between systems.

7.5. Regional financial variances (under or overspend) would be mitigated through the application of local financial management and the use of the contingency held by the Host, as agreed by partners, to minimise exposure to financial fluctuation.

7.6. Residual variances (under or overspend), after mitigations and application of contingency, will be allocated to ICBs proportionately to contributions to the Pooled Fund.

8. POOLED FUND FINANCIAL REPORTING AND ASSURANCE

8.1. The Joint finance subgroup will have responsibility to oversee the management of the pooled fund on behalf of the Joint Committees.

8.2. ICB level in year financial reporting will show contributions to the pool in the ICB position thereby demonstrating a break-even position for specialised commissioning on monthly financial reports.

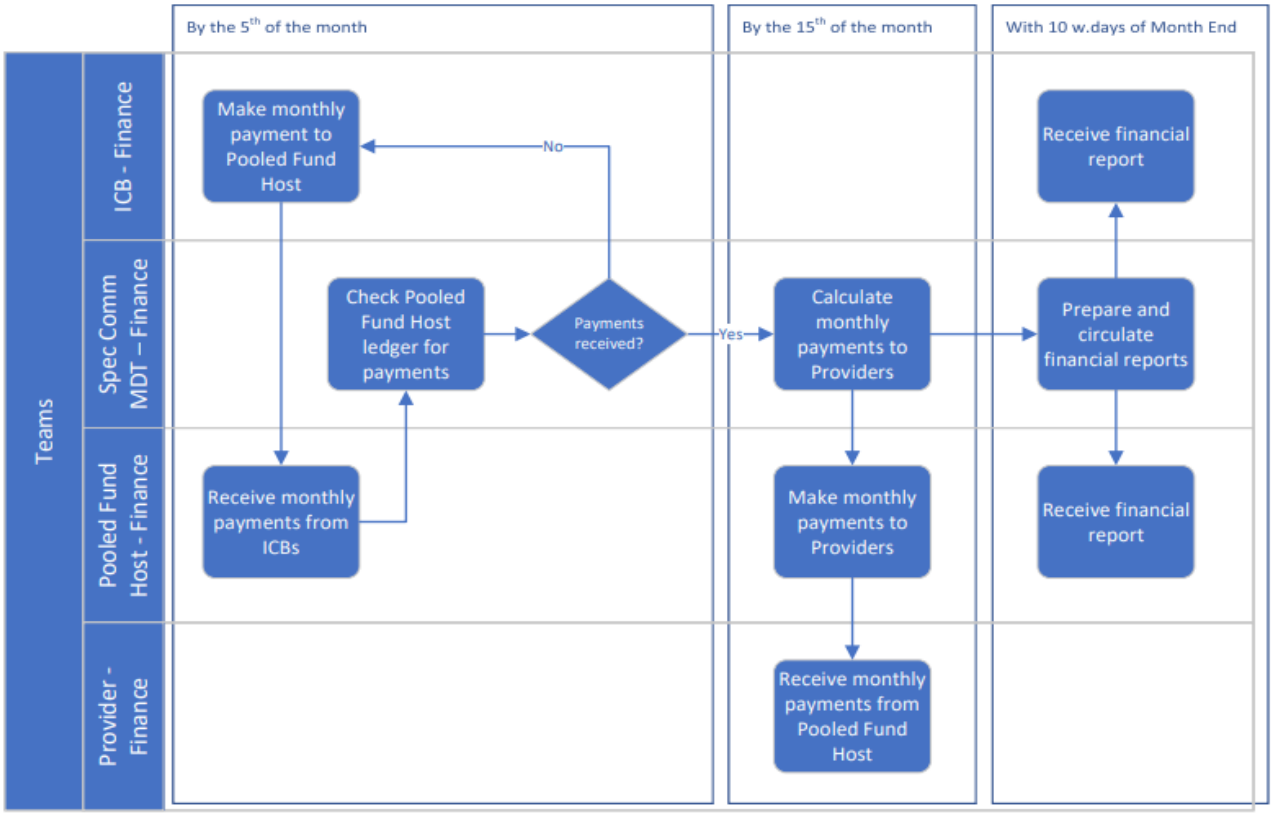
8.3. Performance reporting will be developed at an ICB and multi ICB level to enable local intelligence on performance in delegated specialised services.

8.4. The Specialised Commissioning Team on behalf of the Host will prepare quarterly memorandum finance reports at individual ICB level to ensure all ICBs have full sight of the overall actual performance of specialised commissioning and indicative ICB level performance.

8.5. Year-end reporting will be prepared in line with nationally produced annual accounts timetables recognising any locally agreed requirements.

8.6. As part of the year end process the Specialised Commissioning Team will prepare reconciliation journals to update individual ICB ledgers with detailed Provider level expenditure in line with Pooled Fund contributions.

8.7. Financial Flow arrangements are illustrated below



PART B: OTHER FINANCIAL ARRANGEMENTS

9. BUDGETARY DELEGATION

9.1. Commissioning decisions will be made in line with the Arrangements agreed by the East/West Midlands Joint Commissioning Committee which has Delegated Authority to set approval limits in line with those arrangements. Initial approval limits, subject to the agreement of the Joint Committees are set out in Annex 1 to this schedule.

9.2. ICBs have agreed to delegate budgetary responsibility to the specialised commissioning team for the processing and delivery of specialised services transactions. These delegations are to facilitate the delivery of contract signature, purchase orders and non-purchase order invoices and budgetary virement and are set out in Annex 2 to this schedule.

9.3. For 2024/25, the specialised commissioning team will be employed by NHS England on behalf of the partner ICBs. From 2025/26 the specialised commissioning team will be employed by the Host ICB.

10. AUDIT ARRANGEMENTS

10.1. Transactions through ICB ledgers will be subject to audit through existing internal audit arrangements. It will be the responsibility of ICBs to ensure that this appropriately referenced in the 2024/25 audit plan.

10.2. In 2024/25 Specialised Commissioning Team responsible for the management of specialised commissioning resources will continue to be employed by NHS England but will access the ledger of the Host ICB to process transactions for specialised services.

10.3. In 2024/25 the Host ICB will commission a specific review of the financial control, governance and assurance of the Specialised Commissioning Team delivered service to provide assurance to ICBs that the controls in place for specialised services are robust.

11. FINANCIAL MANAGEMENT

11.1. Financial transactions for the 59 delegated specialised services will be processed through the Oracle ISFE ledger system of the Host ICB. Specialised Commissioning team will have appropriate access to ICB ledgers enabled.

11.2. Financial monitoring reports will be produced by the NHSE hosted Specialised Commissioning Team on behalf of the ICBs. The team, for 2024/25, will provide financial support to ICBs for delegated services and NHSE for retained and highly specialised services.

11.3. Financial reports will be prepared monthly within ten working days of the end of the month. Forecast outturn positions will be included in the monitoring reports from quarter 2.

11.4. Monthly budget reporting with variance analysis and forecasting will be provided the Joint Finance Subgroup, Host ICB, and Partner ICBs including:

- ICB reporting based on pool contribution,
- Overall pool financial performance report to be shared with all ICBs,
- Management and review of reserves and investments.

Annex 1 to Schedule 4

Commissioning Decisions Budgetary Delegation Schedule

Description of Delegation (All Delegations are Annual Values)	**Delegated Limits**		
	Director of Specialised Commissioning	**MASCG**	**Joint Committees**
Approval of extensions to contracts and contract variations	N/a	Up to £2.5m	Above £2.5m
Approval of business cases for investment for **existing services** within **existing budget envelope**	Unlimited		
Approval of business cases for investment for **existing services** with **additional investment**	Up to £1m	Up to £2.5m	Above £2.5m
Approval of business cases for investment for **existing services** with **new investment**	Up to £1m	Up to £2.5m	Above £2.5m

Annex 2 to Schedule 4

Operational Budgetary Delegation Schedule

Contract award, signature and variation		
Description of delegation: Approval of contract award reports, providing requirements for competitive tendering have been met. Signature of contracts and contract variations, within the approved budget.		
Delegated Limit Limits are annual values	Up to £2m	Unlimited
Approvers and/or restrictions No variation can be granted to a contract awarded under the PCR threshold where the value of the variation results in the contract value exceeding the PCR threshold.	Commissioning Lead – Acute Specialised Commissioning (Contracting)	Director of Specialised Commissioning Director of Commissioning Finance (specialised commissioning).

Purchase Requisitions, invoices and non POs			
Description of delegation: Approval of purchase requisitions, purchase credit notes, invoices and non-purchase order invoices. Approval of contract payments to NHS providers.			
Delegated Limit	Up to £50k	Up to £2m or 1/12 of contract value for NHS Providers	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Specialised commissioning: Contract Managers or Budget Holders	Director of Specialised Commissioning Director of Commissioning Finance (specialised)	Director of Specialised Commissioning **or** Director of Commissioning Finance (Specialised) **And** Pooled Fund Host CFO

Budget Virements			
Description of delegation: Approval of budget virements/movements within approved revenue and capital budgets.			
Delegated Limit	Up to £50k	Up to £2m	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods	Specialised commissioning Contract Managers or Budget Holders	Director of Specialised Commissioning Director of Commissioning Finance (specialised)	MASCG

and services and the non-purchase order route should only be used in exceptional circumstances.			

SCHEDULE 5: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

PART 1

1. Introduction

1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Partners on a Need To Know basis, in order to enable the Partners to exercise their functions in pursuance of this Agreement.

1.2. References in this Schedule *(Further Information Governance and Sharing Provisions)* to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3. This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:

1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Partners;

1.3.2. describe the purposes for which the Partners have agreed to share Relevant Information;

1.3.3. set out the lawful basis for the sharing of information between the Partners, and the principles that underpin the exchange of Relevant Information;

1.3.4. describe roles and structures to support the exchange of Relevant Information between the Partners;

1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;

1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8. apply to the activities of the Partners' Staff; and

1.3.9. describe how complaints relating to Personal Data sharing between the Partners will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Working Arrangements.

2.2. Each Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant legislation and Guidance.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Services.

4. Lawful basis for sharing

4.1. The Partners shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Partners shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

5.1. Each Partner shall only process the Relevant Information as is necessary to achieve the Specified Purpose and shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2. Access to, and processing of, the Relevant Information provided by a Partner must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be always handled on a restricted basis, in compliance with Data Protection Legislation requirements, and the Partners' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Partners.

5.4. Neither Partner shall subcontract any processing of the Relevant Information without the prior consent of the other Partner. Where a Partner subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

5.5. The Partners shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6. Any particular restrictions on use of certain Relevant Information should be included in a Data Sharing Agreement.

6. Ensuring fairness to the Data Subject

6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. To achieve fairness and transparency to the Data Subjects, the Partners will take the following measures as reasonably required:

6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and

6.1.4. considering carrying out activities to promote public understanding of how data is processed where appropriate.

6.2. Each Partner shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.

6.3. The Partners shall reasonably co-operate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

6.4. Further provision in relation to specific data flows may be included in a Data Sharing Agreement between the Partners.

7. Governance: Staff

7.1. The Partners must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.

7.2. The Partners agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Partners' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Partners must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

7.3. The Partners shall ensure that all Staff required to access Personal Data (including Special Category Personal Data are informed of the confidential nature of the Personal Data. The Partners shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

7.4. Each Partner shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and

appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.5. The Partners shall ensure that:

7.5.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information;

7.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and

7.5.3. specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement entered in accordance with this Schedule.

8. Governance: Protection of Personal Data

8.1. At all times, the Partners shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2. Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by the Partners. The Partners shall co-operate in exploring alternative strategies to avoid the use of Personal Data to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need-to-Know basis.

8.4. If any Partner becomes aware of:

8.4.1. any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted, or unusable; or

8.4.2. any security vulnerability or breach in respect of the Relevant Information,

it shall promptly, within 48 hours, notify the other Partners. The Partners shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5. In processing any Relevant Information further to this Agreement, the Partners shall process the Personal Data and Special Category Personal Data only:

8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by Law or any regulatory body; and

8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6. The Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining, and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1. take account of the nature, scope, context, and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and

8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data and having the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

8.7. Each Partner shall:

8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;

8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display, or distribution, of the Relevant Information;

8.7.3. obtain prior written consent from the originating Partner to transfer the Relevant Information to any third party;

8.7.4. permit any other Partner or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors, or assigns) and comply with all reasonable requests or directions to enable each Partner to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

The Partners shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered in accordance with this Schedule.

8.8. The Partners shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.9. The Partners' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third-party security measures.

9. Governance: Transmission of Information between the Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

9.2. Transfer of Personal Data between the Partners shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, to ensure that the correct patient record and/or data is identified.

9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered in accordance with this Schedule.

9.5. Each Partner shall keep an audit log of Relevant Information transmitted and received during this Agreement.

9.6. The Partners' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Partners.

10. Governance: Quality of Information

10.1. The Partners will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11. Governance: Retention and Disposal of Shared Information

11.1. A non-originating Partner shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted, and formal notice of the deletion sent to the that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Partner they came from.

11.2. Each Partner shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3. If a Partner is required by any Law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Partners in writing of that retention, giving details of the documents or materials that it must retain.

11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated, or amended from time to time.

11.5. The Partners shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6. The Partners shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a crosscut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7. Each Partner shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8. Electronic records will be considered for deletion once the relevant retention period has ended.

In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Partner shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

12.1. The Partners shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2. Complaints about information sharing shall be reported to each Partner. Complaints about information sharing shall be routed through each Partner's own complaints procedure unless otherwise provided for in the Joint Working.

12.3. The Partners shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4. Basic details of the Agreement shall be included in the appropriate log under each Partner's publication scheme.

13. Governance: Single Points of Contact

13.1. The Partners each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

14.1. The Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 6: COMMISSIONING TEAM AGREEMENT and STANDARD OPERATING FRAMEWORK

COVERED UNDER A SEPARATE AGREEMENT - COMMISIONING TEAM AGREEMENT AND OPERATING FRAMEWORK

Appendix 3

Midlands Acute Specialised Commissioning (MASC)

Commissioning Team Agreement and Standard Operating Framework for 2024/25

Contents:

1. Introduction

This agreement sets out the purpose and role of the Midlands Acute Specialised Commissioning (MASC) Multidisciplinary Team, how it will operate and how it will be governed from 1st April 2024 to 31st March 2025.

This Commissioning Team Agreement and Standard Operating Framework should be read in conjunction with:

- Overarching governance documents
  - Delegation Agreement
  - Memorandum of Understanding and Collaboration Agreement
- Key documents produced as part of the above Agreements including,
  - Cash Flow SOP
  - Contracting SOP
  - Financial Risk Share and Pooling Arrangement
  - Quality Assurance Framework
    and other key operating instructions
- National guidance relating to the roles and responsibilities of NHS England in relation to specialised services.

This agreement will commence on 1st April 2024 for one year only. The year will operate as a transition for some defined functions with NHSE remaining the employing organisation.

The Multidisciplinary Team will support the following organisations in the commissioning of delegated services:

- NHS Lincolnshire ICB
- NHS Derbyshire ICB
- NHS Nottingham and Nottinghamshire ICB
- NHS Leicester, Leicestershire, and Rutland ICB
- NHS Northamptonshire ICB

Known as the East Midlands Multi-ICB.

- NHS Birmingham and Solihull ICB
- NHS Black Country ICB
- NHS Coventry and Warwickshire ICB
- NHS Herefordshire and Worcestershire CB
- NHS Shropshire and Telford and Wrekin ICB
- NHS Staffordshire and Stoke-on-Trent ICB

Known as the West Midlands Multi-ICB.

And the following organisation in the commissioning of retained specialised services and financial and governance responsibility High Cost Drugs and clinical networks:

- NHS England

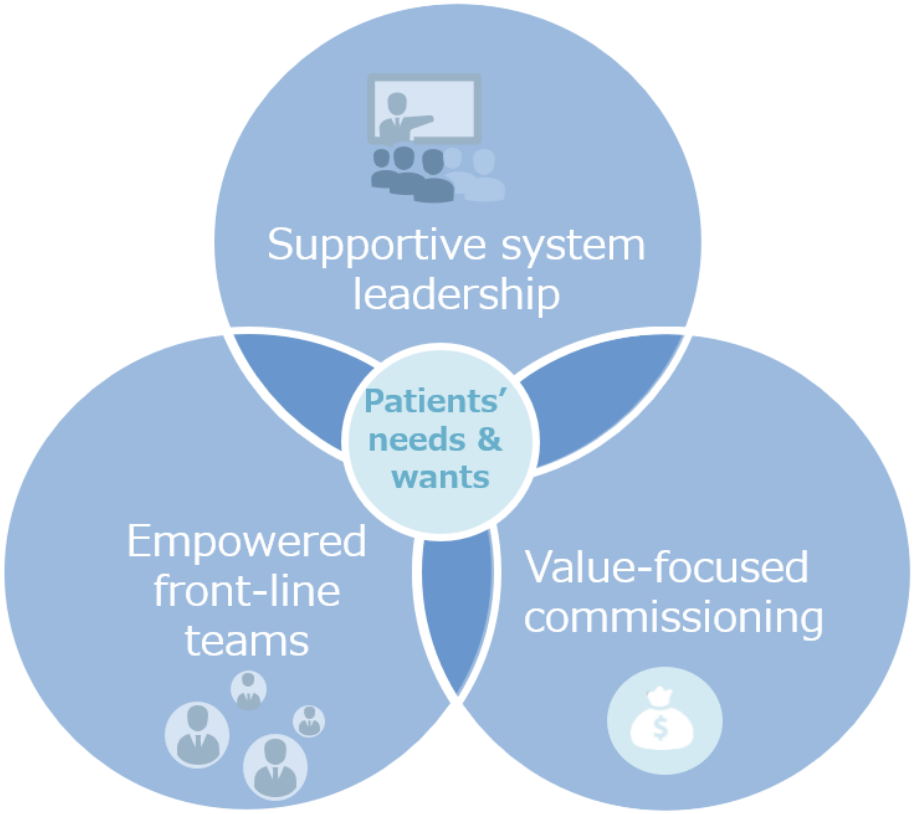
The team will be responsible for commissioning, financial and clinical and quality management of the 59 delegated specialised services on behalf of the East and West Midlands Joint Committees and the retained services on behalf of NHSE in collaboration with the ICBs.

2. Values and Principles

The Multidisciplinary Team will work to support the following:

- **Programmes of Care**:
  Specialist services – which are low volume and high cost – that must be in place and able to meet the needs of patients and families at the right time and in the right way, aligned to national specifications.
- **Patient Pathways**:
  Delegation enables improved working between commissioners and across networks to ensure the best value for patients moving through services.
- **Providers and Partners**:
  That fewer, better relationships create improvements in delivery and new models support this (provider collaboratives)
- **Population Outcomes**:
  That systems can articulate the benefit to their patients of working across all services from prevention through to highly specialist intervention.

The principles of a successful model are set out below:



The Multidisciplinary Team will work coherently and consistently and will champion specialised care on behalf of the 12 commissioning partners. They will work as a part of a network of partners, enabling staff to deliver across complex geographies and as part of multi-layered systems and local collaboration.

3. Key Terms

The following are key terms and abbreviations to support navigation through specialised commissioning and specialised services:

MASC	Midlands Acute Specialised Commissioning
MDT	Multi-Disciplinary Team: The collaboration between specialist components of the MASC that provide the single support offer – Commissioning (inc. Contracting), Pharmacy, Finance, Nursing & Quality, Business Intelligence & Analytics and Regional Communications and Engagement. Complaints will be dealt with by the relevant functional teams.
MASCG	Midlands Acute Specialised Commissioning Group, the Tier 2 sub-group of the East and West Midlands Joint Committees, representing all 12 partners
EMJC/WMJC	East Midlands/West Midlands Joint Committee, the Tier 1 governance structure for the East/West Midlands multi-ICB.
DELEGATED SERVICES	The 59 Specialised Services being delegated from NHSE to Midlands ICB on 1st April 2024
RETAINED SERVICES	The remaining Specialised Services not being delegated on 1st April 2024 which will be retained by NHSE.
POC	Programmes of Care which operate on a Pan-Midlands footprint and to individual contracts (27 NHS and 3 IS) at a system level including; • Blood and Infection • Cancer • Internal Medicine • Trauma; and • Women and Children
DCG	Delegated Commissioning Group for national decisions applied to delegated services including updates to specification. The Regional Director of Specialised Commissioning will represent the ICBs on the Group
NCG	National Commissioning Group for Non-Delegated Services. The Regional Director of Specialised Commissioning will represent NHSE Midlands on the Group
ODN(s)	Operational Delivery Network(s) for Specialised Services
HCDs	High-Cost Drugs

4. Key elements

The following are key elements relating to the operation of the Multidisciplinary Team in 2024/25:

- The Multidisciplinary Team will support the delivery of delegated and retained services. The team will not be split, in terms of time aligned to these, but will be driven by needs as agreed through the MASCG. The 59 delegated services are the predominant areas of focus for the team based on the work plan.

- Corporate support will be provided by NHSE as the host organisation including estates, IT, legal support, HR and business administration.

- The Multidisciplinary Team will link with NHSE Regional and National directorates regarding risk management where this is appropriate.

- Although the responsibility for commissioning of the 59 specialised services is delegated to the Midlands ICBs on 1st April 2024, accountability remains with NHSE. This will be managed by the NHSE Midlands regional team through an Oversight and Assurance Framework informed by subject matter expertise provided by the Multidisciplinary Team and wider regional commissioning integration team.

- The team will work to ensure consistency of communication through the established governance model, recognising the different populations and system issues in the East and West Midlands. The team will remain pan-Midlands in structure.

5. Administrative & Management Services

5.1 Purpose, Roles, Responsibilities and Functions

The Multidisciplinary Team recognises the robust governance required to operate on behalf of 12 organisations and to ensure that conflicts of interest are well managed.

The Multidisciplinary Team represents specialist knowledge in relation to Acute Specialised Services. However, the team will also be working with expert commissioning partners across 11 ICBs to deliver pathway improvements and maximise value in systems and with provider partners.

The Multidisciplinary Team will ensure the day-to-day management and monitoring of Specialised Acute and Pharmacy services provided across the Midlands. This requires ongoing integrated working through the links with the Acute Providers either directly with corporate and clinical teams or via Operational Delivery Networks (ODNs).

The Multidisciplinary Team will report on performance, progress on transformation priorities, and make recommendations for improvement through the Tier 1 and 2 governance groups and through NHSE governance frameworks, aligned to an agreed work programme. The Multidisciplinary Team will manage operational, financial, and quality risks in line with agreed escalation routes in line with this collaborative approach.

The Multidisciplinary team will carry out all duties in relation to the commissioning of delegated services liaising through the East and West Boards and their subgroups. The team details are below but in summary are made up of

Supporting Retained NHSE Functions and Delegated ICB Functions	
Function	Number (includes those who have a wider portfolio beyond specialised services)
Finance	17 WTE
Commissioning & Pharmacy	41 WTE
Quality	8 WTE
Commissioning Support	5 WTE

A list of key contacts is provided below

Core Functions	Lead Officer	Contact details
Commissioning & contracting	Alison Kemp Jon Currington	Alison.kemp1@nhs.net Jon.currington@nhs.net
Pharmacy	Susanna Allen	susanna.allen@nhs.net
Finance	Jon Cooke/ Pete Davies	Jon.cooke1@nhs.net Peter.davies4@nhs.net
Clinical & Quality	Dr Colette Marshall Dr Mel McFeeters	colette.marshall6@nhs.net melanie.mcfeeters@nhs.net
Business Intelligence & Analytics	Simon Collings	Simon.collings@nhs.net
Regional Comms Team	Claire Deeley	claire.deeley@nhs.net
Specialised Networks (ODMs)	Kieren Caldwell	Kieren.caldwell@nhs.net

5.2 Specialised Commissioning & Contracting Team

The Commissioning & Contracting Team is responsible for commissioning prescribed acute specialised services as described in the Manual of Prescribed Services, in line with national service specifications and policies, on behalf of ICBs for delegated services and NHSE for retained services.
The team discharges its responsibilities through a structure of five Clinical Programmes of Care (PoC) which operate on a pan-Midlands footprint and to individual contracts (27 NHS and three Independent Sector (IS) providers) at a system level.

The five PoC are:

- Blood and Infection;
- Cancer;
- Internal Medicine;
- Trauma; and
- Women and Children.

Each PoC is headed by a Commissioning Lead from a clinical, finance or management background with specific expertise in their PoC area. Each of the PoC Leads has a lead responsibility for named ICBs, although at present the role is largely nominal based on the individual contracts their team is responsible for (Appendix 1). The Commissioning Lead for Blood and Infection also has lead responsibility for Contracting across the Midlands.

The Head of Acute Specialised Services oversees all these functions and reports directly to the Director of Specialised Commissioning.

The core functions the team deliver on behalf of ICB partners include:

- Co-ordinating commissioner for the 59 delegated services;
- Contract negotiation and Contract Relationship Management with Midlands Acute Providers;
- Oversight of transformation portfolio focused on improving health outcomes & reducing inequalities.
- Single point of contact for all acute specialised services for Specialised Networks, provider clinicians and management teams and ICB teams; and
- Oversight and assurance of all acute specialised services.

Working with:

- ICB teams;
- Other regional NHS England functions as part of a single Multi-Disciplinary Team (MDT) (e.g. pharmacy, medical, nursing, finance, business intelligence, communications etc.);
- Regional and National NHS England Teams including clinical reference groups;
- Clinical and corporate teams at NHS trusts and other service providers; and
- Cancer Alliances and Specialised Networks

Complaints

All complaints received (on average circa 5-7 per annum across all Specialised services inc retained services) are managed by the Head of Services with input from subject matter experts with clinical and quality review. Complaints will continue to be managed in this way for ICB and NHSE during 24/25.

The team carries out similar functions on behalf of NHS England for the 90 retained services.

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Director of Specialised and Collaborative Commissioning	ESM1	*
Senior Programme Director – Specialised Clinical Networks	Band 9	*
Head of Acute Specialised Commissioning	Band 8D	1.00
Commissioning Lead – Acute Services	Band 8C	5.00
Senior Commissioning Manager	Band 8B	6.00
Programme Manager – specialised commissioning	Band 8B	1.00
Senior Neurorehabilitation Case Manager	Band 8B	1.00
Commissioning Manager	Band 8A	3.00
Neurorehabilitation Case Manager	Band 8A	3.00
Contract Manager	Band 7	2.00
Commissioning Officer	Band 6	2.00
Project co-ordinator	Band 6	1.00
Commissioning Support Officer	Band 5	2.00
Business Support Assistant	Band 4	1.00
	Total	**30.00**

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

5.3 Specialised Pharmacy Team

The role of the Specialised Commissioning Pharmacy team is to support clinical and pharmacy colleagues in Trusts, across regions and nationally in optimising the use of medicines, ensuring that high-cost drugs are introduced efficiently and used consistently in line with national clinical commissioning policy. The team work to improve uptake and access to new High-Cost Drugs (HCDs), ensuring that high-cost medicines are prescribed and delivered in the safest, most cost-effective manner. A contact list for the Pharmacy team including which Trusts they support can be found in Appendix 2.

Responsibilities are discharged in line with national service specifications and clinical commissioning policies with responsibility and accountability for the high-cost drugs budget being with NHS England in 2024/25. The team will collaborate with ICBs via the joint working arrangements to optimise the commissioning of high cost drugs.
The core functions of the Pharmacy team to deliver on behalf of the ICBs for delegated service and NHSE retained services are as follows:

- Medicines prescribed/ dispensed in a manner that provides value for money.
- Consistency of application of prescribing policies for HCDs.
- Optimised value for money re medicines and procurement and use.
- Specialised care provided closer to home with improved quality of life for patients with longer term conditions.
- Strategic view of medicines related issues.
- Efficient use of resources

Working with:

- Acute Trusts and Providers
- Regional ICB and Trust Pharmacy Leads
- Colleagues within Commissioning Team MDT
- NHSE National and Regional teams

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Director of Specialised & Collaborative Commissioning	ESM1	*
Head of Pharmacy Commissioning (Midlands)	Band 8D	1.00
Senior Pharmacy Lead – Midlands	Band 8C	1.00
Pharmacy Programme Manager	Band 8B	3.00
Pharmacy Analyst (Midlands)	Band 7	2.00
	Total	**7.00**

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

5.4 Specialised Finance Team

The Commissioning Finance Team is responsible for working in partnership with all elements of the commissioning directorate to support ICB delegated acute services and NHSE retained services.

The team has wider responsibilities across Acute Specialised Commissioning, Specialised Mental Health and Learning Disabilities, Offender Personality Disorder Service and Health and Justice commissioning portfolios.

The core finance functions are as follows:

- Financial Planning
    - Lead on national allocations processes for all commissioned services – both delegated and non-delegated for 2024/25, ensuring all adjustments are validated and attributed to system population level.
    - Ensure planning methodologies (eg ERF, Needs Based Proposals) are checked and challenged through national finance forums nationally and communicated locally.
    - Support local planning arrangements and engagement both internally and with ICBs to support contract management (in compliance with SOP), negotiation and risk provision.
- Payments
    - Lead all payments to NHS and non-NHS providers in compliance with Standard Financial Instructions/Standing Orders and the agreed Scheme of Delegation. This includes the submission of the monthly payment file and working with Corporate Finance functions to deliver compliance.
- Payment System Engagement
    - Engage at a national level of payment system reform and application. It is the local expertise on the application of Payment Systems and will provide expert advice to Provider business cases and service development proposals.
- Cash Management
    - Co-ordination of all cash requirements for Delegated and Retained Specialised Services
- Budget Management
    - Ensure budgets fully reflect planning assumptions and are phased appropriately in accordance with Best Financial Management Practice for all services including delegated.
- Financial Reporting
    - Maintain robust ledger accounting in accordance with agreed timetables to comply with local and national guidelines to ensure assurance over the accuracy of ledger reporting and finance information for both reporting groups both nationally, regionally and at ICB level.
    - Ensure internal controls for processes are resilient and audit compliant and in accordance with SFIs.
- Investments
    - Provision of expert technical advice to ensure all service proposals are reviewed and approved in accordance with due processes.
- Provision of support to internal and external meetings across MDT Commissioning, Nationally and regionally across all commissioned services.
- Support of ongoing development to Delegation process and workstreams nationally on behalf of Midlands region.

The core functions the team deliver on behalf of partners is as follows:

Financial Management, Financial Planning, Financial Reporting, Audit Compliance, National, System and Provider level engagement

Working with:

- ICB Specialist Networks
- NHS trusts and other service providers
- National and Regional NHS England directorates

The Midlands Specialised Commissioning portfolio consists of Acute and Mental Health services along with management of the associated high-cost drugs and devices allocations and Operational Deliver Networks (ODN) budgets.

The population-based split of allocations relating to service budgets has been adopted in 2023/24 reporting. This will be expanded further in 2024/25 to cover the total allocations including any reserves and contingency.

The Finance team for Specialised Services consists of:

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	Grade	WTE
Director of Commissioning Finance	ESM 1	*
Deputy Director of Finance Specialised Commissioning	Band 9	1.0
Assistant Director of Finance	Band 8D	2.0
Assistant head of Finance	Band 8C	2.0
Senior Finance Manager	Band 8B	2.0
Finance Manager	Band 8A	3.0
Finance Officer	Band 7	1.0
Finance Support	Band 5	2.0
Finance Support	Band 4	1.0
Finance Assistant	Band 2	2.0
	Total	**16.0**

* Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

The finance team is responsible for all Specialised Commissioning finance including non-acute and retained services.

5.5 Specialised Services Clinical and Quality Team

The Clinical and Quality team are responsible for managing quality in relation to all specialised services in line with the national Quality Framework for Specialised Services 2024/25, on behalf of ICBs for delegated services and NHSE for retained services.
They operate in accordance with the Midlands Quality Assurance Framework, the National Quality Board's (NQB) National Guidance on Quality Risk Response and Escalation in Integrated Care Systems (NQB 2022) and 'A Shared Commitment to Quality' (NQB 2020) and align to the following agreed principles:

- Integration with NHSE/ICB regional governance
- Clear lines of accountability and escalation for each stage of the quality assurance process
- Share intelligence in an open, timely way.
- Proactively monitor and follow up on early warning signs.
- Agree responsibilities, accountabilities, and governance routes, taking a system-led approach where possible, at all stages of the process.
- Monitor and mitigate future risks.
- Commitment to drive quality improvement through ongoing learning and development.

The core functions the quality team deliver to support delivery of the statutory quality duties are as follows:

- Reviewing the data on the quality of acute specialised services e.g. Specialised Services Dashboards, and triangulation with wider data sources and metrics.
- Identification & management of quality risks using agreed governance and escalation mechanisms.
- SME input into the incident oversight process in line with PSIRF and the management of complaints.
- Provision of clinical and professional advice and support for commissioning managers and clinical and quality teams.
- Support quality improvement & transformation, reduce unwarranted variation, including national & regional programmes, Midlands Quality Surveillance & Improvement Framework.

Working with:

- Formal Operational Delivery Networks (ODNs) & Informal Clinical Networks
- Regional and national teams - Commissioners, national quality group for specialised services, Clinical Reference Groups (CRGs), System Teams, Subject Matter Experts (SMEs), ASC pharmacy team
- ICB Quality Teams, Provider Trusts

The Specialised Services Clinical and Quality team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Regional Medical Director - Commissioning	ESM1	*
Deputy Director of Nursing & Quality	Band 9	*
Assistant Director of Nursing & Quality: Acute SC	Band 8D	1.00
Head of Clinical Quality Reviews: Specialised Commissioning	Band 8C	1.00
Head of Quality: Acute Specialised Commissioning	Band 8C	1.00
Senior Quality Officer	Band 7	1.00
Quality Officer	Band 6	2.00
	Total	**6.00**

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

5.6 Business Intelligence & Analytics Team

The Commissioning Business Intelligence & Analytics functions provide analytical support across the commissioning portfolio. The team is led by NHSE employed BI and Analytics staff with most of the team's analytical capacity and capability being supplied by Arden and GEM CSU through a nationally held and agreed contract. This contract will remain in place for 2024/25 and will be reviewed during that time in collaboration with NHSE regional commissioning team and the ICBs. The core functions are as follows:

- Act in with accordance and the delivery of the NHS Long Term Plan specifically pertaining to Specialised and Direct Commissioning within NHSE Midlands Region;
- Support commissioning through the development of insight-based analytics including planning, performance, assurance, and oversight of regional delivery against annual Operational Planning.

- Provide population health-based analysis to deliver improved outcomes for patients and ensure wider management of pathways of care.
- Deliver a high-quality integrated commissioning BI function which is reflective of, and responsive to the needs of delegated and retained commissioning teams within the Midlands.
- Support the NHSE national team in identifying and delivering data and analytics strategic priorities in preparation for delegation of specialised services, reflective of regional priorities in the Midlands.
- Collaborate effectively in creating an efficient workforce model to deliver a BI service that is responsive to changing needs.

The core functions the team deliver on behalf of partners is as follows:

- Performance and assurance for commissioning programmes
- Data Quality
- AIVs and Challenges
- Planning and Priority Setting
- Demand and Capacity

Working with:

- ICBs
- Specialist Networks
- External Data Providers i.e. Academic Health Science Provision
- NHS trusts and other service providers
- Department of Health and Social Care
- National NHS England directorates

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Head of Planning and Decision Support	Band 9	*
Head of Data and Information	Band 8D	*
Senior Planning Manager	Band 8B	*
	Total	*

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

5.7 Specialised Networks

The core functions include:

- Lead major programmes (i.e. currently paediatric sustainability and neonatal cot configuration) which include specialised networks.
- Oversight of programme delivery across 24 networks
- Risk management and operational delivery/transactional change success via network work programmes
- Engagement with key stakeholders is effective, timely and useful.
- Improving network board functionality.

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions

Role	Grade	WTE
Senior Programme Manager – Integrated Commissioning	Band 9	*

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

The role of the Programme Director is to:

- Develop and deliver the strategy for acute specialised networks.
- Provide subject matter leadership to network leadership teams which are imbedded in provider organisations.
- Oversee the collaborative development of network work programmes.
- Lead the Collaborative Clinical Executive Forum, securing regional clinical engagement into the key strategic decisions made by the Acute Specialised Commissioning Team.
- Support the development of Acute Provider Collaboratives including, but not limited to EMAP and WMAP.
- Develop systems for clinical quality assurance and responsiveness when it involves specialised clinical networks.

5.8 Regional Communications and Engagement Team

The role of the Regional Communications and Engagement team is to:

- Develop communications strategies and plans around individual services – new services, changes to services or closures of services – working together with specialised operating teams, relevant ICB and provider/s.
- Engage with stakeholders and patient groups around these services.
- Brief relevant ICB and NHS colleagues
- Hold regular meetings with ICBs and providers as well as having mechanisms for cascading news and materials from national teams.
- Promote the work of specialised services within ICBs and NHS England through internal mechanisms.
- Manage any media queries, liaising with specialised team and provider and gaining approval from ICB communications.
- Develop any proactive activity such as media releases, social media, or stakeholder materials with approval from ICB communications teams.
- Share newsletters and regional updates with system ICB communications leads.
- Update and maintain regional NHSE web pages for any information relevant to specialised services.
- ICB & NHSE responsibilities in relation to the duty to consult with patients and the public under section 13Q can be found in Appendix 3

The core functions the team deliver on behalf of partners is as follows:

- Handling of Media queries
- Development of materials such as press releases, social media, and stakeholder briefings.
- Development of internal news stories
- Advice on stakeholder and patient engagement
- Managing stakeholder and patient consultations

Working with:

- ICBs
- Specialised Networks
- NHS trusts and other service providers
- NHS England national and regional directorates

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Regional Communications and Engagement Lead	Band 8C	1.0*
Communications Manager	Band 7	0.8*
	Total	**2.00***

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

6. Costs and Liabilities

6.1 Costs

During the 2024/25 transitional year where NHS England will continue to employ all staff and functions that support the 59 delegated services.
The costs associated with the provision of the Administrative and Management Services set out in section 5 by the Specialised Services Multi-disciplinary team shall not be included within the Delegated Funds allocated or transferred to the ICBs for 1st April 2024 to 31st March 2025 and that NHS England shall meet those costs.

6.2 Liabilities

NHS England shall be liable for any losses arising out of negligent acts or omissions in respect of the provision of Administrative and Management Services except where such losses arise as a result of action taken in accordance with instruction from any ICB or a failure of an ICB to provide on request appropriate instruction.

NHS England will meet the liabilities as a result of:

- Death or personal injury caused by its negligence.
- Fraud
- Fraudulent misrepresentation

7. Learning and Development

7.1 MaST training and professional development

The costs associated with the provision of agreed ongoing learning and development including mandatory (MaST) training for the Specialised Services Multidisciplinary team will be met by NHSE.

100% compliance is required by all staff for the MaST training detailed below:

Equality, Diversity and Inclusion

As part of the system leadership arrangements for the NHS, we recognise the importance of becoming a role model for the rest of the NHS in respect of issues relating to equality, diversity, and inclusion in the workplace.

Fraud Awareness
This course focuses on providing you with awareness of the key aspects of fraud and corruption in the NHS and help you know your responsibilities to combat it.

Data Security Awareness
This course focuses on the importance of data security in health and social care. It will help you understand how to comply with the law, define potential threats and how to identify and avoid breaches.

Health and Safety
This course focuses on health and safety in the workplace. You will gain an understanding for responsibilities under Health and Safety Law, different types of safety signage, basic fire safety principle, basic moving, and handling techniques and why incident reporting is so important.

Safeguarding Children & Adults at Risk of Harm or Abuse
This course introduces safeguarding children and adults at risk of harm or abuse. It focuses on safeguarding in the NHS, data sharing, domestic abuse, and associated legislation as well as what you can do when raising a concern.

Records Management
This course introduces you on the importance of records management, legal and contractual requirements, and guidance on how to keep information secure.

Patient Safety
This course introduces patient safety for all NHS staff. It focuses on the essentials for creating patient safety and helps recognise that the NHS is a system of essential and interconnected parts; a team with a common goal.

7.2 Dynamic Conversations

NHSE will meet all costs and requirements of ensuing all members of the Specialised Services Multi-disciplinary team have regular performance and development through regular Dynamic Conversations.

Dynamic Conversations are an opportunity for both line managers and team members to have meaningful, fluid, and organic 1:1s. Dynamic Conversations put wellbeing at the forefront of initial conversations and will help to support colleagues through change.

NHSE will ensure that monthly 1:1s with line managers are regularly scheduled.

8. Escalations, FoI & Incident Management

8.1 Freedom of Information and Parliamentary Requests

All Freedom of Information and Parliamentary Requests relating to Delegated Services should be forwarded to the Multi-Disciplinary Team will ensure the appropriate handling, management, and response, ensuring where appropriate that ICBs are informed and engaged. The team will also ensure they provide reasonable support to ICBs in responding to freedom of information and parliamentary correspondence as required.

8.2 Incident Response and Management

The Multi-Disciplinary Team shall provide such reasonable support as required by an ICB in relation to local incident management for Delegated Specialised Services.

8.3 Provider Selection and Procurement

The Multi-Disciplinary Team shall act on instructions from the ICBs in relation to provider selection and procurement processes for the Delegated Specialised Services.

8.4 Escalations

If an ICB has cause to raise concerns regarding the performance, actions or conduct of a member of the Multi-Disciplinary Team the ICB will in the first instance contact by email the Director of Specialised & Collaborative Commissioning, who will where possible provide an acknowledgement within 7 days of receipt.

The Director of Specialised & Collaborative Commissioning will provide the ICB with feedback and action taken with 30 days.

If for any reason the ICB is unhappy with the response the concerns can be escalated to the NHS England Regional Director of Commissioning

9 Confidential information

The ICBs and NHSE shall always use its best endeavours to keep confidential and ensure that its employees and agents keep confidential any information in relation to the business and affairs of another Partner.

If the information referred to herein is subject to a freedom of information (FOI) or other request to share the data, then NHS England will be responsible for the fulfilment of the request, but will seek views from the ICBs before undertaking this in accordance with the Freedom of Information Code of Practice issued by the Cabinet Office under section 45 of the Freedom of Information Act 2000.

The ICBs and NHSE will not make any press announcements about this Agreement or publicise this Agreement or any of the terms in any way. The ICBs and NHSE shall ensure that any such information disclosed is solely for the purpose of performing its obligations under this Agreement.

10 Finance

10.1 Scope

Schedule 4 of the ICB Collaboration Agreement provides detail of the approach to risk sharing and other financial arrangements, this section specifies how the Specialised Commissioning Finance Team within the Multidisciplinary Team will operate on behalf on the ICBs during 2024-25.

10.2 Multidisciplinary Team – Specialised Commissioning Finance Team

The role, functions and staffing model of the Specialised Commissioning Finance Team within the Multidisciplinary Teams is described in section 5.4 above. The team will aim to work on behalf of and in partnership with ICBs on financial planning and allocations, contract finance, financial management including risk management, financial reporting, financial control and cash management.

The team will also support NHSE Midlands on retained services and work with the National Finance Team to support future delegations. The team will continue to work across Midlands ICBs to ensure the maintenance of an efficient and effective service across both delegated and retained specialised services.

The Specialised Commissioning Finance Team will support other functions within the Multidisciplinary Team covering planning, service reviews and provider performance issues. For 2024/25, work with ICB and providers will be enhanced to extend existing arrangements covering contract arrangements, financial reporting, and risk management, building on the current finance, contracts and operational steering groups.

10.3 Multidisciplinary Team – Discretion relating to finances.

The issues of scope and limitations to decision making are addressed specifically in schedule 4 of the Collaboration Agreement

Historic investment decisions have been reviewed to ensure that the suggested limits would be operationally appropriate in respect of:

- The approval limits across systems and by MASCG
- Contract Awards
- Purchase Requisitions, Invoices and Non-Purchase Orders
- Budget virements

10.4 Multidisciplinary Team – Making payments in accordance with contracts.

The arrangements for making payments in accordance with contracts has been outlined as part of the delegation arrangements in the Cashflow SOP. NHS England will engage with ICBs to share contract payment schedules for NHS and Non-NHS providers linked to Contracting SOP.

The team will also be responsible for:

- Engagement to ensure supplier payment information is current and inclusive.
- Production of timetable for monthly activities shared and aligned with ICB officers.
- Operation of Financial Limits agreed in line with SFI's by ICB CFOs.
- Specific arrangements for monthly sign reporting sign offs and contract adjustments.
- Detail of ERF adjustments.

10.5 Multidisciplinary Team – Expectation in relation to financial reporting

The development and engagement between Specialised Commissioning Finance Team and ICBs in respect of Financial Reporting will be conducted through the East and West Midlands Joint Committees' formal Finance Sub-Group. This will include;

- Allocations for 59 delegated specialised services would be made to the eleven ICBs in the Midlands.
- ICBs would transfer allocations for the commissioning of these specialised services to the identified host ICB.
- The Specialised Commissioning Finance Team would manage specialised services through the host ledger managing financial risk across all eleven ICBs.
- All contractual payments would be managed by the Multidisciplinary Team through the single joint Specialised Commissioning contract (see Contracting SOP).
- In-year financial management would be undertaken at a multi-ICB level, mitigating the risk of variation between systems.

- Regional financial variances (under or overspend) would be mitigated through a contingency held by the host to minimise exposure to financial fluctuation as part of the risk sharing agreement.
- ICB level in-year financial reporting would show contributions to the pool in the ICB position thereby demonstrating a break-even position for specialised commissioning on monthly financial reports.
- Performance reporting would be developed at an ICB and multi ICB level to enable local intelligence on performance in these services.
- The Specialised Commissioning Finance Team would prepare finance reports at organisational level to ensure all ICBs have full sight of the overall actual performance of specialised commissioning and indicative ICB level performance.
- Residual variances after mitigations would be allocated to ICBs based on contributions to the pool.
- Adjustments will be made to timescales agreed through the Finance sub-group.

10.6 Multidisciplinary Team – Dispute process in relation to activities undertaken.

In the event of a dispute relating to finance or the activities undertaken by the Specialised Commissioning Finance Team, the following escalation routes will apply;

- Address with NHS England Senior Finance Leads through to Director of Commissioning Finance
- Escalation to Finance Subgroup
- Further escalation to Joint Committees

10.7 Multidisciplinary Team – Access to ledgers

ICB CFOs will be required to approve access to ICB ledger to assure internal controls and processes. In addition, validation of ledger codes for specialised services, together with confirmation of supplier codes prior to the commencement of 2024/25 on each of the ICB ledgers will be required.

Appendix 1 – Contract Leads for NHSE Specialised Contracts

Area	ICB	Provider	Provider Acronym	Provider Code	Contract Lead	Escalation lead
East	Derby and Derbyshire	University Hospitals of Derby and Burton	UHDB	RTG	Nick Hey	Nick Hey
East	Derby and Derbyshire	Chesterfield Royal Hospital NHS Trust	CRH	RFS	Nick Hey	Nick Hey
East	Leicester, Leicestershire and Rutland	University Hospitals of Leicester NHS Trust	UHL	RWE	Steph deCelis	Dom Tolley
East	Lincolnshire	United Lincolnshire Hospitals NHS Trust	ULHT	RWD	Nick Hey	Nick Hey
East	Lincolnshire	Lincolnshire Community Health Service NHS Trust	LCHS	RP7	Dawn Newman	Nick Hey
East	Northamptonshire	Kettering General Hospital NHS Trust	KGH	RNQ	Steph deCelis	Dom Tolley
East	Northamptonshire	Northamptonshire General Hospital Trust	NGH	RNS	Steph deCelis	Dom Tolley
East	Nottingham and Nottinghamshire	Nottingham University Hospitals NHS Trust	NUH	RX1	Nick Hey	Nick Hey
East	Nottingham and Nottinghamshire	Sherwood Forest Hospitals NHS Trust	SFHT	RK5	Dawn Newman	Nick Hey
West	Birmingham and Solihull	Birmingham Community Healthcare NHS Trust	BCHC	RYW	Nikita Panesar	Leila Marchant
West	Birmingham and Solihull	Birmingham Women's and Childrens Hospital NHS Foundation Trust	BWCH	RQ3	Sarah Simkins	Sumana Bassinder
West	Birmingham and Solihull	Royal Orthopaedic Hospital NHS Foundation Trust	ROH	RRJ	Leila Marchant	Sumana Bassinder
West	Birmingham and Solihull	Sandwell and West Birmingham Hospitals NHS Trust	SWBH	RXK	Leila Marchant	Sumana Bassinder
West	Birmingham and Solihull	University Hospital Birmingham NHS Foundation Trust	UHB	RRK	Leila Marchant	Sumana Bassinder
West	Coventry and Warwickshire	University Hospitals Coventry and Warwick NHS Trust	UHCW	RKB	Emma Partridge	Laura Morris
West	Coventry and Warwickshire	South Warwickshire Foundation Trust	SWFT	RJC	Jasmeet Najran	Emma Partridge
West	Coventry and Warwickshire	George Eliot Hospital NHS Trust	GEH	RLT	Jasmeet Najran	Emma Partridge
West	Coventry and Warwickshire	Coventry and Warwickshire Partnership Trust	CWPT	RYG	Maria Muro	Emma Partridge
West	Herefordshire and Worcestershire	Worcestershire Acute Hospitals NHS Trust	WAHT	RWP	Nick Hey	Nick Hey
West	Herefordshire and Worcestershire	Wye Valley NHS Trust	WVT	RLQ	Maria Muro	Emma Partridge
West	Shropshire, Telford and Wrekin	Shrewsbury and Telford Hospitals NHS Trust	SATH	RXW	Jasmeet Najran	Emma Partridge
West	Shropshire, Telford and Wrekin	Robert Jones Agnes Hunt Foundation Trust	RJAH	RL1	Jasmeet Najran	Emma Partridge
West	Staffordshire and Stoke on Trent	University Hospital of North Midlands NHS Trust	UHNM	RJE	Emma Partridge	Laura Morris
West	Staffordshire and Stoke on Trent	Midland Partnership	MPFT	RRE	Maria Muro	Emma Partridge
West	The Black Country	The Dudley Group of Hospitals NHS Foundation Trust	DGOH	RNA	Nikita Panesar	Leila Marchant
West	The Black Country	The Royal Wolverhampton NHS Trust	RWHT	RL4	Leila Marchant	Sumana Bassinder
West	The Black Country	Walsall Healthcare NHS Trust	WHT	RBK	Leila Marchant	Sumana Bassinder

Appendix 2 – Specialised Pharmacy Contacts

ICB	Provider	Pharmacist Lead	Pharmacy Analyst Lead
Birmingham and Solihull	University Hospitals Birmingham NHS Foundation Trust	Susanna Allen	Jeetender Dhap
Birmingham and Solihull	Birmingham Women's and Children's Hospital NHS Foundation Trust	Susanna Allen	Emma Shannon
Birmingham and Solihull	Royal Orthopaedic Hospital NHS Foundation Trust	Anand Mistry	Jeetender Dhap
The Black Country	Royal Wolverhampton Hospitals NHS Trust	Anand Mistry	Jeetender Dhap
The Black Country	The Dudley Group of Hospitals NHS Foundation Trust	Dhiren Bharkhada	Emma Shannon
The Black Country	Walsall Healthcare NHS Trust	Anand Mistry	Jeetender Dhap
The Black Country	Sandwell and West Birmingham Hospitals NHS Trust	Anand Mistry	Jeetender Dhap
Coventry and Warwickshire	University Hospitals Coventry and Warwickshire NHS Trust	Anand Mistry	Jeetender Dhap
Coventry and Warwickshire	South Warwickshire NHS Foundation Trust	Dhiren Bharkhada	Jeetender Dhap
Coventry and Warwickshire	George Eliot Hospital NHS Trust	Dhiren Bharkhada	Jeetender Dhap
Coventry and Warwickshire	Coventry and Warwickshire NHS Partnership Trust	Anand Mistry	Emma Shannon
Herefordshire and Worcestershire	Worcestershire Acute Hospital NHS Trust	Anand Mistry	Emma Shannon
Herefordshire and Worcestershire	Wye Valley NHS Trust	Anand Mistry	Jeetender Dhap
Shropshire, Telford and Wrekin	Shrewsbury and Telford Hospitals NHS Trust	Dhiren Bharkhada	Emma Shannon
Shropshire, Telford and Wrekin	Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust	Anand Mistry	Emma Shannon
Staffordshire and Stoke-on-Trent	University Hospitals North Midlands NHS Trust	Dhiren Bharkhada	Jeetender Dhap
Staffordshire and Stoke-on-Trent	Midlands Partnership Foundation Trust	Anand Mistry	Emma Shannon
Derbyshire	Chesterfield Royal Hospital NHS Foundation Trust	Anand Mistry	Emma Shannon
Derbyshire	University Hospitals Derby and Burton	Dhiren Bharkhada	Jeetender Dhap
Nottinghamshire	Nottingham University Hospitals NHS Trust	Susanna Allen	Emma Shannon
Nottinghamshire	Nottingham Treatment Centre	Dhiren Bharkhada	Jeetender Dhap
Nottinghamshire	Sherwood Forest Hospitals NHS Foundation Trust	Dhiren Bharkhada	Jeetender Dhap
Lincolnshire	Lincolnshire Community Health Services NHS Trust	Anand Mistry	Emma Shannon
Lincolnshire	United Lincolnshire Hospitals NHS Trust	Anand Mistry	Emma Shannon
Leicester, Leicestershire and Rutland	University Hospitals Leicester	Dhiren Bharkhada	Jeetender Dhap
Northamptonshire	Kettering General Hospital NHS Foundation Trust	Dhiren Bharkhada	Jeetender Dhap
Northamptonshire	Northampton General Hospital NHS Trust	Dhiren Bharkhada	Emma Shannon
Northamptonshire	Northamptonshire Healthcare NHS Foundation Trust	Anand Mistry	Jeetender Dhap

Appendix 3: Fulfilling statutory duties (13Q) & Communications & Engagement

Introduction

The delegation of 59 specialised services to ICBs will mean some changes in the way communications and engagement are handled. This document aims to clarify the roles and responsibilities after delegation of this initial groups of 59 services in April and before planned transfer of staff in April 2025.

General principles

Each ICB will be responsible for communications and engagement for the 59 delegated specialised services within its own system.

In this transitional year, the existing commissioning communications team of Communications and Engagement Lead and Communications Manager will continue to manage activity for the 59 delegated services, working with the existing operating teams, and reporting to the relevant ICB or ICBs.

The regional NHS Midlands media team will retain responsibility for matters where there is a risk to NHS reputation – for instance if the impact is significant or wider than one joint committee (East and West).

Full details of specialised services contacts in comms and engagement and in the operational teams will be shared.

Reactive media enquiries

Media enquiries will be flagged to communications team and with ICB and specialised operating team. Providers may be liaised with, and ICB communications will be kept informed by NHSE communications team. The ICB/s will approve the final planned response (they may choose to deliver the response if they wish).

Proactive activity

National activity will be cascaded via the NHS Midlands communications team to all ICBs individually – for instance new treatments.

Individual activity around services will be undertaken by the NHSE communications team working with the operational team and provider and reporting into ICB communications teams.

Healthwatch and engagement

Responsibility for engagement with Healthwatch groups and other system-wide stakeholders will be treated as follows:

- Individual services at trusts will be carried out by providers with approvals from ICBs – for instance location changes; changes in service levels
- Region-wide services (e.g. renal services; paediatric reviews) will be carried out by NHSE communications with prior approval from ICBs

NHS England in the Midlands will include region-wide news regarding access to services, investment, healthcare trends etc in updates to MPs, DsPH etc but ICBs will be informed and involved in each instance.

Patient and stakeholder engagement to fulfil statutory duties (13Q)

NHS England will be responsible for ensuring statutory duties are met.

NHSE communications team will liaise with specialised operating team and providers to ensure that engagement and consultation activity is being undertaken whenever necessary.

NHSE communications team will report to ICB communications and to the NHS England national team as part of the six monthly reporting duties.

HOSC

Specialised operating teams are sometimes required to liaise with HOSCs.

If this arises in the period to April 2025, ICB communications teams will be informed and involved.

Appendix 4

Service Profile Pack Derby & Derbyshire ICB

Midlands Specialised Delegation Programme

Date of issue: MAR 2024

Introduction

This service profile pack contains essential high-level information regarding the 59 specialised services being delegated to your ICB on the 1st April 2024. It has been co-designed by ICB and NHSE representatives from the Clinical & Quality workstream of the Midlands Specialised Delegation Programme and provides some examples of the clinical case for change and how delegation will better support better services for patients. It includes information about the services that are being delegated, where they are being provided, the volume of current activity and the planning priorities for 2024/25.

A suite of service profiles containing details of clinical outcomes, patient safety concerns and workforce challenges will be available at the time of delegation. The service profile for Vascular Services is included as an example.

Dr Colette Marshall
Regional Medical Director of Commissioning, NHS England

Dr Clara Day
Chief Medical Officer, BSOL ICB

Sally Roberts
Chief Nursing Officer, Black Country ICB

Dr Nil Sanganee
Chief Medical Officer, LLR ICB

Kay Darby
Chief Nursing Officer, LLR ICB

Contents

1. Case for Change

Why delegate specialised services?

ICBs and providers to have **freedom to design services and to innovate** in meeting the national standards where they take on delegated or joint commissioning responsibility

ICBs and providers able to **pool specialised budget and non-specialised budgets** to best meet the needs of their population, tackle health inequalities and to join up care pathways for their patients

ICBs and providers able to use world class assets of specialised services to **better support their communities closer to home** (e.g. designing local public health initiatives, greater diagnostics and screening)

What should this mean for our patients, populations and their communities?

Quality of patient care

Patients will receive more **joined up care** – better communication and sharing of information between professionals and services.

More of a **holistic, multi-disciplinary approach** to care. A range of professionals can be involved in planning a patient's care.

Increase focus and investment on **prevention**.

Patients will receive the **right care at the right time in the right place**.

Better **step-down care** to support patients who are ready to leave specialised care.

Equity of access

Population based budgets means decisions on spend are based on the **needs of a local population** – the demographics, health behaviours etc rather than on activity in hospitals.

Specialised clinical expertise will have a role in managing population health and to **challenge underlying drivers of health inequalities**.

Providers and professionals working collaboratively, free from organisational constraints and commissioning boundaries, will help improve **quality of care and tackle unwarranted variation**.

Opportunity to **level up access across the country**

Value

Investment in preventative care could **reduce demand** for specialised services.

Providers and professionals can **better manage patient demand**, even when one part of the system becomes stretched. Patients can be re-directed or transferred so they have faster and better access to treatment

A whole system approach creates opportunities **to protect and build 'workforce resilience'**, as shown during the pandemic.

Pooled/delegated budgets allow **underspends to be shared or reinvested** and avoids commissioning pressures on any one organisation.

- Accessible care
- Tailored care
- Seamless care
- Effective care
- Preventative care

Case study examples of benefits are included in Appendix A.

2.Contracted Delegated Services by Provider

Contracts Overview

- The contract portfolio for Specialised Services in the Midlands in 2023/24 includes
  - 27 Main NHS Provider Contracts
  - 2 NHS Standalone Service Contracts
  - 4 Standalone Independent sector Contracts
- These contracts are currently managed for NHS England by the Midlands Acute Specialised Commissioning (MASC) Team
- Following the delegation of the 59 Specialised Services in April 2024, the MASC Team will continue to manage these contracts on behalf of the 11 ICBs for delegated services and on behalf on NHSE for retained services.

- **The next slide contains a list of which delegated specialised services are provided by Trusts within the Derby &Derbyshire system.**

- **Further details including the following contact details is available in Appendix 1.1;**
  - Commissioning Lead
  - Contract Manager
  - Quality Lead
  - Finance Lead

Specialised Services provided by Trust in Derby & Derbyshire ICS

University Hospitals of Derby & Burton
Adult specialist rheumatology services
Adult specialist cardiac services
Adult specialist ophthalmology services
Adult specialist orthopaedic services
Adult specialist renal services
Adult specialist services for people living with HIV
Adult specialist vascular services
Complex spinal surgery services (adults and children)
Fetal medicine services (adults and children)
Specialist adult gynaecological surgery and urinary services for females
Specialist adult urological services for men
Specialist dermatology services (adults and children)
Radiotherapy services (adults and children)
Specialist cancer services (adults)
Specialist cancer services for children and young adults
Neonatal critical care services
Paediatric critical care services
Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)
Adult Critical Care

Chesterfield Royal Hospital
Adult specialist services for people living with HIV
Specialist cancer services (adults)
Neonatal critical care services
Adult Critical Care

3. Activity Data by ICB

Activity Overview

- Specialised Services are delivered to Midlands' patients at Trusts across the Midlands. In addition, some Midlands patients access Specialised Services in Trust outside of the Midlands region.

- Midlands' providers treat patients from the Midlands but also patients from other regions.

- The following slide (Slide 11) gives an overview of these activity flows for patients and providers in the Derby & Derbyshire system for Month 1 to 9 of 2023

- Slide 12 aggregates the same information at a regional level and gives an overview of activity flows for patients and providers in the Midlands region for comparison.

Example

NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG)	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
B03 - SPECIALISED CANCER SURGERY	38,854	24,461	33,655	63,315	72,509	96,970

- **Further detail, including a drill-down to individual provider. is available in Appendix 2.1.**

Total Activities for QJ2 : NHS Derby & Derbyshire ICB

Activity Period: M01-M09 2023/24 (Apr 2023 – Dec 2023)

NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG)	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
B03 - SPECIALISED CANCER SURGERY	38,854	24,461	33,655	63,315	72,509	96,970
A06 - RENAL SERVICES	38,749	17,151	26,303	55,900	65,052	82,203
B02 - CHEMOTHERAPY	27,975	10,623	14,482	38,598	42,457	53,080
B01 - RADIOTHERAPY	13,316	6,450	14,350	19,766	27,666	34,116
E08 - NEONATAL CRITICAL CARE	7,491	2,392	4,167	9,883	11,658	14,050
D04 - NEUROSCIENCES	0	-	11,866	-	11,866	11,866
A05 - CARDIOTHORACIC SERVICES	1,262	338	9,530	1,600	10,792	11,130
E06 - METABOLIC DISORDERS	0	-	9,654	-	9,654	9,654
A09 - SPECIALISED RHEUMATOLOGY	3,289	2,889	1,034	6,178	4,323	7,212
F03 - HIV	5,958	-	655	-	6,613	6,613
E03 - PAEDIATRIC MEDICINE	0	-	6,268	-	6,268	6,268
E02 - SPECIALISED SURGERY IN CHILDREN	-	-	5,239	-	-	5,239
D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	366	87	3,215	453	3,581	3,668
B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES	143	53	2,877	196	3,020	3,073
A04 - VASCULAR DISEASE	1,197	445	1,150	1,642	2,347	2,792
A02 - HEPATOBILIARY AND PANCREAS	-	-	2,687	-	-	2,687
E07 - PAEDIATRIC INTENSIVE CARE	439	358	1,659	797	2,098	2,456
D01 - REHABILITATION AND DISABILITY	0	-	1,957	-	1,957	1,957
E04 - PAEDIATRIC NEUROSCIENCES	0	-	1,757	-	1,757	1,757
E05 - CONGENITAL HEART SERVICES	-	-	1,422	-	-	1,422
A01 - SPECIALISED RESPIRATORY	0	-	1,351	-	1,351	1,351
A03 - SPECIALISED ENDOCRINOLOGY	0	-	1,099	-	1,099	1,099
D02 - MAJOR TRAUMA	-	-	640	-	-	640
D03 - SPINAL SERVICES	117	53	392	170	509	562
A08 - SPECIALISED DERMATOLOGY	233	100	216	333	449	549
F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES / E03 - PAEDIATRIC MEDICINE	0	-	397	-	397	397
E09 - SPECIALISED WOMENS SERVICES	3	-	249	-	252	252
D10 - SPECIALISED ORTHOPAEDIC SERVICES	17	24	39	41	56	80
A07 - SPECIALISED COLORECTAL SERVICES	14	9	56	23	70	79
D07 - SPECIALISED PAIN	-	-	47	-	-	47
F04 - INFECTIOUS DISEASES	0	-	6	-	6	6
Unknown	25	6	298	31	323	329
Grand Total	**139,448**	**65,439**	**158,717**	**204,887**	**298,165**	**363,604**

Total Activities for Midlands Region

Activity Period: M01-M09 2023/24 (Apr 2023 – Dec 2023)

	A	B	C	A+B	A+C	A+B+C
NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG)	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
A06 - RENAL SERVICES	761,379	38,806	37,405	800,185	798,783	**837,589**
B03 - SPECIALISED CANCER SURGERY	723,206	8,546	74,570	731,752	797,776	**806,322**
B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES	332,751	343	2,546	333,094	335,297	**335,640**
A05 - CARDIOTHORACIC SERVICES	225,064	8,465	18,289	233,529	243,353	**251,818**
B02 - CHEMOTHERAPY	190,405	17,030	27,686	207,435	218,091	**235,121**
B01 - RADIOTHERAPY	173,641	3,242	31,152	176,883	204,793	**208,035**
E03 - PAEDIATRIC MEDICINE	156,469	7,358	9,089	163,827	165,558	**172,916**
E06 - METABOLIC DISORDERS	154,286	3,165	401	157,451	154,687	**157,852**
D04 - NEUROSCIENCES	99,651	4,807	26,781	104,458	126,432	**131,239**
E02 - SPECIALISED SURGERY IN CHILDREN	103,670	2,598	11,090	106,268	114,760	**117,358**
E08 - NEONATAL CRITICAL CARE	105,630	1,225	9,172	106,855	114,802	**116,027**
D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	92,348	1,555	5,811	93,903	98,159	**99,714**
D01 - REHABILITATION AND DISABILITY	45,596	1,068	2,513	46,664	48,109	**49,177**
A02 - HEPATOBILIARY AND PANCREAS	31,850	3,463	4,058	35,313	35,908	**39,371**
E05 - CONGENITAL HEART SERVICES	31,235	917	3,217	32,152	34,452	**35,369**
E04 - PAEDIATRIC NEUROSCIENCES	25,760	425	4,088	26,185	29,848	**30,273**
F03 - HIV	25,665	488	1,529	26,153	27,194	**27,683**
A09 - SPECIALISED RHEUMATOLOGY	23,300	79	2,256	23,379	25,556	**25,635**
A04 - VASCULAR DISEASE	20,593	516	2,420	21,109	23,013	**23,529**
A01 - SPECIALISED RESPIRATORY	15,767	90	4,701	15,857	20,468	**20,558**
A03 - SPECIALISED ENDOCRINOLOGY	17,142	563	2,381	17,705	19,523	**20,086**
E07 - PAEDIATRIC INTENSIVE CARE	13,978	221	2,659	14,199	16,637	**16,858**
D02 - MAJOR TRAUMA	5,499	516	201	6,015	5,700	**6,216**
D03 - SPINAL SERVICES	4,113	296	549	4,409	4,662	**4,958**
A08 - SPECIALISED DERMATOLOGY	3,594	14	1,074	3,608	4,668	**4,682**
F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES / E03 - PAEDIATRIC MEDICINE	2,640	74	804	2,714	3,444	**3,518**
E09 - SPECIALISED WOMENS SERVICES	2,661	10	117	2,671	2,778	**2,788**
D10 - SPECIALISED ORTHOPAEDIC SERVICES	2,081	460	66	2,541	2,147	**2,607**
F04 - INFECTIOUS DISEASES	120	-	2,202	120	2,322	**2,322**
D07 - SPECIALISED PAIN	812	3	901	815	1,713	**1,716**
A07 - SPECIALISED COLORECTAL SERVICES	970	7	135	977	1,105	**1,112**
Unknown	3,956	93	1,035	4,049	4,991	**5,084**
Grand Total	**3,395,830**	**106,444**	**290,897**	**3,502,273**	**3,686,727**	**3,793,170**

4. Quality Dashboard Overview

Quality Dashboard Overview

The following slides provide the following information on delegated specialised services

- How many units in the Midlands are delivering the service?
- Is the service required to submit data to the Specialised Services Quality Dashboard? (see next slide for definition on an SSQD)
- Is the service supported by an Operational Delivery Network (ODN) or other Clinical Network?
- Is the team aware of any Serious Incidents (Sis) relating to the service?
- Is the team aware of any complaints relating to the service?
- Is the team aware of any CQC reports relating to the service?
- Is the team aware of any other intelligence relating to the service?

Example

Priority	Service	Units	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
1	ACC	61	Y	Y	Y	N	1 UHB	Network Peer Reviews, GIRFT
		There are 61 sites in the Midlands delivering ACC (Adult Critical Care)	There are SSQDs relating to ACC	There is a Network for ACC	There are SIs relating to ACC	There are no complaints relating to ACC	There is a CQC report relating to ACC at UHB	There network peer reviews and a GIRFT report relating to ACC

Specialised Services Quality Dashboard (SSQD)

- SSQDs are designed to provide assurance on the quality of care by collecting information about outcomes from healthcare providers. SSQDs are a key tool in monitoring the quality of services, enabling comparison between service providers and supporting improvements over time in the outcomes of services commissioned by NHS England.

- For each SSQD, there is a list of agreed measures for which data is to be collected. Healthcare providers, including NHS Trusts, NHS Foundation Trusts and independent providers, submit data for each of the agreed measures.

- Each SSQD is ‘refreshed’ with up-to-date outcomes submitted from national data sources, and where necessary healthcare providers, on a quarterly basis. The information provided by the SSQDs is used by NHS England specialised services commissioners to understand the quality and outcomes of services and reasons for excellent performance. Healthcare providers can use the information to provide an overview of service quality compared with other providers of the same service.

Quality Overview Dashboard (1 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
1	ACC	61	Y	Y	Y	N	1 UHB	Network Peer Reviews, GIRFT
2	Cancer- Chemotherapy	43	Y	Y	Y	N	N	GIRFT
3	Cirrhosis of the liver	36	Y	Y	N	N	N	N
4	Neonatal Care	25	Y	Y	Y	N	N	Network Peer Reviews
5	Cardiology: implantable cardioverter defibrillator (ICD)	17	Y	Y	Y	N	N	National Audit
6	Cardiology: primary percutaneous coronary intervention (PPCI) (Adult)	11	Y	Y	N	N	N	National audit, GIRFT
7	Cardiac MRI	11	Y	Y	N	N	N	National audit, GIRFT
8	In centre haemodialysis: main & satellite units	11	Y	Y	Y	N	N	N
9	Cardiac surgery (Adults)	10	Y	Y	Y	N	N	National Audit, GIRFT
10	Haemophilia (All ages)	10	Y	Y	N	N	N	National Audits
11	Fetal medicine – (West Mids has AIP & Fetal Med)	9	Y	Y	N	N	N	National Audits
12	Cancer: anal	8	Y	Y	N	N	N	National Audits, GIRFT
13	Specialised kidney, bladder, & prostate cancer services	8	Y	Y	Y	N	N	GIRFT
14	Cardiac: electrophysiology & ablation services	7	Y	Y	N	N	N	National Audits, GIRFT
15	Thoracic surgery (adults)	6	Y	Y		N	N	N
16	Hepatobiliary & pancreas (Adult)	6	Y	Y	N	N	N	N
17	Cancer: pancreatic (Adult)	5	Y	Y	N	N	N	N
18	Cancer: malignant mesothelioma (Adult)	4	Y	Y	N	N	N	N
19	Level 3 - Paediatric Critical Care	4	Y	Y	N	N	Y	GIRFT
20	Adult congenital heart disease (ACHD)	2	Y	Y	N	N	N	National Audits, GIRFT(Cardiology)
21	Stereotactic radiosurgery & stereotactic radiotherapy (Intracranial) (All ages)	2	Y	Y	N	N	N	N
22	Testicular cancer	2	Y	Y	N	N	N	GIRFT

Quality Overview Dashboard (2 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
23	Cancer: Clinical chemotherapy	28	N	Y	N	N	N	N
24	Cancer: chemotherapy ITC	18	N	Y	N	N	N	N
25	Cancer chemotherapy Higher Intensity	14	N	Y	N	N	N	N
26	Renal – assessment & prep for renal replacement therapy	10	N	Y	N	N	N	N
27	Haemodialysis to treat established renal failure	10	N	Y	N	N	N	N
28	Peritoneal dialysis to treat established renal failure	10	N	Y	N	N	N	N
29	Renal dialysis – intermittent haemodialysis & plasma exchange to treat acute kidney injury	10	N	Y	N	N	N	N
30	Level 2 - Paediatric Critical Care	8	N	Y	N	N	I KGH	N
31	Complex spinal surgery (All ages)	8	N	Y	N	N	N	N
32	Paed surgery: surgery (and surgical pathology, anaesthesia & pain)	7	N	Y	N	N	N	N
33	Colorectal: transanal endoscopic microsurgery (TEMS)	7	N	Y	N	N	N	N
34	Specialised HIV services (Adults)	7	N	Y	N	N	N	N
35	Specialised cancer surgery: non-surgical	6	N	Y	N	N	N	N
36	Paed medicine: respiratory	5	N	Y	Y	N	N	N
37	Neurosciences: specialised neurology (Adults)	5	N	Y	N	N	N	N
38	Cardiology: inherited cardiac services (All ages)	5	N	Y	N	N	N	N
39	Neurosurgery: Adults	4	N	Y	Y	N	N	N
40	Brain & other rare CNS tumours	4	N	Y	N	N	N	N
41	Major trauma (Adult)	4	N	Y	Y	N		Network Peer Reviews
42	Specialised services for haemoglobinopathy (All ages): haemoglobinopathies coordinating care centres	3	N	Y	N	N	N	N
43	Major trauma (children)	2	N	Y	Y	N	N	Network Peer Reviews
44	Paed surgery: chronic pain	2	N	Y	N	N	N	

Quality Overview Dashboard (3 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
45	Specialised immunology (All ages)	13	Y	N	N	N	N	National Audits, GIRFT
46	Vascular disease: arterial	11	Y	N	Y	N	N	National Audits, GIRFT
47	Specialised rheumatology services (Adult)	10	Y	N	N	N	N	Y GIRFT
48	Haemophilia (All ages)	10	Y	N	N	N	N	Y National Audits
49	Implantable hearing aids for microtia, bone anchored hearing aids….	7	Y	N	N	N	N	N
50	Paed medicine: rheumatology	7	Y	N	N	N	N	N
51	Specialised complex surgery for urinary incontinence and vaginal prolapse (16yrs & above)	7	N	N	N	N	N	N
52	Colorectal: faecal incontinence (Adult)	6	Y	N	N	N	N	N
53	Interstitial lung disease	6	Y	N	N	N	N	QSIP self-assessment pilot
54	Intestinal failure (Adult)	6	Y	N	N	N	N	N
55	Specialised endocrinology services (Adult)	6	Y	N	N	N	N	N
56	Cystic fibrosis (children)	5	Y	N	N	N	N	N
57	Cystic fibrosis (Adult)	4	Y	N	N	N	N	N
58	Complex disability equipment: prosthetic specialised services (all ages) with limb loss	3	Y	N	N	N	N	N
59	Positron emission tomography – computed tomography (PET CT) (All ages)	3	Y	N	N	N	N	N
60	Cleft lip and/or palate	3	Y	N	N	N	N	N
61	Complex gynae: congenital gynae anomalies (Children 13yrs & above and adults)	4	Y	N	N	N	N	N
62	Fetal medicine (East Midlands don't have network)	3	Y	N	N	N	N	N
63	Specialised resp services (Adult): severe asthma	3	Y	N	N	N	N	N
64	Metabolic disorders (Children)	3	Y	N	N	N	N	N
65	Metabolic disorders (Adult)	1	Y	N	N	N	N	N
66	Adult highly specialist pain management services	1	Y	N	N	N	N	N
67	Spinal cord injuries	1	Y	N	N	N	N	N
68	Complex gynae/female urology: genito-urinary tract fistulae (Girls & women aged 16yrs & above)	1	Y	N	N	N	N	N

Quality Overview Dashboard (4 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
69	Specialised HIV (Adults)	19	N	N	N	N	N	N
70	Specialised ophthalmology (Paeds)	10	N	N	N	N	N	N
71	Colorectal: transanal endoscopic microsurgery (TEMS) (Adult)	7	N	N	N	N	N	N
72	Paed medicine: gastro, hepatology & nutrition	7	N	N	N	N	N	N
73	Paed medicine: endocrinology & diabetes	6	N	N	N	N	N	N
74	Colorectal: complex IBD (Adults)	6	N	N	N	N	N	N
75	Specialised rehabilitation services for patients with highly complex needs (All ages)	6	N	N	N	N	N	N
76	Specialised allergy services (All ages)	6	N	N	N	N	N	N
77	Specialised dermatology services (All ages)	6	N	N	N	N	N	N
78	Neurosciences: specialised neurology (Adults)	5	N	N	N	N	N	N
79	Paed medicine: respiratory	5	N	N	N	N	N	N
80	Specialised ophthalmology (Adult)	5	N	N	N	N	N	N
81	Specialised orthopaedics (Adult)	5	N	N	N	N	N	N
82	Colorectal: distal sacrectomy (Adult)	4	N	N	N	N	N	N
83	Complex gynae – severe endometriosis	4	N	N	N	N	N	N
84	Paed medicine: haematology	4	N	N	N	N	N	N
85	Specialised ear surgery: cochlear implants	3	N	N	N	N	N	N
86	Complex disability equipment: communication aids	2	N	N	N	N	N	N
87	Metabolic disorders (lab services)	2	N	N	N	N	N	N
88	Environmental control equipment for patients with complex disability (All ages)	2	N	N	N	N	N	N
89	Paed medicine: renal	2	N	N	N	N	N	N
90	Paed medicine: specialised allergy services	2	N	N	N	N	N	N
91	Paed neuroscience: neurology	2	N	N	N	N	N	N
92	Paed medicine: immunology & infectious diseases	1	N	N	N	N	N	N

5. Quality Service Profile
Specialised Vascular (Arterial) Services

(Included as an example of profiles to follow)

Overview of the Quality Service Profiles

The following slides provide an example of the level of information held for each delegated specialised service. This Quality Service Profile for Vascular Services is provided as an example. The full suite of Quality Service Profiles is being prepared to be handed over at the point of delegation.

The following information is included in the Quality Service Profiles

- Which Midlands providers are delivering the service?
- What are the contact values and activity levels used for contract monitoring?
- What site are delivering the service?
- What local intelligence does the commissioning team hold about the service?
- What patient safety information does the quality team hold about the service?
- What information on clinical outcomes does the quality team hold about the service?
- What information on workforce and sustainability does the quality team hold about the service?

Further information in relation to Vascular Services is included in appendices 5.1-5.3.

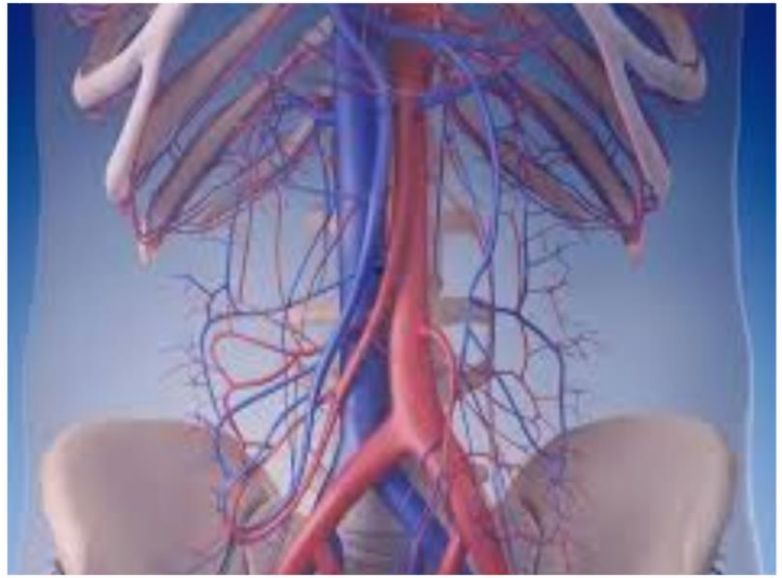
Specialised Vascular (Arterial) Services - Overview

Eleven (5 East & 6 West) Midlands Providers (Based on 2022/23 and all Points Of Delivery). Values based on SLAM.

			Contract Monitoring Actual Price	Contract Monitoring Actual Activity
Grand Total			£19,530,304	27,310
RJE : UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£2,236,112	4,243
RKB : UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,470,165	942
RNA : THE DUDLEY GROUP NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£89,878	657
RNS : NORTHAMPTON GENERAL HOSPITAL NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£883,025	2,045
RR1 : HEART OF ENGLAND NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£5,956,526	2,033
RRK : UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£510,404	819
RTG : UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,339,425	1,324
RWD : UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,271,398	3,552
RWE : UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,526,080	4,834
RWP : WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£860,810	827
RX1 : NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£2,681,339	4,047
RXW : THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£705,142	1,987

The 11 Arterial Centres in the Midlands have no, one or more spokes as listed below
(information based on Trust returns to the National Vascular Registry (NVR)):

	Arterial centre (Hub)	Associated Centre (Spoke)
East Midlands	Nottingham University Hospital (Nottingham City Hospital)	Kings Mill (Mansfield)
	University Hospitals Leicester (Glenfield)	
	University Hospitals of Derby and Burton (Royal Derby Hospital)	Chesterfield Royal Hospital
	Northampton General Hospital	Kettering General Hospital
	United Lincolnshire Hospitals (Pilgrim Hospital Boston)	ULHT Lincoln County Hospital
West Midlands	University Hospitals North Midlands (Royal Stoke)	County Hospital Stafford, Leighton Hospital Crewe;
	Shrewsbury & Telford Hospitals (Royal Shrewsbury Hospital)	Princess Royal Telford;
	Dudley Group Hospitals (Russell's Hall)	New Cross Wolverhampton, Manor Hospital Walsall;
	University Hospitals Birmingham (Birmingham Heartlands Hospital)	QE Birmingham, Good Hope Sutton Coldfield, Solihull Hospital, City Hospital Birmingham, Sandwell Hospital
	Worcester Acute Hospitals (Worcester Royal Infirmary);	
	University Hospitals Coventry & Warwickshire (Walsgrave)	George Eliot, Warwick Hospital



Specialised Vascular (Arterial) Services - Overview

The Action on Vascular (AoV) Project Closure Report (2023) using **National Vascular Registry (NVR) data** included a summary of outstanding issues for the Midlands region.

- In 2018, there were 12 vascular Arterial Centres in the Midlands. Following a merger in the **West Midlands**, one centre ceased providing inpatient vascular care – **Queen Elizabeth, Birmingham.** This did not result in a compliant service at **UHB (Heartlands),** with IR staffing and activity levels being low.
- Of the remaining hospitals in West Midlands none is fully compliant. Activity and staffing are low in **SaTH**, activity is low at **Dudley** and **UHCW**, with **Carotid Endartectomy (CEA)** activity low at **UHNM** and finally, **IR** staffing is low at **WAH**.
- There have been no changes in the provider landscape in **East Midlands**. Three hospitals have **acceptable staffing but low activity** - **UHDB (CEA), NUH Abdominal Aortic Aneurysm (AAA)** and **UHL (AAA).** The challenges in **NGH** and **ULHT** have been partially mitigated by the link with **UHL**, but activity and staffing remain low.
- Based on current activity the region could support nine or ten arterial centres (if activity levels in the index procedures fall no further), but current patient flows result in all of the current centres failing to meet minimum activity requirements with the exception of **WAH.**
- Complex aneurysm procedures are currently undertaken at ten centres. Based on current activity the region is unlikely to be able to support more than three centres undertaking this work. Currently only one centre does more than 12 complex procedures per year **(UHB).**

Specialised Vascular (Arterial) Services

The below information is validated data as of 09/01/2024

Patient Safety	
Serious Incidents (consider PSIRF/LFPSE when available)	**Appendix 5.1** Details of two incidents reported between the period of April 2022 – present
Never Events	None identified
CQC Reports	None identified

Workforce & Sustainability	
Workforce/ Recruitment & retention	GIRFT and Vascular Society recommend a minimum of 6 vascular surgeons and 6 Interventional Radiologists providing 24/7 cover in an arterial centre. Recruitment and retention of IR consultants is a challenge nationally and particularly for smaller centres. This can lead to service fragility and challenges in terms of sustainability (see below).
GMC national training survey/ NETS – national education trainees survey	GMC NTS 2023 – no red flags, green flag for regional training in East Midlands (rated significantly better than expected)
Summary of known risks of service/provider organisation	Census data collected in January 2023 as part of the national Action on Vascular Programme highlighted the following: Worcester – low IR staffing (4 consultants) SaTH – 5 surgeons and low IR staffing (3 consultants) UHB – low IR staffing (4 consultants) ULHT – 5 surgeons and low IR staffing (3 consultants) NGH – low IR staffing (3 consultants)
Other Information	None identified

Clinical Outcomes	
Notable examples of high performance / innovation	None identified
Specialised Services Quality Dashboard (SSQD):	**Appendix 5.2** Providers are required to submit; • Quarterly:13 quality indicators • Annually: 3 quality indicators Indicators include activity data for elective and emergency aneurysms, endarterectomy and amputation; as well as morbidity and mortality metrics
Mortality data	Most recent National Vascular Registry report reveals no mortality outliers for the index procedures (aortic aneurysm surgery, carotid endarterectomy, amputation, lower limb revascularisation).
GIRFT	• National rollout of NCIP portal to consultant vascular surgeons is now under way - Getting It Right First Time - GIRFT Published 08 Jan 24 • arterial - Getting It Right First Time - GIRFT
National Audits	• National Vascular Registry State of the Nation report 2023 – HQIP Published: 09 Nov 2023 • Impact of the COVID-19 pandemic on vascular surgery in the UK (NVR) – HQIP Published: 08 Jun 2023
Other information sources (if Applicable)	**Appendix 5.3** Update from NHSE Trauma POC Lead Aug 23, CQUIN - critical limb ischaemia continues. CQUIN08 Revascularisation within 5 Days Objective: Revascularise patients with chronic limb-threatening ischaemia within 5 days, in line with the national standard, to reduce to length of stay, in-hospital mortality rates, readmissions and amputation rates. Target: 45% to 65% Q1 Scores - Specialised Commissioning Incentives Workspace - FutureNHS Collaboration Platform

6. Services currently classified as Enhanced Monitoring or Intensive Support

Overview of the ASC Quality Highlight report

There is an agreed Quality Assurance framework in place to manage risk across the 12 organisations for 2024/25. Clinical and Quality risks are reported when they are at an Intensive Level or an Enhances level surveillance in line with the NQB guidance. During 2023/24 these have been reported to the East and West Joint Committees, which will continue in 2024/25.

There are no services currently at an Intensive Level of surveillance

There are current 3 services that are being delegated that are at an Enhanced level of surveillance. The following slides contain a copy of January's ASC Quality Highlight report. This report is presented to the Midlands Acute Specialised Commissioning Group (MASC) and the East & West Midlands Joint Committees monthly.

The Quality Highlight report details

- Which services which are subject to enhanced monitoring or intensive support
- Any information relating to the issue/concern and its impact
- Any mitigating actions which are being carried out to address the issue/concern
- Any other intelligence received by the quality team that month
- Any learning or best practice to be shared

Acute Specialised Commissioning Highlight Report – East Midlands

Date:	18/01/2024

Key messages

No new quality concerns raised at an enhanced or intensive surveillance level for the Acute Specialised Services in the East Midlands Systems for January 2024
Quality concerns and issues arising in Specialised Services are assessed utilising the NHSE Midlands Quality Assurance Framework and are identified as on Routine, Enhanced or Intensive Surveillance in line with NQB Guidance.

Key Messages

#	**Concern/Issue** *New or Ongoing and Escalation Level*	**Programme of care /Speciality**	**Organisation & Integrated Care System (ICS)**	**Concern/Issue identified, Description/Impact** *Please include whether this requires **formal escalation** to RQG following discussion at commissioning meetings*	**Proposed mitigation/Action being taken/Key Learning Points**
1	Ongoing – Enhanced Surveillance	Neonatal Services	Kettering General Hospital (KGH) Northants ICB	• 01/09/23 Emerging theme identified by EM ODN in relation to resuscitation, stabilisation and escalation of deteriorating neonates. This has been based on triangulation of information from serious incident reports and mortality reviews undertaken over the last 2 years, as well as HSIB reports and patient and staff feedback. • 18/9/23 further concerns raised by the EMNODN regarding clinical practice on the unit. Decision taken by NHS England (Midlands) to immediately pause KGH's designation as a Local Neonatal Unit (LNU) and to close the unit to new admissions for babies who meet LNU criteria as a precautionary step.	• Formal letter to trust from ODN outlining concerns 08/09/23. • 13/09/23 exec call (NHSE, ICB and Trust) to review the actions in place, their sustainability, and medium/long term actions or strategic work need to collectively undertake. Immediate actions taken include doubling up of rota to ensure quality and safety and provided assurance to NHSE whilst further consideration of options for action, including the impact, is undertaken. • 18/09/23 NHSE review of available information in relation to concerns raised by EM ODN. Decision taken to immediately pause KGH designation as a Local Neonatal Unit (LNU) and to close the unit to new admissions for babies who meet the criteria normally treated at an LNU on patient safety grounds, whilst further inquiry is undertaken and to allow the required action and assurance work to be completed. • Silver & Gold IMT calls put in place to monitor progress with completing the actions as well as to manage patient flow in order to mitigate the impact for affected patients on the maternity pathway that have been identified in the QIA/EQIA that has been completed. • External Peer Review Visit undertaken 28/11/23 to evaluate the progress, including the additional skills training. Good progress noted in a number of areas, and a decision taken to stand down the Silver and Gold Calls and move to monthly monitoring of completion of the remaining actions. • These monthly meetings are now established, and the Peer Review Report is being finalised and will be sent to the trust by 22/01/24.

Acute Specialised Commissioning Highlight Report – East Midlands

INTELLIGENCE SHARING - horizon scanning, trends etc
Neonatal Unit Care Neonatal care has been agreed as one of the joint NHSE/ICB priority areas and a paper outlining the intentions was previously presented to MASCG and the E & W Joint Commissioning Committees. Linked to the national focus on maternity and the Ockenden review at NUH, as well as in the wake of the Lucy Letby trial, there is significant media attention on neonatal care. Key challenges in neonatal care also include significant staffing challenges in a number of units, plus regional work continues in relation to high neonatal mortality rates. A number of reports have been produced over the last 6 months by N&Q, PH & Commissioning teams based on MBRRACE and local unit data, and action is in progress through the ODNs as well as through each LMNS. Oversight will continue through MASCG, the E & W JCCs as well as through the Regional Perinatal Quality Group which the ICB's also attend. Work has also begun to develop a combined maternity and neonatal daily Sitrep across the region which will collate the operational position in each unit and system, and also then enable reports to be produced showing trends. The second phase of this work is to agree the key quality outcome metrics for neonatal care that can then be added to the Maternity Heatmap that already exists. An NHSE internal Perinatal Improvement Programme Group has also been established to coordinate actions across all involved directorates which includes specialised commissioners. **Fetal Medicine Services** There are a number of services in the region that have reported capacity issues in the Consultant workforce Mutual aid conversations are urgently being progressed and the issue has also been flagged to the regional Fragile Services Working Group.
LEARNING AND SHARING - best practice, outcomes
Please share below any examples of positive assurance, good news stories, innovation, lessons learned, best practice, thematic work and intelligence that would be helpful to other regions N/A

7. Fragile Services

Overview of Fragile Services database

The Fragile Services database is a list of services that the quality or commissioning team is monitoring due to information being received which suggests the service may be subject to some fragility.

This could be as a number of any of the following causes

- Capacity pressures
- Demand pressures
- Workforce issues
- Recruitment and retention issues
- Training and education issues
- Potential lack of provider

The Fragile Service Programme reviews the level of risk and takes appropriate mitigating actions. Whilst some fragile services can be attributed to a specific ICB, some affect whole pathways and have an impact at a regional level.

Fragile Services

The table below contains a count of the number of services across the region that have been bought to the attention of the Fragile Services Programme. These services are across ICB and Specialised Commissioned services as fragile services have the potential to affect the whole pathway.

	ICB specific						Generic	Total
Midlands Region							34	34
East Midlands	LLR	Notts	N'hants	Lincs	Derby		3	92
	21	35	8	15	10			
West Midlands	BSOL	BC	C&W	H&W	SSOT	STW	2	63
	16	8	6	15	4	12		
								189

Fragile Services in delegated Spec Comm services: Derby & Derbyshire ICB

Specialty	Site	Reason for fragility	Detail and actions
Haematology		Lack of consultant workforce	Affecting oncology and haemoglobinopathies; regional work ongoing via EMAP
Oncology		Lack of consultant workforce; demand and capacity issues	NGH now working closely with Leicester with joint appointments, weekly East Mids operational meeting to structure mutual aid between units.

Other services on the fragility register which may impact on pathways for delegated services are:

- Stroke services at Chesterfield
- Ophthalmology UHDB
- Gynaecology at Chesterfield
- CAMHs at Chesterfield
- ENT at Chesterfield
- Learning disability in Chesterfield

8. Deep Dives

Completed Deep Dives

As part of Joint Working on Specialised Services in 2023-24, the Midlands Acute Specialised Commissioning Team conducted a series of deep dives into priority services which were present to the East & West Midlands Joint Committees and the Clinical Collaborative Executive Forum (CCEF).

The following deep dives have been included in the appendices for information.

- **Appendix 8.1**
  Adult Critical Care

- **Appendix 8.2**
  Vascular Services

- **Appendix 8.3**
  Haemoglobinopathy

- **Appendix 8.4**
  Neonatal Services

9. 2024-25 Priorities

Overview of 2024-25 Priorities

As part of the 2024-25 planning round the Specialised Commissioning MDT have engaged with ICB to agree the 2024-25 priority pathways for specialised services in the Midlands.

The 9 priorities approved by ICBs and NHSE at the Midlands Acute Specialised Commissioning Group were as follows

- Neonatal Intensive Care,
- Adult Critical Care,
- Haemoglobinopathy,
- Severe Asthma,
- Oncology Review,
- Acute Aortic Dissection,
- Paediatric Critical Care,
- Multiple Sclerosis,
- Spinal Cord Injury.

Further details of each priority are included in Appendix B.

10. Links

Links

- NHS commissioning » Specialised services (england.nhs.uk)
- NHS England » Prescribed specialised services manual
- NHS commissioning » National Programmes of Care and Clinical Reference Groups (england.nhs.uk)
- NHS England » Service specifications
- NHS England » Commissioner assignment method 2024/25
- Prescribed Specialised Services Tools - NHS Digital
- NHS England » Directly commissioned services reporting requirements
- Integrating specialised services within Integrated Care Systems - FutureNHS Collaboration Platform

Appendix A.
Case for change examples

Example of how ICSs are already making a difference -Virtual e-clinics for kidney disease

- Patients with renal failure in Tower Hamlets now get more time with a specialist consultant thanks to the local ICS redesigning services around the sickest patients.
- Kidney doctors at Barts Health NHS Trust and GPs in the area set up a virtual e-clinic for GPs so they can send questions on kidney patients direct to consultants for a quick reply. The system also flags up patients that might need specialist treatment
- Since it began, waiting times for outpatients have dropped from as much as 15 weeks to just five days for advice, increasing face to face time for consultants and patients for those who most need it.
- The demand for outpatient appointments has reduced to a fifth of previous levels freeing up to time and money for reinvestment in NHS services.
- More integrated commissioning of specialised renal services would make these sorts of innovations easier as –
  - The same people and organisation would be responsible for commissioning both the specialised (eg dialysis) and non specialised (GP led) parts of the patient pathway reducing complexity and bureaucracy
  - Budgets will be pooled which creates more of an incentive to keep patients out of hospital and treat them closer to home
  - Services can be tailored around the needs of local populations helping to address health inequalities
  - Those who do need specialist services such as dialysis will still be able to access them in line with national standards and policies

"We were seeing a lot of patients who gained little from seeing a consultant, and instead are supporting GPs to help these patients. If we think a patient does need extra care then they can get in to see us far more easily, and into the right specialist clinic. Our team can now focus on those on dialysis, or with more severe kidney disease, where specialists can make the biggest difference."

Dr Neil Ashman, who developed the system with local GP Dr Sally Hull

Case for change examples

Current Commissioning Arrangements	Consequences of Current Arrangements
HIV Services Commissioned nationally but Patient care delivered through HIV services via Local Authorities	Service and workforce fragmentation in some areas across England
Mental Health and LDA Services Most Commissioned by CCGs. Only CYP, adult low and medium secure and adult eating disorder services are nationally commissioned.	Specialised MH services are at the end of the pathway focused on inpatient and interventionalist care leaving little incentive for upstream investment by CCGs
Neurology Spec com funds neurology patients only at certain designated centres / in outpatients where the patient has been referred by a consultant. Neurological needs of patients not seen at a centre are met by hospitals funded by CCGs	Discourages development of local provision by CCGs at sites other than neuroscience centres – patients have to travel further. Discourages service evolution, patients not seen in the right places.
Renal Costs of Kidney disease, dialysis and transplantation is funded via Spec com but surgery and most outpatient care is funded by CCGs. Transport is supported by CCGs and makes up 30% of elective transport in the NHS	Funding for renal medicine is complex and discourages upstream investment in prevention and earlier stages of the pathway.

Introduction of ICSs will…

- Enable NHSE and Local Government to collaborate on the commissioning of HIV and sexual health services strengthening pathways with domestic abuse, Sexual Assault Referral Centres and mental health services.
- Help enable a joint approach to support and deliver recommendations from HIV action plan.
- Help to ensure greater integration in the design of services informed by data and insight on the needs of local communities – helping to reduce inequalities.
- Enable local providers of services for mental health and learning disabilities and /or autism to take control of budgets to improve outcomes by managing whole pathways of care.
- Seek to avoid inpatient admissions and provide high quality alternatives to admission.
- Provide an opportunity to improve quality and access to services by moving decisions closer to communities
- Enhance collaboration between partners including across larger geographical footprints
- Make it easier to deliver upstream interventions in primary care around diagnosis and early treatment, to potentially prevent or delay the need for transplants further down the pathway
- Potentially lead to greater investment in home dialysis with financial benefits (from reduction in travel costs) being reinvested elsewhere.
- Support greater focus on prevention and provision of care closer to home.

What do we want to be different in the new model?

	Planning and Governance	Collaborative Delivery	Funding
PRESENT	Prevention, diagnosis, acute treatment, chronic management and specialised services are planned and commissioned by different organisations with plans based on different historic views resulting in misaligned priorities	Some patients have multiple touchpoints across multiple organisations for the same condition which results in limited opportunities to join up care and support innovation and technological advances	Current funding approach provides limited incentives to reduce cost through innovation which can result in specialised budgets outstripping funding available
FUTURE	All organisations across whole patient pathway working under a single planning structure with aligned incentives and plans based on a single forward view of population needs.	Fewer touchpoints which are built around the needs of the patient enabling greater innovation and collaboration and more joined up services across the patient pathway	Care funded on a population basis and with local organisations working together to set and manage budgets incentivised to innovate and save costs, leading to sustainable systems and more focus on the needs of local populations.

EXAMPLE

Mr Wu, 68yrs
Type II Diabetes
End stage renal failure
Needing dialysis. Can delay the need for dialysis through identification and intervention of his CKD by his GP, thereby improving his quality of life and care experience

Mrs. Jagathesan, 74yrs
Complex cardiac history awaiting a heart procedure, lives far from Cardiac centre. Can attend local hospital for pre-assessment ahead of her surgery, receive follow up care close to home in local or virtual clinics.

Miss Jones, 19yrs
Rare neurological disorder
Waiting for multiple diagnostics. Gets co-ordinated diagnostics through a single point of access, reducing outpatient appointments and enabling faster diagnosis and treatment – meaning better patient experience and cost-effective care

Case for change – examples and themes

Current Arrangements

Sickle Cell

Spec comm funds haematology services.

ICBs funds the upstream pathway – from genetic screening, pre-conception care, newborn screening, primary care, urgent and emergency care.

Fragmented funding and pathways

Neurology

Only funded at certain Neurosciences centres – even if the specialist consultant works at multiple hospitals.

Neurological needs of patients not seen at a centre are met by hospitals funded by ICBs.

Consequences

Lack of joined up care meant that significant service quality issues went unchecked for years.

Opportunities to support patients through core ICB offerings (e.g. community nursing) were missed – haematology didn't have sight of the offering and ICBs didn't have sight of the service.

Disincentives to improve outcomes and £

Discourages development of local services outside the neuroscience centre (investment from ICBs) – patients have to travel further.

Inconsistent provision leading to inequities.

Discourages service evolution, with no common approach to pathway development.

Integration Opportunities

Single commissioner will have a view of the entire end-to-end pathway and will have the mechanism to identify and address issues.

One accountable group for ensuring quality services.

Integrating specialised haematology services in and end-to-end pathway can improve connectivity with ICB core services (maternity, primary care, community support, urgent and emergency care access) for people with Sickle Cell disease.

"steps to the left" and end-to-end pathways

Introduce a consistent approach to commissioning neurology services – enabling improved quality and access, and services closer to home.

Enhance collaboration between partners including across larger geographical footprints.

Create streamlined pathways leading to faster diagnosis and more cost effective care.

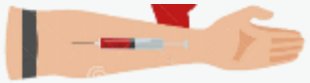
HIV Pilot - Ensuring Comprehensive HIV Screening in Emergency Departments (EDs) Across South London

Almost all hospitals in South London in high or extremely high prevalence areas offer opt-out HIV ED testing.

Cases identified in South London EDs:

- At KCH, the oldest patient identified through ED testing was 95.
- At GSTT, a significant number of patients testing positive in ED have primary infection (20%) with very high viral loads.
- At SGUH, an HIV diagnosis was suspected in only 11 (22%) of the subsequently 50 positive cases.
- At Croydon, newly diagnosed HIV-positive patients now need shorter hospital stays, from an average of 34.9 days down to only 2.4.

2. Opt-out HIV tests are offered to those who need blood tests (c.300,000 people).



5. If a test is reactive, the patient is invited for further tests by the sexual health service.

7. On appropriate treatment, patients with HIV can expect to live as long as someone without HIV. Those with undetectable viral loads cannot pass HIV onto anyone else, even in unprotected sex. Clinicians try to re-engage patients lost to follow-up.

The process of HIV screening in EDs → What happens next → Uptake

1. Over 1 million people attend Emergency Departments* in South London every year.

3. The level of uptake of HIV tests varies across South London, from 34% - 98%.

4. One sample and blood bottle can be used for both the blood tests and the HIV test, meaning the additional costs are largely lab-associated.

6. Newly diagnosed patients are brought into care and put on treatment. Early detection is vital to reduce HIV/AIDS related complications.

This variation across South London means that not all patients who have HIV are being identified. This is due to key factors such as the age of those tested, the length of time before re-testing repeat ED attendees, and general operationalisation of the screening strategy.

This pilot aims to address this through 'levelling up' across south London, supported by a minimum service specification.

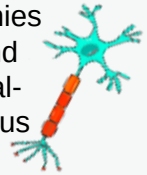
There is variation in lab costs across South London, with costs ranging from £2.50 to £5.55 per test. Some trusts use 2 blood bottles.

~150 patients are newly diagnosed with HIV in EDs in South London every year. Each person living with HIV newly linked to care could avoid NHS costs of over £200,000.

"Making a diagnosis of HIV today does mean spending money on the treatment tomorrow; missing a diagnosis today means greater treatment costs in years to come (and not just for one patient, but for anyone else before or after them in the chain of transmission)."

Home based immunoglobulin therapy (IVIg) in Neurology in South London

1. Home based Immunoglobulin therapy for people with autoimmune neuropathies is safe and effective and less costly than hospital-administered intravenous immunoglobulin (IVIg)



2. Some patients are required to come into hospital (day case units) for recurrent infusions every 3-6 weeks, which may takes place over two to five successive days. Each episode of treatment costs £4k.

3. This is highly disruptive to quality of life. Patients frequently require time off work which makes maintaining employment challenging and costs them greatly through loss of income and travel.

4. Alternatively, many patients are suitable for home therapies – including a subcutaneous injection they can deliver themselves. This can transform the patient experience, and patients report high levels of satisfaction with this option.

5. In addition to being more convenient, this method offers clinical benefits as lower drug doses can be used more frequently. This is better tolerated by patients (reduces adverse reactions), avoids fluctuations in condition between treatment and reduces risk of stroke and other blood related issues related to large doses.

6. This contributes to improved use of hospital estates (freeing capacity in day case units for other activity), reduces drug costs through VAT savings and is cheaper for patients (reduced travel and lost income). Additionally, it offers greater environmental sustainability (reduced travel).

7. The model has been in place at Kings College Hospital for several years. We are proposing to support the Neurosciences centre to establish a service, using learnings from Kings as well as learnings in home care from the OPAT pilot.

8. Funding is available to recruit a CNS to support patients on this pathway. Project management support is available from SLOSS for implementation. **Trust and system support is required to manage and plan for day case activity and income changes.**

Appendix B.
2024-25 priorities – detailed slides

Midlands Oncology Service Review: Fragile		**Lead:** Laura Morris	**Ref:** C1
Delegation Status: Green (HCD retained)	**ICB:** All	**National Priorities: Recovery:** Cancer, Use of Resources. **LTP:** Workforce, Inequalities. **DCG**	
What is the problem in summary? Oncology is identified as a fragile service across the Midlands. Performance challenged, with 8/11 systems in tiered support. Inequity of timely access at Trust and tumour site level. Oncologist vacancy rate is 15% , expected to rise to 25% in 2027 with 20% forecast to retire over 5 years. Midlands has the lowest WTE per population in England. There are also workforce challenges in chemo nurses; therapeutic radiographers and medical physics. Across the Midlands, we spend £522 million on SACT per year (activity, drugs and support costs), plus Radiotherapy spending.		**What are we looking to achieve?** Reduce variation in waiting times; increase productivity and share best practice through the development of new models of care, workforce strategies and shared resource. **Scope:** Workforce; capacity; service models **Specific Partners:** Cancer Alliance (EAG/ECAG); EMAP (priority area); ICB cancer leads	
Planned Deliverables: - Mutual aid framework (Q1). - Develop plans for managing agency/locum costs (Q1). - Review and appraise variety of current financial spends and service models for oncology services (Q2). - Produce Virtual Ward criteria (Q2). - Confirm transformation plans in place at system for virtual or community clinics (Q4)		**How will we know if things have improved (KPI)?** - Reduced and consistent waiting times across systems. - Reduced vacancy rates. - Unit cost reduction. - Consistent approach to managing mutual aid.	

Acute Aortic Dissection		**Lead:** Jon Gulliver	**Ref:** IM1
Delegation Status: Green	**ICB:** All	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? Acute aortic dissection (AAD) is rare and immediately fatal for 48%. For Type A making it to cardiac surgery, mortality is 25%. Surgery is time critical. All cardiac surgery centres have at least one AAD specialist surgeon but with no coordinated regional on-call rota presenting challenges to accessing intervention. There is consensus that coordination will improve outcomes for patients and reduce waits but there is resistance to change.		**What are we looking to achieve?** Reduce variation in access to emergency surgery and improved outcomes through the introduction of coordinated East and West on call rotas. **Scope:** Workforce; capacity; service models **Specific Partners:** Cardiac Transformation Programme, Cardiac Networks.	
Planned Deliverables: - Approved SOP(Q1). - SPOC testing and training(Q1). - Recruit MDT coordinator (Q1). - Establish regional MDT(s) (Q2). - Agree process for collecting and reporting KPI (Q1). - Service go live (Q1 WM, Q2 EM).		**How will we know if things have improved (KPI)?** - In hospital mortality with/without intervention; 1 year mortality. - LOS. - Referral numbers. - Intervention/no intervention. - Time from referral to intervention. - Deaths between diagnosis and intervention Type A. - Deaths between diagnosis and place of safety Type B. - Patient satisfaction.	

Severe Asthma		**Lead:** Jon Gulliver	**Ref:** IM2
Delegation Status: Green	**ICB:** All	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Health Inequalities.	
What is the problem in summary? Severe asthma (SA) is a debilitating, chronic disease with an average of 4 asthma attacks and 4x more A&E visits pa, patients with SA account for ~50% of all asthma-related healthcare costs. Biologic treatment has the potential to improve lives and reduce the use of healthcare/social resource. Access is variable and ~80% of eligible patients are currently not prescribed a biologic.		**What are we looking to achieve?** Increase access to biologics for patients with SA to improve outcomes for patients and reduce the use of other healthcare resource. **Scope:** All patients with severe asthma. **Specific partners:** Respiratory Network	
Planned deliverables: - Review of current treatment and patient pathways for the management of asthma across primary and secondary care including case finding for biologics, diagnosis and treatment optimisation. - Review of the data to understand the inequalities that are present in accessing biologics treatment, based on underlying service and/or patient factors. - Share with respiratory networks and specialist asthma centres to inform options appraisal.		**How will we know if things have improved (KPI)?** - Number of new initiations per ICB - Increase in percentage bio penetration per ICB - Reduction of variation in bio penetration by ICB	

Multiple Sclerosis Service Review: Risk Register		**Lead:** Dom Tolley	**Ref:** T1
Delegation Status: Green	**ICB: BSol; H+W; Black Country**	**National Priorities: Recovery:** Elective, Use of Resources. **LTP:** Workforce, Health Inequalities.	
What is the problem in summary? A review of the MS tertiary service provided by University Hospitals Birmingham to a number of ICBs has found significant waiting times and increasing numbers of patients to be seen for initial consultations to access to Drug Modifying Therapies (DMTs) and lack of structure for the ongoing management of this patient group. There is a lack of good governance with regards to the prescribing and monitoring of these patients, which has a potential of harm.		**What are we looking to achieve?** Improve access of eligible MS patients to DMTs and ongoing care of those already on treatment outside of BSol ICB. **Scope:** All patients eligible MS patients who should fall under the care of UHB. **Specific partners:** None	
Planned deliverables: - Review of West Midlands regional MS DMT pathways and governance and current financial spend for MS DMT patients and produce options appraisal for MASG and JCs, to include the development of Neurology ODNs (Q2) - Develop and implement a revised MS DMT clinical pathway, including shared care agreements (Q4).		**How will we know if things have improved (KPI)?** - Reduction in waiting list and waiting times for MS patients on DMT clinical pathway by the end of 2024/25	

Spinal Cord Injury Services		**Lead:** Dom Tolly	**Ref:** T2
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The Midlands region only has one commissioned Spinal Cord Injury (SCI) rehabilitation unit (RJAH), which has the second longest waiting times for admission in England. The unit cannot manage high cervical spinal injuries, due to lack of ACC, resulting in out of region transfers. The East Midlands does not have a SCI rehabilitation centre. Patients are managed in Sheffield or Stoke Mandeville where there are long waits. This delay in rehabilitation treatment means poorer outcomes (increased rates of HCAI and pressure sores), potential harm and DTOC.		**What are we looking to achieve?** Improved access to SCI and outcomes. Reduction in harm and DTOC resulting into lower use of healthcare resource. **Scope:** All patients presenting with a SCI and requiring rehabilitation. **Specific partners:** None	
Planned deliverables: - Complete a demand and capacity analysis for SCI rehab, including patient acuity and complexity (Q1-Q2). -Review current financial spend for SCI patients and review potential options costs for SCI services (Q1-Q2) - Present review and options papers to MASG and JCs, including QIA and 13Q (Q3), including weaning and ventilated patient services for high c-spine injured patients.		**How will we know if things have improved (KPI)?** - Reduction in LOS SCI patients. - Reduction in DTOC both from Acute beds base and to CHC services - Reducing periods of bed rest. - Reduction in complications.	

Adult Critical Care (ACC) Rehabilitation & Digital Enablement		**Lead:** Dom Tolly	**Ref:** T3
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** UEC, Elective, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The Midlands ACC Strategy has continued to develop a more diverse, resilient and holistic model of ACC care across the 29 ACC units. The major quality, clinical and operational improvement drive in the next 3 years of the strategy is to develop consistent 7-day services for ACC rehabilitation in line with national guidance. In doing so this potentially will reduce in LOS for ACC patients by up to 1.5 days, improve patient outcomes, reduce costs for patient episodes.		**What are we looking to achieve?** Digital enablement will provide clinical support, improved decision making through a networked approach to care through virtual ward rounds. Digital critical care platform will reduce clinical errors in transfers of care between providers, by allowing shared care records. **Scope:** All ACC units. **Specific partners:** EM and WM ACC ODNs.	
Planned deliverables: - Complete digital services review paper (Q1). - Complete ACC rehab gap analysis by provider/ICB (Q2). - Review of current spend for ACC rehab and review potential options costs for services (Q2). - Present review and options papers to MASG and JCs, including QIA (Q3).		**How will we know if things have improved (KPI)?** - Reduction in length of stays for ACC patients. - Reduction in pharmacy and parental nutritional spends.	

Haemoglobinopathies		**Lead:** Nick Hey	**Ref:** BI1
Delegation Status: Amber	**ICB: All**	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The APPG on Sickle Cell and Thalassaemia conducted a review of services and experiences of patients and produced 'No one's listening.' This report revealed many years of sub-standard care, stigmatisation and lack of prioritisation and patients losing trust in the NHS system. A regional review demonstrated wide variance in the level of service on offer to patients and numerous areas for improvement, in particular in improved training and knowledge at non-specialist trusts and A&Es.		**What are we looking to achieve?** Improve outcomes for patients and reduce unnecessary admissions for patients by improving networks of care. **Scope:** All haemoglobinopathy services. **Specific partners:** EM and WM HCCs.	
Planned deliverables: • Med Tech Funding (Spectra Optia) business cases . Potential for approval of additional national funding to support red blood cell exchange services - (Q2). • Review of SCD prevalence, activity and provision (Q1). • Review position against APPG report (Q1). • Review of Specialist Haemoglobinopathy Team provision – Service provision review and re-commissioning (Q4).		**How will we know if things have improved (KPI)?** - Updated review of regional position against No one's listening recommendations demonstrating improvement, especially in non-specialist centres. - Increased access and activity for red blood cell exchange.	

Neonatal Critical Care: Risk Register		**Lead:** Sumana Bassinder	**Ref:** WC1
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** Maternity, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? Neonatal Critical Care remains an area of significant national and regional scrutiny. The Midlands also has one of the highest neonatal mortality rates in the country. There is significant work to do to implement the requirements of the NCCR including configuration, patient pathways, increase cot capacity, workforce strategy, neonatal transport review to support the revised neonatal networks. All against a backdrop of high-profile scrutiny (Ockenden, Thirlwall, Letby, Kirkup).		**What are we looking to achieve?** Improved outcomes for babies and a reduction in mortality rates. **Scope:** All NIC services. **Specific partners:** EM and WM ODNs. Perinatal Programme. LMNS	
Planned deliverables: • Review of WM capacity and configuration (Q1). • Describing patient pathways. • Financial impact of compliance (Q1) • Production of workforce strategy. • Review of neonatal transport. • Ongoing capacity monitoring and compliance review. • Perinatal dashboard (Q1) • Review of PMRT process.		**How will we know if things have improved (KPI)?** - Reduction in mortality rates. - Reduction in babies being transferred out of region for neonatal care. - Reduction in the number of cots closed due to staffing challenges.	

Paediatric Critical Care (PCC)		**Lead:** Sumana Bassinder	**Ref:** WC2
Delegation Status: Green	**ICB: All**	**National Priorities: DCG**	
What is the problem in summary? PCC capacity is an area of concern regionally and nationally for both Level 2 (High Dependency) and Level 3 (Intensive Care). National funding was received in 23/24 to increase Level 2 capacity outside of Level 3 centres but so far only a partial implementation has been achieved. Further work required to identify, increase and progress additional capacity.		**What are we looking to achieve?** Right capacity in the right place. **Scope:** All PIC services. **Specific partners:** EM and WM ODNs.	
Planned deliverables: - Monitoring of delivery of WM plans. - Plan for increase of resilient L2 capacity in the EM in line with GIRFT (Q1) - Demand, capacity and financial review of L2 and L3 provision and production of options appraisal (Q4)		**How will we know if things have improved (KPI)?** - Reduction in OPEL status levels from 23/24 surge baseline during 24/25 surge periods. - Reduction in patients transferring out of area for paediatric critical care. - Improved cot utilisation, closer to home and outside of tertiary centres.	

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MEETING IN PUBLIC

21st March 2024

Item: 152

Report Title	Year End Closing Position 2023/24							
Author	Georgina Mills, Head of Financial Reporting Sukhi Mahil, Assistant Director Workforce Strategy, Planning and Transformation Sam Kabiswa, Assistant Director, Planning and Performance							
Sponsor (Executive Director)	Keith Griffiths, Chief Finance Officer							
Presenter	Keith Griffiths, Chief Finance Officer Craig Cook, Director of Acute Commissioning, Contracting and Performance Linda Garnett, Interim Chief People Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Year End Closing Position 2023/24							
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 Year End Closing position for 2023/24.
Purpose
Update the board on the Year End Closing position for 2023/24.
Background
The updated position has been requested by the Board to assure the delivery of the year end position.
Report Summary
The year end position is forecast at a deficit of £51.9m. This is the reset position of £44.7m deficit with the deduction of the PDC IFRS 16 PFI revaluation benefit.
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**	There is a risk that the system does not create and enable a health and care 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

[To be completed by Finance Team ONLY]

Yes ☐	No☒	N/A☐

Details/Findings	**Has this been signed off by a finance team member?**
The papers are provided for information only and therefore have no financial impact arising.	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
Not applicable.

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Year End Closing Position 2023/24

Operations

Urgent and Emergency Care

- **4 hr:** We are on course to deliver better performance this year, (in overall terms across our commissioned providers) compared to last (70% in 22/23 vs 74% year to date and striving to achieve 76% by year end).
- **Length of stay:** Our largest Acute Provider (UHDB) is delivering average LOS performance at a level which places them in the top 25% of all Trusts nationally.
- **Urgent Community Response:** We have over-achieved against our plan to ensure that urgent community referrals are responded to within 2 hours.

Cancer

- **62 day+ waits:** We have reduced the number of long waits by a third over the last 12 months are remain on course to achieve our year-end target.
- **Cancer treatment activity** – we have delivered 10% more cancer treatments this year compared to last.
- **28-day Faster diagnosis** – We have ruled out or diagnosed 6% more cancers within 28 days this year compared to last and are likely to end the year between 72-73% against the 75% target.

Planned Care

- **RTT incomplete waiting list:** Despite losing output due to strikes we are projecting to have 2% fewer people waiting in March 24 compared to the start of the year (April 24).
- **RTT long waits** – despite not achieving the eradication of 65 week+ waits, we have significantly reduced 78+ weeks.
- **VWA** – whilst there is more to do in 23/24, we benchmark above the national average and are the third best performing ICS in the Midlands.

Mental Health, Autism and Learning Disabilities

- We have over-delivered against plan, in relation to increasing the **dementia diagnosis rate**.
- We have delivered key access targets in relation to **IAPT, perinatal mental health** and **community health provision** for people with a severe mental illness.
- We have delivered **MHIS**.

General Practice

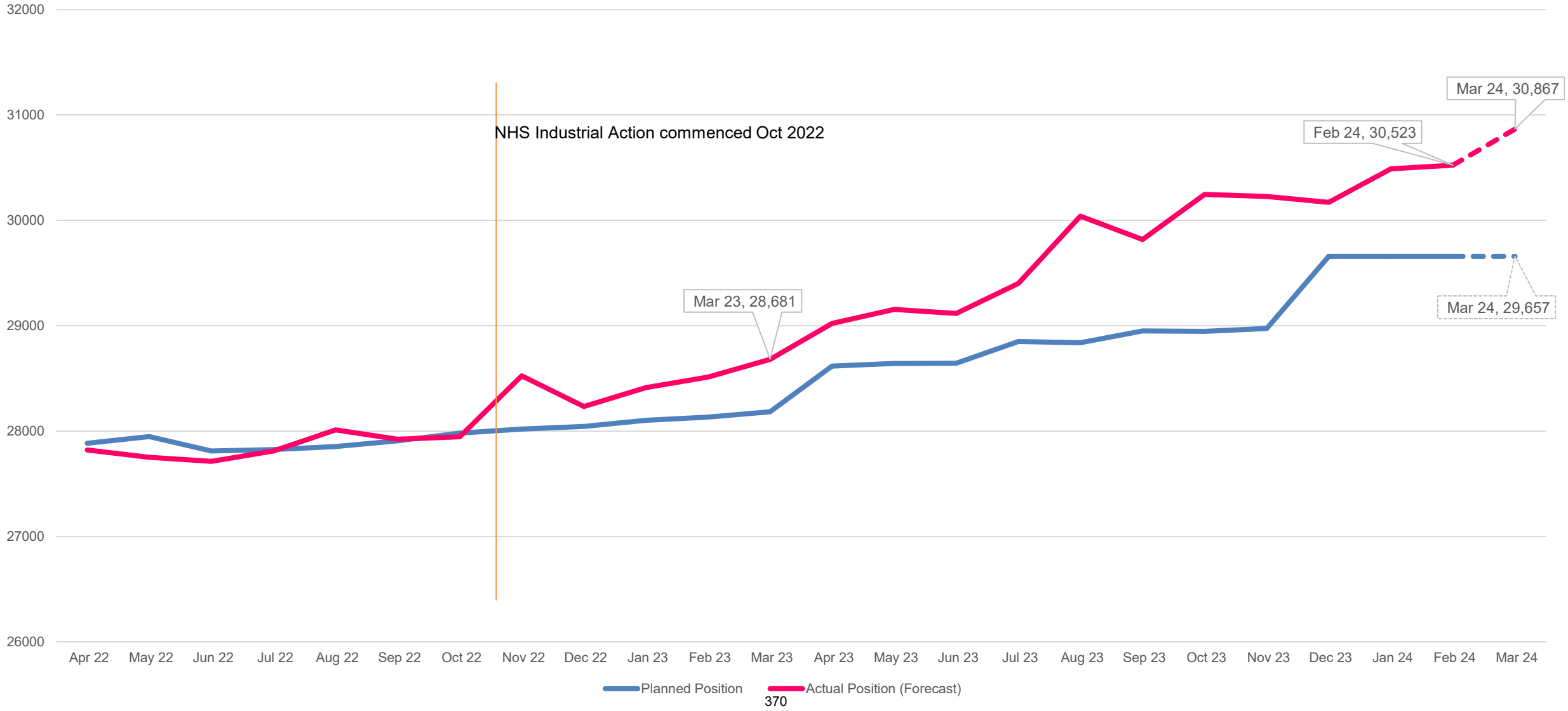
- **General Practice Appointments –** Despite the sustained pressure across General Practice, we have delivered our planned level of appointments in 23/24 which is ~2% higher than 2023/24.

Workforce

- The 2023/24 plan was based on growth of 2.15% (615WTEs).
- Between 2022/23 M12 actual and M10 actual there has been 6.3% growth (1,808WTE).
- There will be 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 Newly Qualified Nurses (NQN) and Newly Qualified Midwives (NQM), in September/October as they qualify.
- Recruitment to vacancies has seen an increase in substantive staff, however vacancy controls have been put in place to review recruitments taking place.
- The increase in bank and agency, the latter which is considered more costly, is because of clinical pressures and increased patient acuity. That said, agency usage has seen a downward trend since the highest point in June 2023.

2023/24 Workforce Trend (Total WTE)

During the H2 system reset, we received a revised forecast outturn (FOT) plan position for **substantive** workforce. M9-M12 planned figures are based on this revised FOT. Future months for actual figures (dashed line) are based on a forecast using the average % change between M8 and M11 of +1.0% which gives a M12 FOT position of 30,867WTE. However it is important to recognise change in the trend in M11 which may result in further levelling off in this position by year end.

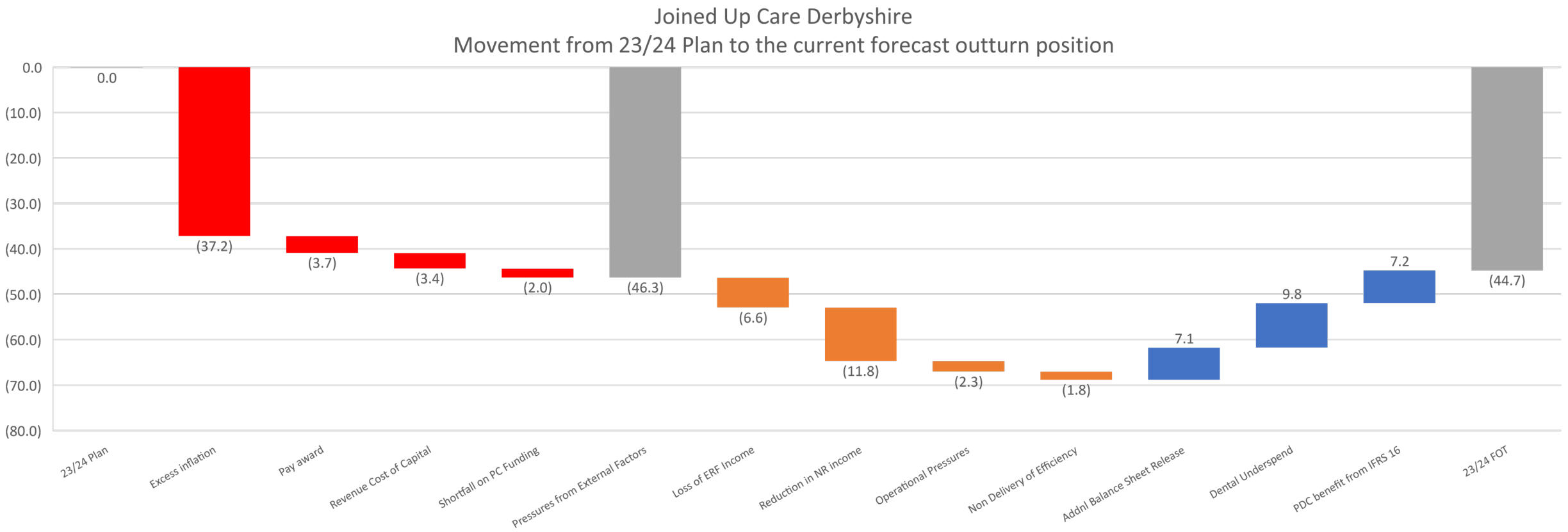


Finance

JUCD committed to a breakeven plan for 23/24 and would have met this had it not been for external factors:

- £134.2m of CIPs have been delivered in 23/24 (98.6% of plan) - £60.1m recurrent and £74.1m non recurrent
- Currently forecasting a 23/24 year end deficit of £44.7m plus £7.2m for the change in treatment of PDC benefit for IFRS16, taking the outturn to £51.9m overspent. This is in line with the position shared as part of the H2 reset.
- The key drivers of this are costs outside the control of the system i.e. excess inflation (£37.2m), Shortfall on pay award funding (£3.7m), Changes in national support on the cost of capital (£3.4m) & a shortfall on primary care funding (£2m) – Totalling £46.3m
- The system has also managed to absorb some of the pressures above and all other pressures related to shortfalls income (inc. ERF) & operational pressures/fragile services
- The risks to delivery of this position relate to National issues and are;
  - Healthcare Support Worker re-banding – c£15m
  - Change in treatment of PDC benefit for IFRS16 - £7.2m

23/24 Forecast Position Bridge



- Note that this is on top of delivery of £134.2m of efficiencies in 23/24
- The operational pressures is a net figure, the system has absorbed the difference through other smaller mitigations
- As of month 11, there is a change in treatment to the PDC benefit from the IFRS16 revaluation and will take the 23/24 position to a deficit of £51.9m

Finance

23/24 System Efficiencies:

- The System has a forecast delivery of £134.2m efficiencies as described in the table (98.6% of plan) - £60.1m recurrent and £74.1m non recurrent
- The ICB had a target to delivery £44.2m efficiencies the forecast is to overdeliver by £3.5m
- Prescribing has delivered £16.7m of cash releasing savings £5.2m above their plan
- Continuing Healthcare is delivering £5.2m recurrent efficiencies.
- The ICB are experiencing difficulties in rebasing out of area acute contracts where activity is significantly lower than 2019/20 baselines.

Efficiencies by Provider Month 11 Position	Full Year Plan £m's	Full Year Forecast £m's	Forecast Variance £m's
NHS Derby and Derbyshire ICB	44.2	47.8	**3.5**
Chesterfield Royal Hospital	15.7	11.4	**(4.3)**
Derbyshire Community Health Services	9.2	9.2	**0.0**
Derbyshire Healthcare	8.8	8.8	**0.0**
EMAS	11.2	11.2	**0.0**
University Hospital of Derby and Burton	47.0	45.9	**(1.1)**
JUCD Total	**136.0**	**134.2**	**(1.8)**

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NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: 153

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 Nurse Officer • Performance – Craig Cook, Director of Acute Commissioning, Contracting and Performance • Workforce - Linda Garnett, Interim ICB Chief People Officer • Finance – Keith Griffiths, Chief Finance Officer
Paper purpose	Decision ☐ Discussion ☐ Assurance ☒ Information ☐
Appendices	Appendix 1 – Integrated Assurance and Performance Report Appendix 2 – JUCD System Finance Report to 31st January 2024
Assurance Report Signed off by Chair	Not Applicable
Which committee has the subject matter been through?	Finance and Estates Committee: 27th February 2024 People Services Collaborative Delivery Board: 28th February 2024

Recommendations
The ICB Board are recommended to **NOTE** the Month 10 performance Operational Plan update against the plan commitments and targets.
Purpose
To update the ICB Board on the Month 10 performance against the 2023/24 operational plan objectives/commitments, quality standards workforce and finance.
Background
The 2023/24 Operational Plan set clear, measurable objectives which are fundamental to the NHS' contribution to improving health outcomes. The plan was submitted to NHSE on the 4th May 2023. The improvements in the plan are planned to be achieved by using our assets more productively with minimal or no growth in workforce. The financial plan assumed a break-even position. Work to develop a more cohesive and integrated framework for future reporting against delivery of the plan is continuing with the aim of: • creating a single version of the truth with greater alignment/triangulation between the various components (quality, performance, workforce and finance); and

- for performance, agree a consistent set of data sets and sources to enable us to better forecast performance. This will also include adopting a more collaborative and common approach to the use of data and reporting of performance against targets and commitments as system.

The work and commitments required to achieve the integrated approach is complex and there is a significant amount of development work still required to create a truly integrated and triangulated monitoring and reporting framework. This development is being phased in collaboration with system partners to ensure ownership. In the meantime, the respective leads are continuing to work together to ensure the position is more joined up.

Report Summary

The summary below highlights the key areas to note, and additional information can be found in the supporting appendices.

Quality

All Age Continuing Care (AACC): NHSE (Midlands) Regional Team commended DDICB on the consistent achievement of the outcome within 28 days of receipt of a positive checklist and the number of assessments exceeding 28 days by 12+ weeks. The ICB also consistently achieves the quality premium target for the percentage of assessments conducted in an acute hospital setting thereby minimising the number of CHC assessments undertaken in an acute hospital setting to support effective hospital discharge and assessment in the right time and right place. The ICB were also commended on joint working with both Local Authorities - Derby City and Derbyshire County - to agree ways of working in regards AACC that minimise delays, disputes and appeals. NHSE recognised the hard work and dedication of the team, the timely submissions of the required monthly Patient Level Dataset and quarterly Funded Care reports and confirmed that they are very assured in terms of our performance and achievements in regards AACC.

Primary Care: CQC carried out announced inspection of Newhall Surgery on 6th December 2023. Although previously rated as 'Good', the new CQC inspection report was published in 2024 with the practice now receiving a rating of Requires Improvement. The practice has developed their action plan to address the concerns raised by the CQC and the PCQT will be meeting with the practice on a quarterly basis to gain assurance on behalf of the ICB offering support and guidance.

Out of Area placement for acute mental health inpatient care: The number of Out of Area placements is impacted due to a number of factors including occupancy levels, service user acuity and workforce. A detailed Recovery Action Plan is in place with oversight at the MH, LD&A Delivery Board. The actions will provide a Purposeful Admissions model to ensure admissions to comply with the fidelity model. Changes to the pathway to improve assessment and decision making have been implemented and work with system partners and the third sector aim to promote utilisation and explore appropriate signposting pathways.

Operational Performance

The summary below highlights the key areas to note in relation to the year-to-date performance (either January 24 or February 24) based on NHSE nationally published and validated data. Additional information can be found in the supporting appendices.

Planned Care and Cancer – April 2023 – January 2024

The number of people waiting 65 weeks or longer on an incomplete RTT pathway

As at the end of January 2024, the ICB had 1,785 more patients on an incomplete waiting list, longer than 65 weeks, compared to plan (UHDB: 1,639 actuals vs. 329 plan; CRH: 343 actual vs. 126 plan)

Cancer waits longer than 62 days

At the end of February 2024 (unvalidated), the average wait at CRH was in line with the trajectory (43 vs 45), while UHDB have 327 patients waiting longer than 62 days against a planned trajectory of 295.

75% of cancers diagnosed within 28 days of urgent referral

The CRH continues to deliver against its target to diagnose or rule out cancer within 28 days of an urgent referral. For UHDB, the Trust delivered performance of 71.5% in January 24 and is taking action to bridge the gap to the 75% target.

Urgent and Emergency Care – April 2023 – February 2024

Percentage of A&E attendances, departing in less than 4 hrs

The specific focus of the target in 2023/24 was for both Acute Trusts to deliver 76% performance for the specific month of March 2024. The run rate for the CRH indicates there is a significant gap to close to achieve this target, with performance of 61.4% and 59.0% in January 24 and February 24.

The position across the sites managed by UHDB is relatively better, with performance of 69.5% and 70.8%, in January 24 and February 24, but still a gap to close to achieve 76% in March 2024.

When assessing broader 4hr performance across all the ICB's commissioned providers (inclusive of the four Urgent Treatment Centres delivered by Derbyshire Community Healthcare Services NHSFT and the Urgent Treatment Centre provided by the One Medical Group in Derby City), the ICB delivered performance of 73.5% in February 24.

Category 2 (C2) 999 response times

In February 2024, EMAS delivered an average C2 response time of 49m45s, which was 19m50s higher than target. From a Derby and Derbyshire ICB perspective, performance was 53m54s in February 24 and has averaged 44m21s year to date.

Mental Health, Learning Disabilities and Autism

The ICB continues to deliver key access targets in relation to IAPT, perinatal mental health and community health provision for people with a severe mental illness. Furthermore, the ICB continues to over-deliver against plan in relation to the dementia diagnosis rate. However, challenges remain with the high level of out of area placements and the LD Annual Health check target, where we behind trajectory.

Primary Care - April 2023 – January 2024

As at the end of January 2024, the Derby and Derbyshire General Practice sector had delivered 5.7m appointments which is in line with the plan it set at the beginning of the year.

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 1, is therefore summarized in two parts:

1. month 10 position against plan (Tables 1a-d); and

2. 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 is being progressed as part of the planning round for 2024/25.

2023/24 Workforce Plan Position Month 10 (NHS Foundations Trusts, including EMAS)

At M10, the total workforce across all areas (substantive, bank and agency) was 1421.79WTE above plan. Two out of five organisations are below the original total workforce plans, these are Derbyshire Healthcare NHSFT (DHcFT) and Derbyshire Community Health Services NHSFT (DCHS). However only DHcFT are below the H2 substantive workforce revised plan position.

Compared to M9, there was an increase in substantive positions (+124.02WTE) and bank usage (+209.32WTE) but there was a decrease in agency usage (-14.94WTE). The majority of the increase in substantive positions was from Support to Nursing Staff (+71.67WTE) and NHS Infrastructure support (+19.81WTE), while there was a decrease from Registered nursing, midwifery and health visiting staff (-8.73WTE).

Whilst overall agency usage continues to decline 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 (243wte actual against a plan of 20wte). This increase is due to increased capacity required to deliver the Cat2 response times. 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 M10 there has been a 6.3% growth in the total workforce since M12 2022/23 (1,808WTEs). 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 M9, the total workforce was 109WTE below M9's plan. The gap was observed mainly from GPs excluding registrars (31 WTE), Nurses (25WTE) and Other – admin and non-clinical staff (24 WTE). It is recognised that the level of detail available to provide a comprehensive view of primary care is not yet evident and discussions continue 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 M10 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 M10 position is an overspend against the pay budget of £8.5m with 834WTE over-establishment (substantive, bank and agency).

It is not yet possible to make a direct correlation between the pay-bill and the actual WTEs and there is an outstanding 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 and review any opportunities to reduce these costs without impacting on capacity to deliver in the first instance. This requires the support from the finance community as the data will need to be extracted through the ledger systems.

Agency KPIs

In M10 JUCD agency cost amounted to 2.6% of total pay costs, 1.1% under the national target of 3.7%.

The current agency spend is above the planned spend of £26.2m, resulting in a £15.0m overspend. However, it is at 96% of the annual cap of £38.7m (an underspend of £1.7m).

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.

Actions

- As well as the plans to hold substantive workforce growth to year end, 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. admin and clerical exit strategies).

Finance

As of the 31st January 2024, the JUCD year to date position is a £44.4m deficit against a £5.9m planned deficit, a £38.5m overspend against the plan. The main factors driving this are excess inflation and a reduction in income.

NHSE National team recognised a forecast deficit of £44.7m as a genuine likely position for JUCD and based on year to date performance, the system is confident this will be achieved prior to the impact of industrial action. Additional costs relating to Junior Doctors industrial action have further increased this deficit by £3.5m to give a total forecast position of £48.3m. This reflects pressures that were not known at the time of planning and also pressures on delivering the agreed plan, including planned efficiencies and workforce costs. It has been agreed as a System that every opportunity to improve the out-turn position will be identified and considered.

The worst-case scenario of a £72.5m deficit includes additional risks related to not delivering the agreed JUCD Operational Plan, such as, health care assistant re-banding at an estimated cost of £20m, pressures on capacity and activity and drugs costs.

The system efficiency delivery is £1.4m ahead of plan year to date, split into £23.5m behind plan on recurrent efficiencies and £24.9m over plan on non-recurrent efficiencies. Unless planned levels of recurrent efficiencies can be delivered, it will impact in future years.

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**	There is a risk that the system does not create and enable a health and care 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?

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

Appendix 1

Derby and Derbyshire Integrated Care Board

Integrated Assurance and Performance Report

January 2024

Dr Chris Clayton ICB Chief Executive Officer
Prof Dean Howells, Chief Nurse Officer
Craig Cook, Director of Acute Commissioning, Contracting and Performance
Linda Garnett, Interim ICB Chief People 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 Messages 1					
#	Concern or Issue	Programme/Specialty i.e. Maternity, cancer	Organisation/Place / System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
1	Safety	Maternity	UHDB/CRH	Delivery of Maternity Services	**UHDB** **High Perinatal Mortality:** The Stillbirth rate in December 2023 was 4.43/1000 births and remains an outlier. The extended perinatal mortality thematic review has been completed and the learning and action plan are being developed to share with the LMNS. **Quality and Safety of Maternity services:** 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. The NMC will be undertaking a review with UHDB in March 2024. **Maternal Morbidity:** The rate of third- and fourth-degree tears is 27.33/1000 (3 month rolling) remaining above the national average of 24/1000 (3 months rolling). The rate of postpartum haemorrhage is 38/1000 deliveries remaining above the national average of 31/1000 deliveries. The maternity improvement plan includes quality improvements for management of obstetric haemorrhage however this still remains an area of concern. **CRH** **Maternal Morbidity:** The rate of third- and fourth-degree tears has remained consistently above the national average (24/1000) of 42.39/1000. The trust is monitoring to identify any themes.
2	Safety	IPC	System wide	NHSE HCAI thresholds for 2023/24 are predicted to breach at both acute trust and System level.	As a Derbyshire System at the end of Q3: • CDI performance is currently 35% over trajectory and the threshold for the year has been breached at both acute trusts and as a result at system level. • MRSA blood stream infections – 14 cases reported against a zero tolerance (10 healthcare associated and 4 community associated), • Number of Gram-negative infections reported are increasing. Recovery plans remain in place. Post infection reviews are not identifying any new learning and trusts are implementing PSIRF methodology for IPC 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. UHDB await report from December 2023 visits. Additional support has been offered by regional teams and ICB to CRH while awaiting appointment of IPC lead nurse

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 2					
#	Concern or Issue	Programme/Specialty i.e. Maternity, cancer	Organisation/ Place/ System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
3	Safety	Community - Equipment	DCHS	The MHRA continues to receive reports of deaths and serious injuries from entrapment or falls relating to medical beds, bed rails (also known as bed safety rails), trolleys, bariatric beds, lateral turning devices and bed grab handles (also known as bed levers or bed sticks).MHRA Bed Rails Alert	The MHRA Bed rails alert (NatPSA/2023/010/MHRA) has a 7-point action plan for completion by 1st March. The alert stipulates providers must update their bed rail policy, offer enhanced training and risk assessments for current bed rail users, including historical and new prescriptions. DCHS has revised its bed rail policy in relation to the required reviews for bed rails and levers. Additionally, supplementary training is in place and being rolled out. DCHS is concerned about the potential MHRA requirement for retrospective reviews for patients issued with equipment over the past years. This would have significant resource implications for community services.
4	Safety	Out of Area placement for acute mental health inpatient care	DHcFT	The number of Out of Area placements is impacted due to a number of factors including occupancy levels, service user acuity and workforce	• Detailed Recovery Action Plan in place with oversight at the MH, LD&A Delivery Board. These include • Purposeful Admissions model to ensure purposeful admission to comply with the fidelity model • Changes to the pathway to improve assessment and decision making have been implemented. • Working with the third sector to promote utilisation of the crisis cafes and explore appropriate signposting pathways. • Working with system partners and the third sector to promote utilisation and explore appropriate signposting pathways. • Working with operational services to implement community based Clozaril initiation • Gatekeeping Framework • Enhance the impact from the community Emotional Regulation Pathway • Derbyshire Mental Health Response Vehicle • To implement MAST in CMHTs
5		Primary Care	Newhall Surgery	CQC carried out announced inspection of Newhall Surgery on 6th December 2023. Previously rated as Good in 2016 the new CQC inspection report was published on 18th January 2024 with the practice now receiving a rating of **Requires Improvement.**	The practice will develop their action plan to address the concerns raised by the CQC and the PCQT will be meeting with the practice on a quarterly basis to gain assurance on behalf of the ICB offering support and guidance. The first quarterly meeting is planned to take place on 7th February 2024. CQC noted good practice related to - There was strong evidence to support that the practice's most vulnerable patients, - There was a proactive approach to safeguard patients. - Staff dealt with patients with kindness and respect and involved them in decisions about their care. - Patients' views were listened to and used to influence developments. However remote clinical searches identified areas where the monitoring and review of patients being prescribed medicines required strengthening. The monitoring of patients with long-term conditions needed to be strengthened to support effective outcomes and the optimum management of their condition.

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

Derbyshire Community Health Services and Derby City Council are in negotiations leading to the formal partnership agreement using section 75 of the Health Act 2006, to jointly deliver a range of reablement and urgent support services aimed at helping people remain independent at home for as long as possible.

Walton Hospital's Community Discharge Centre (CDC) opened two new services recently with further developments planned throughout 2024. Phlebotomy (blood tests) and ultrasound diagnostic services opened in December, allowing more flexibility and choice for patients. The service is run by colleagues and teams from Chesterfield Royal Hospital NHS Foundation Trust. Healthy communities CDCs are 'one-stop shops' designed to provide an easier and altogether better patient experience by having a host of diagnostic facilities and services in one place.

The Designated Dr for Looked after Children post remains vacant. Unable to appoint at recent interview. Post to be readvertised and continues to be covered on an interim arrangement by the Clinical Director/ Consultant Paediatrician. Vacancy remains on ICB risk register

All Age Continuing Care (AACC) – at the recent Quarterly assurance meeting with NHSE (Midlands) Regional Team DDICB were commended on our consistent achievement of:

- the two quality standards (Assessment outcome within 28days of receipt of a positive checklist and the number of assessments exceeding 28 days by 12+ weeks). The ICB also consistently achieves the quality premium target for the percentage of assessments conducted in an acute hospital setting thereby minimising the number of CHC assessments undertaken in an acute hospital setting to support effective hospital discharge and assessment in the right time and right place.
- The ICB were also commended on joint working with both Local Authorities - Derby City and Derbyshire County - to agree ways of working in regards AACC that minimise delays, disputes and appeals.

NHSE recognised the hard work and dedication of the team, the timely submissions of the required monthly Patient Level Dataset and quarterly Funded Care reports and confirmed that they are very assured in terms of our performance and achievements in regards AACC.

Performance

Craig Cook, Director of Acute Commissioning, Contracting & Performance
Dr Deji Okubadejo, Non-Executive Member

Planning Compliance with Operational Plan

Derby and Derbyshire Integrated Care Board

Area	Objective	Level	2324 YTD Plan / Latest Monthly Position	2324 YTD Actual / Latest Monthly Position	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Comment
Primary Care	Increase General Practice appointment activity	ICB	5,735,204	5,743,535	471,753	538,841	568,802	536,175	549,860	635,504	684,853	609,378	510,009	638,360	
	Increase referrals into Community Pharmacy Consultation Services (Quarterly Target)	ICB	28,214	20,878	*2,562*	*2,484*	*2,305*	*2,338*	*2,013*	*1,963*	*2,352*	*2,092*	*2,769*		
	Recover dental activity to pre-pandemic levels (Quarterly Target)	ICB	1,276,470	1,169,748	*1,169,748*										This is YTD dental activity at 06/03/24. this represents 76.2% 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	65.5%	67.7%	66.3%	66.4%	67.1%	67.7%	68.0%	68%	68%	68%	68%	68%	
	Provide access for 28,294 people to receive IAPT in 23/24 (Quarterly Target)	ICB	21,024	21670	2,265	4,700	7,205	2,370	4,895	7,355	2,720	5,325	7,110		Rolling total each quarter
	Increase the number of women accessing specialist perinatal services in 2023/24 (Quarterly Target).	ICB	828	900	260	370	465	535	595	665	745	830	900		
	Increase the number of children and young people accessing a mental health service (Quarterly Target).	ICB	13,450	12725	10,630	10,720	11,205	11,545	11,660	11,750	11,870	12,410	12,725		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	11,436	12015	11,730	11,685	11,690	11,635	11,530	11,520	11,590	11,645	12,015		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	44%	41%	2.7%	6.7%	11.5%	15.7%	21%	24%	29%	36%	41%		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	35	36	45	49	48	42	47	43	39	37	37	36	Revised targets have been agreed with the Regional Team. The revised target for January is: Adults - 35 C&YP - 3
	Reduce the number of children who are autistic, have a learning disability or both who are in inpatient beds	ICB	3	5	6	7	4	3	2	2	5	6	5	5	
	Reduce out of area placements - Bed Days	DHCFT	3,312	8,425	555	1,200	2,065	785	1,675	2,675	1,135	2,395	3,685		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	2324 YTD Plan / Latest Monthly Position	2324 YTD Actual / Latest Monthly Position	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	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	79%	78%	77.0%	77.8%	78.2%	79.4%	78.1%	76.7%	80.5%	80.4%	76.5%	75.0%		YTD CRH are slightly below plan but above national standard
		UHDB	70%	69%	66.9%	70.0%	71.6%	71.6%	69.5%	66.9%	65.4%	67.2%	71.6%	71.5%		
	Reduce the number of people waiting longer than 62 days for their first definitive treatment for cancer.	CRH	45	43	47	48	47	47	53	54	49	47	52	46	43	
		UHDB	295	327	473	453	310	366	416	516	458	466	420	393	327	
Planned Acute Care	No person waiting longer than 65 weeks on an RTT pathway at the end March 2024.	CRH	126	343	314	313	314	312	342	291	317	264	328	343		
		UHDB	329	1,639	1,704	1,924	1,985	2,073	2,572	2,588	2,391	1,824	1,883	1,639		
		DDICB	406	2,191	1,813	1,988	2,059	2,143	2,776	2,803	2,660	2,097	2,278	2,191		
	No person waiting longer than 78 weeks on an RTT pathway.	CRH	0	6	16	14	6	12	14	13	7	10	11	6		
		UHDB	0	243	144	130	99	112	200	241	299	237	242	243		
		DDICB	0	309	195	193	129	148	201	230	263	247	313	309		
	No person waiting longer than 104 weeks on an RTT pathway.	CRH	0	0	0	0	0	0	0	0	0	1	0	0		
		UHDB	0	0	0	0	1	0	0	0	0	0	0	0		
		DDICB	0	3	3	6	0	2	0	1	1	1	0	3		
	At least 85% of people receive a diagnostic test within 6 weeks by March 2024.	CRH	78%	85%	82.9%	82.5%	85.1%	84.0%	83.3%	84%	87%	90%	88%	88%		Percentage compliance is based on seven diagnostic tests (MRI / CT / Non Obs Ultrasound / Echocardiography / Colonoscopy / Flexi Sigmoidoscopy / Gastroscopy
		UHDB	73%	75%	68.1%	70.0%	71.6%	71.1%	70.9%	75%	80%	83%	81%	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	63%	65%	67.9%	64.8%	68.8%	70.9%	65.7%	69.1%	63.8%	59.9%	59.9%	61.4%	59.0%	
		UHDB	63%	69%	66.7%	68.4%	67.7%	71.8%	69.4%	69.4%	67.9%	67.6%	68.9%	69.5%	70.8%	
	30 minutes or less for EMAS to respond to a category 2 incident, on average.	ICB			00:31:00	00:35:00	00:40:00	00:38:48	00:39:33	00:42:31	00:49:27	00:42:48	01:00:11	00:48:56		From December the target has been amended to 39 mins (original target 30 mins) in line with revised trajectory.
		EMAS			00:33:32	00:34:23	00:39:34	00:36:16	00:36:49	00:42:33	00:52:44	00:41:02	00:56:09	00:49:59	00:49:36	
	Both Acute Trusts to operate at an average general and acute occupancy rate of 92%.	CRH	92.5%	95.2%	94.2%	94.5%	94.0%	92.4%	91.8%	93.3%	94.6%	96.2%	94.1%	96.4%	96.5%	The operational plan targets for February are 84% CRH and 92% UHDB.
		UHDB	93.4%	94.3%	89.8%	93.3%	94.0%	92.2%	91.7%	92.5%	94.0%	96.1%	93.9%	96.7%	95.4%	Both Trusts are above the operation plan target and the national 92% target.
	At least 70% of referrals into the Urgent Community Response Service to be responded to within 2 hours.	ICB	70%	67%	67%	90%	89%	91%	91%	88%	88%	78%	*50%*	*67%*		Local data consistently shows 80% and above achievement, national data for Dec and Jan has some data issues
	Increase virtual ward capacity.	ICB	255	165	120	120	120	140	160	165	165	165	165	165	165	Month end snapshot
	Increase virtual ward utilisation.	ICB	80%	38%	33.0%	26.0%	60.0%	21.0%	36%	46%	39%	49%	35%	62%	38%	

Planning Compliance with Operational Plan

Derby and Derbyshire Integrated Care Board

Area	Activity Metric	Level	2324 YTD Plan / Latest Monthly Position	2324 YTD Actual / Latest Monthly Position	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Comment
Community Data	D2A - The number of people discharged by location and discharge pathway per month	ICB	81,462	89,997	7,585	8,360	8,378	8,654	8,525	8,096	8,138	8,324	7,819	8,258	7,860	
	D2A - Pathway 0 - Non-complex discharge		73,797	82,294	6,989	7,676	7,652	7,943	7,834	7,422	7,464	7,614	7,186	7,368	7,146	
	D2A - Pathway 1 - Home with Support		4,526	4,177	300	381	384	380	382	376	394	380	331	497	372	
	D2A - Pathway 2 - Intermediate Care		2,511	2,836	236	256	276	259	250	243	232	268	239	311	266	
	D2A - Pathway 3 - 24-hour care placement		628	690	60	47	66	72	59	55	48	62	63	82	76	
	Community Waiting List - Quarterly Target	ICB	21,659	21,949	24,352	23,483	24,186	21,865	25,971	24,703	24,573	22,846	23,207	21,949		24,026 target is the Mar 23 waiting list position
	Community Waiting List by weeks - 0-1 weeks	ICB			4,260	3,343	3,217	3,081	3,770	3,242	2,724	2,231	1,899	2,597		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				2,360	2,124	2,304	2,046	1,961	2,003	1,923	1,627	1,577	1,863		
	Community Waiting List by weeks - 2-4 weeks				2,688	3,184	3,231	3,236	3,240	2,991	3,021	2,550	2,807	2,463		
	Community Waiting List by weeks - 4-12 weeks				6,956	6,590	6,368	6,417	7,672	6,787	6,667	6,392	6,636	4,983		
	Community Waiting List by weeks - 12-18 weeks				2,198	2,458	2,594	2,369	2,841	2,879	3,271	2,855	2,860	2,889		
	Community Waiting List by weeks - 18-52 weeks				4,413	4,493	4,994	3,781	4,860	5,118	5,429	5,683	5,827	5,471		
	Community Waiting List by weeks - over 52 weeks				1,124	1,291	1,478	935	1,627	1,683	1,538	1,508	1,601	1,683		
	Community Waiting List by weeks - Unknown				353											

Workforce

Linda Garnett, Interim ICB Chief People Officer
Margaret Gildea, Non-Executive Member

Table 1a: 2023/24 Workforce Plan Position Month 10 (NHS Foundations Trusts, including EMAS)

Derby and Derbyshire Integrated Care Board

ICB Total	Reporting Period: Jan 2024					
	Month 10			Trend		
	Plan	Actual	Variance from plan	Previous month	Changes in actual vs previous month	Trend (Actual) previous 12 months
Workforce						
Total Workforce (WTE)	29,066.77	30,488.56	-1,421.79	30,170.16	↑	
Substantive (WTE)	27,645.08	28,275.90	-630.83	28,151.88	↑	
Bank (WTE)	1,169.22	1,704.45	-535.23	1,495.13	↑	
Agency (WTE)	252.47	508.21	-255.74	523.15	↓	
Cost						
Pay Cost (£'000) ^	123,178	131,695	-8,517	129,982	↑	

Note: Plan figures are as submitted in the 23/24 operational plan submission.
^ Planned pay costs include the agreed AfC pay uplift from M5, but do not fully reflect the workforce impact as a result of efficiency plans consistently for all Trusts.
^ For the Pay Cost, UHDB use 'Total employee benefits excluding capitalised costs' for both budget & actual, while the others would be using 'Total gross staff costs' for both budget & actual.

- The total workforce across all areas (substantive, bank and agency) was 1421.79WTE above plan at M10.
- Compared to M9, there was an increase in substantive positions (+124.02WTE) and bank usage (+209.32WTE) but there was a decrease in agency usage (-14.94WTE).
- The majority of the increase in substantive positions was from Support to Nursing Staff (+71.67WTE) and NHS Infrastructure support (+19.81WTE), while there was a decrease from Registered nursing, midwifery and health visiting staff (-8.73WTE).

Table 1b: 2023/24 Workforce Plan Position Month 10 - Provider Summary

Derby and Derbyshire Integrated Care Board

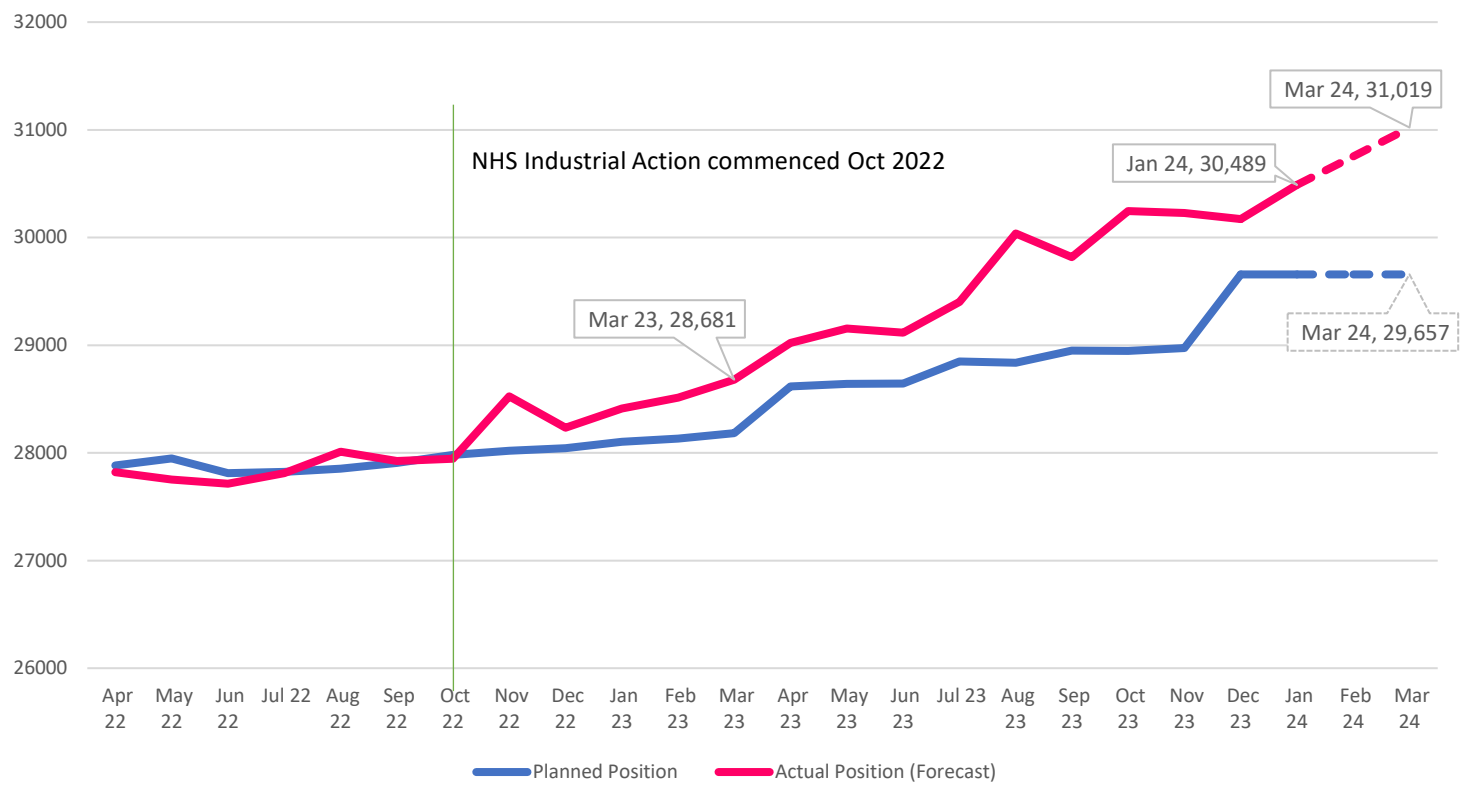
The table below identifies the substantive FOT identified as part of the H2 system reset exercise. It is recognised that the FOT position relates to M12; the purpose of the variance from FOT, identified below is to demonstrate how close each organisation is to achieving that position.

		2023/24 Plan	Actual	Variance from plan	Revised H2 FOT Plan	Variance from H2 FOT Plan
CRH	Workforce (WTE)					
	Total Workforce	4,701.68	5,005.34	-303.66		
	Substantive	4,311.22	4,604.72	-293.50	4,597.00	-7.72
	Bank	295.20	286.83	8.37		
	Agency	95.26	113.79	-18.53		
	Cost (£)					
	Pay Cost (£'000)	£19,528	£21,373	-£1,845		
DCHS	Workforce (WTE)					
	Total Workforce	3,859.32	3,833.18	26.14		
	Substantive	3,789.16	3,689.15	100.01	3,686.00	-3.15
	Bank	45.55	99.66	-54.11		
	Agency	24.61	44.37	-19.76		
	Cost (£)					
	Pay Cost (£'000)	£13,791	£14,139	-£348		
DHcFT	Workforce (WTE)					
	Total Workforce	3,168.08	3,107.91	60.17		
	Substantive	2,964.22	2,936.05	28.17	3,055.00	118.95
	Bank	158.05	146.96	11.09		
	Agency	45.81	24.80	21.01		
	Cost (£)					
	Pay Cost (£'000)	£13,018	£13,487	-£469		
EMAS *	Workforce (WTE)					
	Total Workforce	4,266.38	4,581.11	-314.73		
	Substantive	4,193.72	4,277.21	-83.49	4,187.64	-89.57
	Bank	52.66	60.78	-8.12		
	Agency	20.00	243.12	-223.12		
	Cost (£)					
	Pay Cost (£'000)	£17,425	£18,344	-£919		
UHDB	Workforce (WTE)					
	Total Workforce	13,071.31	13,961.12	-889.81		
	Substantive	12,386.75	12,768.77	-382.02	12,717.00	-51.77
	Bank	617.76	1,110.22	-492.46		
	Agency	66.79	82.13	-15.34		
	Cost (£)					
	Pay Cost (£'000)	£59,417	£64,352	-£4,935		

Table 1c: Workforce Growth Trend (Total WTEs)

M9-M12 planned figures are based on the revised FOT. Future months actual figures (dashed line) are based on a forecast using the average change since the M8 reset exercise.

Derby and Derbyshire Integrated Care Board



- The 2023/24 original plan was based on growth of 2.15% (615WTE).
- Between M12 2022/23 and M10 there has been 6.3% growth (1,808WTE).
- Between M12 actual and the revised FOT there would be 3.4% growth (976WTE) which is lower than the original plan. However, we are currently 832WTE over our revised FOT position.
- Using the % change between M8 and M10 of +0.9%, we forecast a M12 position of 31,019WTE, which is 1,362WTE above the FOT.

- 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, it is important to ensure the baseline positions are accurate going into 2024/25. Also, any growth in the workforce position to March 25 needs to be clearly matched with associated finance and performance delivery. Work is underway to improve triangulation across the 3 component parts in the 2024/25 planning round.

Workforce Total WTE	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	29,657	29,657	29,657	29,657
Actual *(Forecast)*	27,821	27,752	27,712	27,811	28,011	27,924	27,946	28,524	28,233	28,413	28,512	28,681	29,022	29,154	29,117	29,402	30,039	29,818	30,246	30,227	30,170	30,489	*30,752*	*31,019*
Variance	-64	-197	-98	-14	158	17	-36	505	189	310	378	496	402	509	473	544	941	870	1,297	1,252	522	832	*1,095*	*1,362*

Table 1d: 2023/24 Primary Care Workforce (M9)

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.

NHS Derby and Derbyshire Integrated Care Board

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	Nov-23	Dec-23	Dec-23	Mar-24
Total Workforce (WTE)	**3,378**	**3,367**	**3,377**	**3,385**	**3,439**	**3,394**	**3,434**	**3,424**	**3,548**	**3,447**	**3,469**	**3,505**	**3,614**	**3,647**
GPs excluding registrars	766	748	740	742	767	736	762	756	795	749	747	758	789	778
Nurses	364	353	354	353	365	349	343	341	363	337	337	338	363	361
Direct Patient Care roles (ARRS funded)	465	512	506	523	510	541	558	556	580	578	603	626	636	669
Direct Patient Care roles (not ARRS funded)	282	270	268	267	286	267	268	271	290	273	273	275	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	1,509	1,508	1,532	1,542

Summary

- At M9, the total workforce was 109WTE below M9's plan. The gap was observed mainly from GPs excluding registrars (31 WTE), Nurses (25WTE) and Other – admin and non-clinical staff (24 WTE).

Caveats to the data:

- **Primary Care data is up to M9 due to the data availability from GP team.**
- **Only quarterly plans are available, so we 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 Sources:
Provider Finance Returns (PFR)
Finance - Deputy DoFs (extracted from Finance Ledgers)
Provider Workforce Returns (PWR extracted from)

Derby and Derbyshire Integrated Care Board

	M10 Pay Budget	M10 Pay Actual	M10 Pay Variance	YTD Pay Budget	YTD Pay Actual	YTD Pay Variance *	Establish-ment (as per Finance) **	Staff in Post (Substantive) M10 Actual	Vacancy ***	Vacancy Rate ***	Bank M10 Actual	Agency M10 Actual	Net Staffing (Substantive, Bank & Agency Total) M10 Actual	Establish-ment V Actual Variance
	£'000	£'000	£'000	£'000	£'000	£'000	WTE	WTE	WTE	%	WTE	WTE	WTE	WTE
ICB Total	123,178	131,694	-8,516	1,244,321	1,284,597	-40,275	29,655	28,276	1,379	4.65%	1,704	508	30,489	-834
CRH	19,528	21,373	-1,845	201,035	215,559	-14,524	4,800	4,605	195	4.07%	287	114	5,005	-205
DCHS	13,791	14,139	-348	137,075	139,972	-2,897	3,809	3,689	120	3.15%	100	44	3,833	-24
DHcFT	13,018	13,487	-469	128,095	133,548	-5,452	3,049	2,936	113	3.70%	147	25	3,108	-59
EMAS ^	17,425	18,344	-919	172,704	164,092	8,612	4,375	4,277	98	2.24%	61	243	4,581	-206
UHDB ^^	59,417	64,352	-4,935	605,412	631,426	-26,014	13,622	12,769	853	6.26%	1,110	82	13,961	-339

Notes:

* 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

^^ UHDB reflects 'Total employee benefits excluding capitalised costs' as the Pay Cost for both budget & actual (for other Trusts this is 'Total gross staff costs') for both budget & actual.

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 overall YTD position is an overspend against the pay budget of £40.3m with 834WTE over-establishment at M10 (total workforce).

It is not yet possible to make a direct correlation between the pay-bill and the actual WTEs and there is an outstanding 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 and review any opportunities to reduce these costs without impacting on capacity to delivery in the first instance. This requires the support from the finance community as the data will need to be extracted through the ledger systems.

2023/24 M10 JUCD Agency

Derby and Derbyshire Integrated Care Board

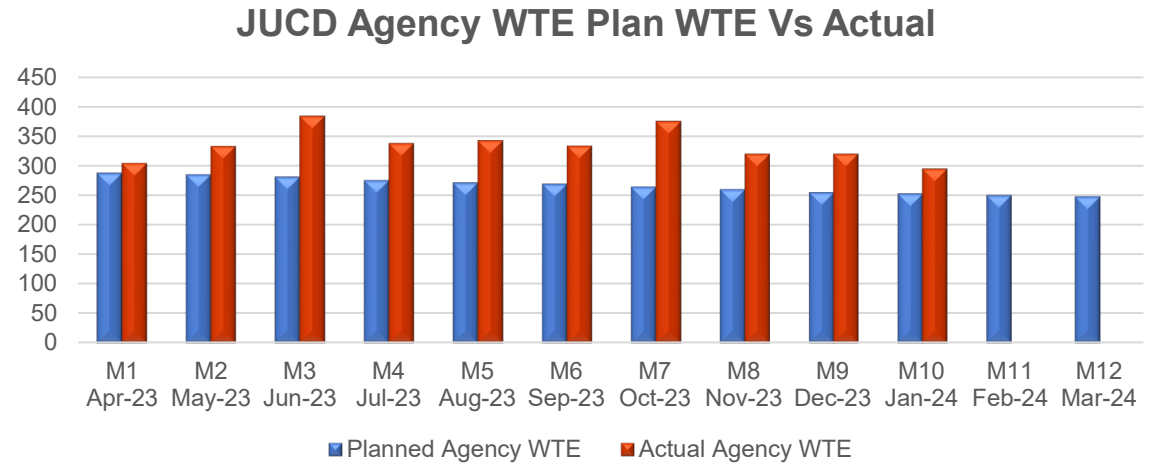
KPI Summary:

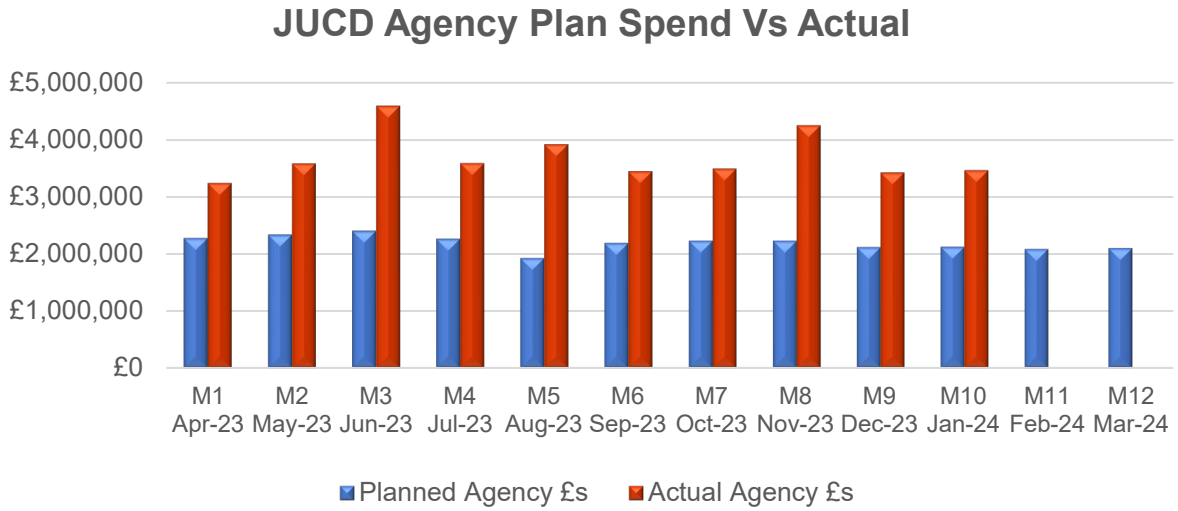
- In M10 JUCD agency cost amounted to 2.6% of total pay costs, 1.1% under the national target of 3.7%
- YTD JUCD planned agency usage was £22.1m, the system has spent £37.1m which is an overspend £15.0m
- Off framework usage was 124 shifts in M10, 2.7% of total agency shifts (4.0% YTD).
- There were 2,493 non price cap compliant shifts, 52.4% of the total agency shifts (51.5% YTD).
- Admin and Estates came to 353 shifts in M10, 7.8% of total agency shifts (21.5% YTD). YTD the total Admin and Estates agency usage appears to be distorted due the EMAS position which equates to 8,496 out of a total of 12,332 for all providers. The YTD Admin and Estates position for EMAS is 96% 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.

M10 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 10 System Finance Summary – Financial Position

Derby and Derbyshire Integrated Care Board

As of 31st January 2024, the JUCD year to date position is a £38.5m overspend against the plan.

The main drivers of the year to date overspend include excess inflation (£29.9m) and income assumptions made at the planning stage which have not materialised including a shortfall on ERF (£7.7m). Other challenges include an increased demand for services, complex patients and workforce capacity issues.

The ICB met with NHSE to agree movement to the system's most likely position in month 9. £44.7m was the recognised figure by both parties.

The forecast position reported by the system at month 10 is an overspend of £48.3m, this is after the NHSE recognised position of £44.7m plus £3.5m for the recent industrial action relating to Junior Doctor strikes.

The forecast pressures continue from YTD including, excess inflation (£37.2) and income assumptions (£8.1m) which includes the reduction of ERF income. Other areas of overspend include the revenue cost of capital and January and February's industrial action.

I&E position by Provider Month 09 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	4.1	**4.1**	0.0	9.6	**9.6**
Chesterfield Royal Hospital	(1.9)	(19.8)	**(17.9)**	(0.0)	(21.6)	**(21.6)**
Derbyshire Community Health Services	(0.1)	(1.6)	**(1.5)**	(0.0)	(2.7)	**(2.7)**
Derbyshire Healthcare	0.6	(2.3)	**(2.9)**	0.0	(4.4)	**(4.4)**
EMAS	(0.0)	0.1	**0.1**	0.0	0.0	**0.0**
University Hospital of Derby and Burton	(4.6)	(24.9)	**(20.3)**	0.0	(29.2)	**(29.2)**
JUCD Total	(5.9)	(44.4)	(38.5)	(0.0)	(48.3)	(48.3)

Month 10 System Finance Summary – Risk

NHS
Derby and Derbyshire
Integrated Care Board

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

Estimated £24.1m risks in meeting the recognised £44.7m year end deficit.

£20m relates estimated costs at CRH and UHDB for the national Health Care Assistant claim for re-banding. DHc settled payments in 2021 and DCHS are looking to settle in the near future.

The remainder relating to income, drugs costs and efficiencies.

JUCD is confident on the ability deliver £44.7m outside of the Health Care Assistant Claim and an additional risk identified in month 11 of £7.2m relating to the PFI IFRS 16 revaluation PDC benefit being taken centrally

Month 10 Position	2023/24 Organisations Forecast Range		
Organisation	Best Case £m's	Likely Case £m's	Worst Case £m's
NHS Derby and Derbyshire ICB	9.6	9.6	7.7
Chesterfield Royal Hospital	(21.6)	(21.6)	(26.6)
Derbyshire Community Health Services	(2.7)	(2.7)	(3.4)
Derbyshire Healthcare	(4.2)	(4.4)	(4.9)
East Midlands Ambulance Service	0.0	0.0	(1.1)
University Hospitals of Derby And Burton	(29.2)	(29.2)	(44.2)
JUCD Total Surplus/(Deficit)	(48.1)	(48.3)	(72.5)

Month 10 System Finance Summary – Efficiencies

Derby and Derbyshire Integrated Care Board

The annual efficiency plan is to deliver £136m. Year to date the achievement is £1.4m ahead of a planned £108.9m, with a forecast of £2.2m under plan by the end of the year.

For the efficiencies that are expected to be delivered the plans are all fully developed and there is little risk on the projected delivery.

Recurrent efficiencies are £23.5m behind plan to date, forecast to increase to £32.7m by the end of the year. There is a need to identify recurrent transformational change to move the system to a financially sustainable position.

Efficiencies by Provider Month 10 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	36.1	40.9	**4.9**	44.2	47.6	**3.4**
Chesterfield Royal Hospital	12.4	9.5	(2.9)	15.7	11.2	(4.5)
Derbyshire Community Health Services	7.6	7.3	(0.4)	9.2	9.2	**0.0**
Derbyshire Healthcare	7.3	7.5	**0.2**	8.8	8.8	**0.0**
EMAS	9.3	9.4	**0.1**	11.2	11.2	**0.0**
University Hospital of Derby and Burton	36.1	35.6	(0.5)	47.0	45.9	(1.1)
JUCD Total	**108.9**	**110.3**	**1.4**	**136.0**	**133.8**	(2.2)

Month 10 System Finance Summary – Capital

Derby and Derbyshire Integrated Care Board

- The year to date capital position is an underspend of £10m, with a forecast year end underspend of £6.1m
- By month 11 plans have been put in place to ensure the capital envelope has been fully utilised
- The developments which are currently behind plan year to date for are projected to achieve plan by year end
  - Neonatal critical care works
  - The Kings Treatment Centre and Community Diagnostic Centre developments in UHDB
  - Ward upgrade programme at CRH
  - EMAS fleet costs
- The main forecast underspend relates to DCHS and the Belper and Community Diagnostic Centre developments
- Derbyshire Healthcare's plan to eradicate dormitories is still in progress for 2024/25
  - Inflation and flooding have increase costs by £7.5m leaving insufficient funds to finish the project
  - Discussions are ongoing to identify if there is some national funding available.

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	7.4	5.2	2.2	9.7	9.7	(0.0)
Derbyshire Community Health Services	5.2	14.2	(9.0)	21.4	15.3	6.1
Derbyshire Healthcare	57.0	56.9	0.1	69.1	69.0	0.1
EMAS	10.8	7.0	3.8	10.0	10.1	(0.1)
University Hospital of Derby and Burton	29.1	16.2	13.0	37.5	37.5	0.0
JUCD Total	109.5	99.4	10.0	147.8	141.7	6.1

Month 10 System Finance Summary – Cash

Derby and Derbyshire Integrated Care Board

The cash balances also include cash held for capital commitments, this amounts to £47.5m for the remainder of the year

CRH and UHDB have requested cash support from NHSE/DHSC for quarter four and this has been approved, meaning cash can be managed to the end of the financial year

The ICB is still expected 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 to support the 2023/24 financial position

The table below describes the cash balance at Month 10 and the forecast balance at year end before the application of the cash support, which has now been approved.

Provider Cash Month 10 Position	Opening Balance 01/04/23 £m's	Cash Plan Month 10 £m's	Cash Balance Month 10 £m's	Cash Variance Month 10 £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	14.7	21.4	6.7	19.9	15.8	(4.1)
Derbyshire Community Health Services	37.3	30.1	29.8	(0.3)	34.1	29.9	(4.2)
Derbyshire Healthcare	53.9	26.1	38.5	12.4	23.7	23.7	0.0
EMAS	18.2	18.3	32.1	13.8	13.7	21.4	7.6
University Hospital of Derby and Burton	48.4	41.4	38.3	(3.2)	35.6	5.7	(30.0)
JUCD Total	178.0	130.6	160.0	29.4	127.0	96.3	(30.6)

Month 10 System Finance Summary – Workforce

Derby and Derbyshire Integrated Care Board

YTD there is an overspend of £41.8m across the system with and an overspend of £57.4m expected by the end of the year.

The overspend includes pressures relating to covering staff due to industrial action and this increased significantly during December and January.

£15.0m 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 10 Position	2022/23 M12 £m's	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	201.0	215.6	(14.5)	239.9	260.1	(20.1)
Derbyshire Community Health Services	170.8	137.1	140.0	(2.9)	164.7	168.5	(3.8)
Derbyshire Healthcare	155.6	128.1	133.5	(5.5)	154.2	160.5	(6.3)
EMAS	198.0	172.7	164.1	8.6	207.6	200.1	7.5
University Hospital of Derby and Burton	750.5	605.4	632.9	(27.5)	724.5	759.1	(34.6)
JUCD Total	1,528.3	1,244.3	1,286.1	(41.8)	1,490.8	1,548.2	(57.4)

Appendix 2 – JUCD System Finance Report to 31st January 2024 (M10)

1. Introduction

This report details the JUCD System Financial Position as at 31st January 2024, focusing on the I&E position, delivery of efficiencies, capital and cash, along with details of the risks across the submitted plan.

2. Executive Summary

Income and Expenditure Performance

As at 31st January 2024, the JUCD year to date position is a £44.4m deficit against a £5.9m planned deficit, a £38.5m overspend against plan. The position continues to be driven by pressures outside of the plan including, excess inflation and pay award with pressures on delivering the plan due to unrealised income and operational overspends.

Table 2.1 below outlines the year to date and forecast positions as at month ten.

Table 2.1 *JUCD I&E Position Summary as at 31st January 2024*

I&E Position by Provider Type Month 10 Position	Month 10 Planned Variance £m's	Month 10 Actual Variance £m's	Month 10 Variance to Plan £m's		Annual Planned Variance £m's	Annual FOT Variance £m's	FOT Variance to Plan £m's
Chesterfield Royal Hospital	(1.9)	(19.8)	(17.9)		(0.0)	(21.6)	(21.6)
Derbyshire Community Health Services	(0.1)	(1.6)	(1.5)		(0.0)	(2.7)	(2.7)
Derbyshire Healthcare	0.6	(2.3)	(2.9)		0.0	(4.4)	(4.4)
EMAS	(0.0)	0.1	0.1		0.0	0.0	0.0
University Hospital of Derby and Burton	(4.6)	(24.9)	(20.3)		0.0	(29.2)	(29.2)
Other NHS Acute	0.0	(2.3)	(2.3)		0.0	1.8	1.8
Other NHS Mental Health	0.0	(1.3)	(1.3)		0.0	(1.5)	(1.5)
Other NHS Community Services	0.0	0.6	0.6		0.0	0.5	0.5
Acute Independent Sector	0.0	0.6	0.6		0.0	(1.9)	(1.9)
Mental Health Independent Sector	0.0	(3.2)	(3.2)		0.0	(3.5)	(3.5)
Community Services Non NHS	0.0	(1.0)	(1.0)		0.0	(1.7)	(1.7)
Continuing Health Care	0.0	(0.0)	(0.0)		0.0	0.0	0.0
Primary Care Prescribing	0.0	(6.0)	(6.0)		0.0	(7.1)	(7.1)
GP Co-Commissioning	0.0	(1.6)	(1.6)		0.0	(2.0)	(2.0)
Other GP Primary Care	0.0	1.8	1.8		0.0	1.9	1.9
Pharmacy	0.0	0.8	0.8		0.0	0.0	0.0
Optometry	0.0	(0.3)	(0.3)		0.0	0.0	0.0
Dental	0.0	8.2	8.2		0.0	9.8	9.8
Other Programmed Services	0.0	(3.7)	(3.7)		0.0	(5.4)	(5.4)
ICB Running Costs	0.0	1.9	1.9		0.0	3.3	3.3
ICB Operational Costs Other Programme	0.0	9.4	9.4		0.0	15.4	15.4
Grand Total	**(5.9)**	**(44.4)**	**(38.5)**		**(0.0)**	**(48.3)**	**(48.3)**

CRH have an overspend of £17.9m to date with excess inflation and additional pay costs contributing towards the variance along with £4.8m of new allocations the Trust had assumed in planning which have not been received. The year to date position for UHDB is a total overspend of £20.3m which includes a net impact of £8.1m for excess inflation and industrial action. An overspend position is also being report by DHcFT with pressures from increased

activity for complex patients, and out of area and transport costs. DCHS is reporting a variance to plan of £1.5m relating to a number of factors including excess inflation and efficiencies. EMAS has a small underspend to date mainly due to a fortuitous one-off income benefit. The ICB are also reporting an underspend position of £4.1m with excess inflation costs offset by mitigations including over-achievement on efficiencies and a benefit for dental.

The forecast outturn positions for all organisations are based on the financial reset position information provided to NHSE. A deficit of £44.7m was identified in discussions held with the National Team and there are further additional costs of £3.5m incurred for the Junior Doctors strike action in December and January. It has been agreed nationally that these costs can also be reported in the position, giving a total forecast deficit of £48.3m. JUCD remains committed to delivering the best possible position it can.

Capital

The system currently has slippage in year to date relating to delays in a number of developments, but plans are in place to manage this across the year end by bringing forward unavoidable 2024/25 commitments into this year.

Looking ahead, inflation and bad weather have resulted in Derbyshire Healthcare being £7.5m short in relation to the cost of the eradication of dormitories. It will not be possible to complete the project without additional resources being made available which would mean we would be unable able to achieve 100% eradication of dormitories. NHSE have indicated the full £7.5m shortfall cannot be funded nationally, therefore a reprioritisation of the systems 2024/25 capital plan will be required.

Cash

Due to the success of CRH and UHDB's applications for cash support for the fourth quarter, cash will be managed for the remainder of the year. NHSE have also been informed it is likely that the ICB will require £30m additional cash over the cash limit due to the amount of non-recurrent balance sheet and other flexibilities used to achieve the financial position. This is currently being transacted.

ERF

Based on the national data covering the period April to September 2023, the system has achieved 100.4% performance against a target of 100.0%. This reflects the impact of the agreed baseline changes submitted by JUCD providers. Based on the revised guidance for ERF, in month 10 an allocation has been received for the full remaining holdback amount of £3.7m. As the performance has been higher than target an allocation of £1.2m has also been received to recognise the overperformance achieved.

3. Income and Expenditure Performance

As at 31st January 2024, the year to date system position is a £44.4m deficit against a £5.9m planned deficit. The variances to plan are predominantly made up of costs which were not a consideration at planning, mainly industrial action and excess inflation offset by £12.2m of support allocation support, as well as activity and pay pressures.

The year to date variances to plan are shown in the following table.

Table 3.1 *Year to date movement from plan*

JUCD Year to Date Movement from Plan Month 10 Position	ICB £m's	CRH £m's	DCHS £m's	DHcFT £m's	EMAS £m's	UHDB £m's	Total £m's
Industrial Action (Gross Amount)		(4.4)		(0.1)		(7.4)	**(11.9)**
Excess Inflation Above National Guidance (Gross Amount)	(17.9)	(3.8)	(0.9)	(0.3)	(0.1)	(6.9)	**(29.9)**
Pay Award		(0.9)	(0.1)	(0.2)	(0.6)		**(1.8)**
Efficiencies	4.9	(2.3)	(0.4)	0.2		(0.6)	**1.8**
Revenue Cost of Capital		(0.2)		(2.1)	0.3	(0.6)	**(2.6)**
Industrial Action and Excess Inflation Support	3.0	3.0				6.2	**12.2**
Complex Patient - Agency & transport costs				(2.5)		(0.9)	**(3.4)**
Out of Area and Transport Costs				(1.3)			**(1.3)**
Inpatient Ward Overspends, Additional Observations				(5.3)			**(5.3)**
Additional Rota Fill Rate		(3.5)					**(3.5)**
Income Assumptions Identified in Planning		(4.8)				(2.9)	**(7.7)**
Dental Benefit	8.8						**8.8**
Other	(6.0)	(1.0)	(3.0)		0.5	(7.3)	**(16.8)**
Mitigations	11.3		2.8	8.6			**22.7**
Total	**4.1**	**(17.9)**	**(1.6)**	**(2.9)**	**0.1**	**(20.3)**	**(38.6)**

Table 3.2 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.

Table 3.2 *JUCD I&E position best, most likely and worst case forecast position.*

Month 10 Position	2023/24 Organisations Forecast Range		
Organisation	Best Case £m's	Likely Case £m's	Worst Case £m's
NHS Derby and Derbyshire ICB	9.6	9.6	7.7
Chesterfield Royal Hospital	(21.6)	(21.6)	(26.6)
Derbyshire Community Health Services	(2.7)	(2.7)	(3.4)
Derbyshire Healthcare	(4.2)	(4.4)	(4.9)
East Midlands Ambulance Service	0.0	0.0	(1.1)
University Hospitals of Derby And Burton	(29.2)	(29.2)	(44.2)
JUCD Total Surplus/(Deficit)	(48.1)	(48.3)	(72.5)

The likely scenario is based on the financial reset deficit that NHSE National team have recognised as the genuine likely outturn for the system plus additional direct costs of £3.5m for Junior Doctors industrial action in December and January. The ICB is forecasting a surplus due to additional mitigations which were not anticipated in planning which will support the system bottom line.

The best case includes a small improvement in pressures relating to patient activity and agency staff costs. The worst case scenario incorporates risks related to delivering the JUCD Operational Plan, including the risk on health care support working re-banding claim currently estimated at £20m, 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.

Risks

Risks to reaching the year-end likely position that is being reported at month ten are those that are outside the system's control as well as those that might prevent the delivery of the Operational Plan. Mitigating these risks is necessary to deliver the best possible position and where possible mitigations have been identified for the risks deemed to be within our control.

The worst case scenario of £72.5m for JUCD includes risks of £24.1m as detailed in Table 3.3 below.

Table 3.3 *System Identified Risks*

Area of Risk Month 10 Position	Difference between Likely and Worst Case
Efficiency delivery	(0.4)
Industrial Action	(0.1)
Baseline and Non-Recurrent Income	(1.1)
Drugs Costs	(0.4)
Revenue Cost of Capital	0.7
HCA Back Pay	(20.0)
Other	(2.8)
Total	**(24.1)**

The current largest single risk is £20m for a national Health Care Assistant claim for re-banding. This relates to CRH and UHDB for potential increases in pay costs due to discussions that are still ongoing around health care workers changing from band 2 to band 3 and the possible effective date of any change. Derbyshire Healthcare settled payments to their staff in 2021 and DCHS are looking to settle payments in the very near future. Currently each organisation is treating the situation individually and no national guidance on an approach has been received.

Efficiencies

Table 3.4 below sets out the month ten efficiencies by organisation and the actual delivery against those plans. The year to date position includes over-delivery for the ICB, Derbyshire Healthcare and EMAS with other providers reporting under-delivery to date. The total forecast achievement for the year is £2.2m behind plan. The ICB is forecasting to achieve £3.4m above plan with CRH and UHDB both expecting to under-deliver. For the efficiencies that are expected to be delivered the plans are all fully developed.

Table 3.4 *System Efficiency Delivery – NHSE Submitted Financial Report*

Efficiencies by Provider Month 10 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	36.1	40.9	**4.9**	44.2	47.6	**3.4**
Chesterfield Royal Hospital	12.4	9.5	(2.9)	15.7	11.2	(4.5)
Derbyshire Community Health Services	7.6	7.3	(0.4)	9.2	9.2	**0.0**
Derbyshire Healthcare	7.3	7.5	**0.2**	8.8	8.8	**0.0**
EMAS	9.3	9.4	**0.1**	11.2	11.2	**0.0**
University Hospital of Derby and Burton	36.1	35.6	(0.5)	47.0	45.9	(1.1)
JUCD Total	108.9	110.3	1.4	136.0	133.8	(2.2)

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

Table 3.5 *YTD and Full Year Efficiencies Split Recurrent and Non-Recurrent*

Efficiencies Month 10 Position	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Forecast	Forecast Variance
Recurrent						
NHS Derby and Derbyshire ICB	18.9	18.4	(0.5)	23.9	21.4	(2.5)
Chesterfield Royal Hospital	9.4	3.8	(5.6)	11.9	4.5	(7.4)
Derbyshire Community Health Services	5.8	4.3	(1.5)	7.0	5.2	(1.8)
Derbyshire Healthcare	5.5	1.8	(3.7)	6.6	2.2	(4.4)
EMAS	7.7	7.4	(0.3)	9.2	8.9	(0.3)
University Hospital of Derby and Burton	25.5	13.6	(11.9)	33.1	16.8	(16.4)
Total Recurrent	**72.8**	**49.3**	(23.5)	**91.7**	**58.9**	(32.7)
Non-Recurrent						
NHS Derby and Derbyshire ICB	17.2	22.5	**5.3**	20.3	26.2	**5.9**
Chesterfield Royal Hospital	3.0	5.7	**2.7**	3.8	6.7	**2.9**
Derbyshire Community Health Services	1.8	3.0	**1.2**	2.2	4.0	**1.8**
Derbyshire Healthcare	1.8	5.7	**3.9**	2.2	6.6	**4.4**
EMAS	1.6	2.1	**0.4**	2.0	2.3	**0.3**
University Hospital of Derby and Burton	10.6	22.0	**11.4**	13.8	29.1	**15.3**
Total Non-Recurrent	**36.1**	**61.0**	**24.9**	**44.3**	**74.9**	**30.6**
JUCD Total	108.9	110.3	1.4	136.0	133.8	(2.2)

The recurrent efficiencies to date have under-delivered by £23.5m and are expected to be £32.7m behind plan by the end of the year. The recurrent forecast outturn of £58.9m equates to 43% of the total plan for efficiencies. This highlights that non-recurrent efficiencies are supporting the current year position which will increase the pressure going into 2024/25. There is a need to identify and mobilise recurrent transformational change to move the system to a financially sustainable position.

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 various 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 junior doctors strikes during December and January further strain on our already stretched system with more strikes planned for the end of February. All system partners are reporting significant operational pressures via the OPEL system, with UHDB consistently reporting at OPEL level 4 with wait times in ED , numbers of patients who are medically fit for discharge and impact on bed capacity being flagged as particular issues.

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 our 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.

Winter is now causing considerable stress in the acute sector. Additional beds and chairs are being opened to cope with demand that continues to fall into the acute sector, with ability to move into social or community care settings remaining limited. The additional costs of the NEL pathway will add further risk to the deliver of the current year forecast.

The technical accounting under IFRS 16 for PFIs has now commenced with the month 9 NHSE forms requiring an assessment of the impact which will then be under review from external auditors. The exact impact of the change in accounting treatment and its impact on the financial performance measurement for providers will be confirmed at the year end. A £7m benefit has been assumed to be within the financial performance measurement at this time, with a material value impacting the bottom line position outside of the financial performance measurement.

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 due to the significant challenges around recruitment and retention. Continued increase in activity in our wound care services is driving a significant increase in consumable costs such as dressings.

MHLD&A

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

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.

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. Workforce

Workforce

JUCD is reporting an overspend of £41.8m to date with a year-end forecast of £57.4m over as detailed in table 5.1 below.

Table 5.1 *Workforce Costs from Provider Finance Return*

Staff Costs by Provider	2022/23 M12	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Forecast	Forecast Variance
Month 10 Position		£m's	£m's	£m's	£m's	£m's	£m's
Chesterfield Royal Hospital	253.4	201.0	215.6	(14.5)	239.9	260.1	(20.1)
Derbyshire Community Health Services	170.8	137.1	140.0	(2.9)	164.7	168.5	(3.8)
Derbyshire Healthcare	155.6	128.1	133.5	(5.5)	154.2	160.5	(6.3)
EMAS	198.0	172.7	164.1	8.6	207.6	200.1	7.5
University Hospital of Derby and Burton	750.5	605.4	632.9	(27.5)	724.5	759.1	(34.6)
JUCD Total	1,528.3	1,244.3	1,286.1	(41.8)	1,490.8	1,548.2	(57.4)

CRH has an overspend of £14.5m to date with the main pressures from industrial action and covering vacancies. UHDB also has an overspend of £27.5m to date mainly relating to bank and agency cover for industrial action and sickness.

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 10 Position	2022/23 M12 £m's	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	7.8	12.2	(4.4)	9.1	15.3	(6.2)
Derbyshire Community Health Services	1.4	1.1	1.2	(0.1)	1.3	1.5	(0.2)
Derbyshire Healthcare	7.6	4.4	7.8	(3.3)	5.3	9.0	(3.7)
EMAS	0.7	0.7	1.6	(0.9)	0.8	1.9	(1.1)
University Hospital of Derby and Burton	14.5	8.1	14.4	(6.2)	9.8	16.8	(7.0)
JUCD Total	39.7	22.1	37.1	(15.0)	26.3	44.4	(18.1)

The year to date overspend is £15.0m with an expected overspend of £18.1m by the end of the year. Agency costs to date and forecast equate to 3% of the total staff costs. Both CRH and UHDB have seen increasing costs for agency staff providing vacancy cover and UHDB has also incurred additional costs in supporting one-off projects. The main costs for DHcFT continue to be in relation to the previously mentioned complex eating disorder patient as well as increased costs for medics and nursing on wards.

JUCD is over-plan for WTE as detailed in table 5.3 below. This is consistent with the overspend that is being reported.

Table 5.3 *Workforce Plan for 2023/24 & WTE from Provider Workforce Return*

Workforce WTE M10	M10 Planned WTE	M10 Actual WTE	M10 Variance WTE
Chesterfield Royal Hospital	4,701.7	5,005.3	(303.7)
Derbyshire Community Health Services	3,859.3	3,833.2	26.1
Derbyshire Healthcare	3,168.1	3,107.8	60.3
EMAS	4,266.4	4,581.1	(314.7)
University Hospital of Derby and Burton	13,071.3	13,961.1	(889.8)
JUCD Total	29,066.8	30,488.6	(1,421.8)

The below table shows the WTE information by type of staff and shows that all areas have higher WTE than planned.

Table 5.4 *WTE by Type of Staff*

Workforce WTE	M10 Planned WTE	M10 Actual WTE	M10 Variance WTE
Substantive	27,645.1	28,275.9	(630.8)
Bank	1,169.2	1,704.5	(535.2)
Agency	252.5	508.2	(255.7)
JUCD Total	29,066.8	30,488.6	(1,421.8)

6. Capital

The system is behind plan year to date relating to delays in a number of developments and JUCD is currently forecasting an underspend on these projects. The System is looking at other opportunities to ensure we make best use of the resources available.

***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	7.4	5.2	2.2	9.7	9.7	(0.0)
Derbyshire Community Health Services	5.2	14.2	(9.0)	21.4	15.3	6.1
Derbyshire Healthcare	57.0	56.9	0.1	69.1	69.0	0.1
EMAS	10.8	7.0	3.8	10.0	10.1	(0.1)
University Hospital of Derby and Burton	29.1	16.2	13.0	37.5	37.5	0.0
JUCD Total	**109.5**	**99.4**	**10.0**	**147.8**	**141.7**	**6.1**

Derbyshire Healthcare's plan to eradicate dormitories is still in progress for 2024/25, however it may not be possible to be completed in 2025/26. Inflation and flooding have increase costs by £7.5m leaving insufficient funds to finish the project resulting in not achieving 100% eradication of dormitories. NHSE have indicated the full £7.5m shortfall cannot be funded nationally, therefore a reprioritisation of the systems 2024/25 capital plan will be required.

The material forecast variance for DCHS relates to Belper £4.9m and CDC £1.2m. Derbyshire Healthcare have offered to take £300k of the CDC money to support DCHS. The system are awaiting Memorandum of Understanding agreements from NHSE to transact this.

7. Cash

The table below shows the cash balance to be £29.4m more than plan at the end of January and is expected to be £30.6m less than plan by the end of the financial year with UHDB, CRH and DCHS projecting a cash balance lower than plan. CRH's reported cash position also includes cash which is held by their wholly owned subsidiary DSFS.

The cash balances also include cash held for capital commitments, this amounts to £47.5m for the remainder of the year.

***Table 7.1** Cash Balances from Provider Finance Return*

Provider Cash Month 10 Position	Opening Balance 01/04/23 £m's	Cash Plan Month 10 £m's	Cash Balance Month 10 £m's	Cash Variance Month 10 £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	14.7	21.4	6.7	19.9	15.8	(4.1)
Derbyshire Community Health Services	37.3	30.1	29.8	(0.3)	34.1	29.9	(4.2)
Derbyshire Healthcare	53.9	26.1	38.5	12.4	23.7	23.7	0.0
EMAS	18.2	18.3	32.1	13.8	13.7	21.4	7.6
University Hospital of Derby and Burton	48.4	41.4	38.3	(3.2)	35.6	5.7	(30.0)
JUCD Total	**178.0**	**130.6**	**160.0**	**29.4**	**127.0**	**96.3**	**(30.6)**

Since CRH and UHDB's applications for cash support for the fourth quarter have been approved, cash can be managed for the remainder of the year.

It is still expected that the ICB will need an additional £30m funding than the cash limit it was given at the beginning 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 Committee are asked to **NOTE**:

- The deficit position being reported for month ten.
- 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.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: 154

Report Title	Holistic Discharge Review							
Author	Sue Sunderland, Non-Executive Member (Audit and Governance)							
Sponsor (Executive Director)	Dr Chris Weiner, Chief Medical Officer							
Presenter	Sue Sunderland, Non-Executive Member (Audit and Governance) Dr Chris Weiner, Chief Medical Officer							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☐
Appendices	Appendix 1 – Holistic Discharge Summary Findings Appendix 2 – Questions for discussion presentation							
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 **DISCUSS** the questions highlighted in the presentation and agree appropriate next steps.
Purpose
The paper presents a summary of current discharge arrangements with a view to agreeing a way forward to improve the effectiveness of some of those arrangements.
Background
Discharge is a critical element of the effective management of patient flow through hospital. When discharge arrangements are working effectively then it can help alleviate the pressure on bed availability and ease pressure within the U&EC pathway. Discharge pathways involve partnership working not just within health but with local authority and voluntary sector partners and is therefore an area where co-ordination and co-operation across the system is important. I was tasked by the Chair with looking at the current discharge arrangements with a view to leading a Board session on the topic, which this paper forms the basis of. I would like to thank everyone who has given up their time to speak to me. A separate audit is being undertaken by 360 Assurance of how discharge from hospital is being managed and overseen by considering the strength of the controls in place. These two pieces of work should be complementary.

In September 2023 an intermediate care framework for rehabilitation, reablement and recovery following hospital discharge was published by NHS England. This framework consists of best practice guidance and a number of recommended actions that systems should consider. This framework is aimed at ICBs but is designed to support them in working in partnership. Several of the areas considered by my review can be linked into the priorities identified by this framework.

Report Summary

My overall impression is that we have a lot of committed and passionate individuals working hard to improve arrangements for both supporting patients on discharge but also in trying to prevent their admission in the first place. At the same time there is potential to improve the strategic focus and cost effectiveness of the current arrangements. The areas considered by my review are:

- How we are performing as a system
- Whether we have a holistic approach to discharge arrangements
- Whether we understand how much money is being spent on discharge arrangements and whether we are getting best value from this money

The extent to which we have responded to the priorities set out in the NHS England intermediate care framework, specifically around our approach to:

- Multidisciplinary discharge teams
- Strength based assessments
- Criteria based discharge & 7 day per week discharge arrangements
- Mental Capacity Act assessments
- Virtual wards
- Team up – admission avoidance

Whilst the paper outlines questions for further exploration under each area our Board discussion this morning will focus on those that best link to the intermediate care framework priorities. Progress in these areas has the potential to significantly impact on the speed and effectiveness of discharge and consequently increase bed availability as well as improving the patient experience.

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**	There is a risk that the system does not create and enable a health and care 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		
[To be completed by the Finance Team ONLY]		
Yes ☐	No☐	N/A☒
Details/Findings The paper is for discussion only and does not therefore have any financial impact		**Has this been signed off by a finance team member?** Not applicable.
Have any conflicts of interest been identified throughout the decision-making process?		
None identified		
Project Dependencies		
Completion of Impact Assessments		

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

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

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

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None identified

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

Appendix 1

Holistic discharge summary findings

Background

Discharge is a critical element of the effective management of patient flow through hospital. When discharge arrangements are working effectively then it can help alleviate the pressure on bed availability and ease pressure within the U&EC pathway.

Discharge pathways involve partnership working not just within health but with local authority and voluntary sector partners and is therefore an area where co-ordination and co-operation across the system is important.

I was tasked by the Chair with looking at the current discharge arrangements with a view to leading a Board session on the topic, which this paper forms the basis of. I would like to thank everyone who has given up their time to speak to me.

A separate audit is being undertaken by 360 Assurance of how discharge from hospital is being managed and overseen by considering the strength of the controls in place. These two pieces of work should be complementary.

In September 2023 an intermediate care framework for rehabilitation, reablement and recovery following hospital discharge was published by NHS England. This framework consists of best practice guidance and a number of recommended actions that systems should consider. This framework is aimed at ICBs but is designed to support them in working in partnership. Several of the areas considered by my review can be linked into the priorities identified by this framework. So whilst the paper outlines questions for further exploration under various headings our Board discussion this morning will focus on those that best link to the framework priorities.

Conclusion

My overall impression is that we have a lot of committed and passionate individuals working hard to improve arrangements for both supporting patients on discharge but also in trying to prevent their admission in the first place. At the same time there is potential to improve the strategic focus and cost effectiveness of the current arrangements.

How are we performing as a system

The integrated assurance and performance report to the ICB in December does not show specific indicators regarding the number of delayed discharges, although snapshot figures show a fluctuating but gradually reducing trajectory across each pathway at each acute. This is slightly at odds with the comment on the U&EC performance section which states that the number of patients in an acute hospital bed who no longer meet the criteria to reside is not significantly different this year compared to the same period last year. It also indicated that the reasons for delayed discharges can be categorised as follows:

- 21% due to delays associated with hospital process issues
- 45% due to social care capacity
- 22% due to community care capacity and
- 12% due to other reasons

There are several other indicators within the integrated assurance and performance report that are affected at least in part by the effectiveness of discharge arrangements including:

- Proportion of people attending ED waiting longer than 4 hours to be treated, admitted or discharged – current performance shows an improving trajectory for both acutes towards the plan target for the end of Mar 24
- Number of people waiting longer than 65 weeks on a RTT pathway – current performance shows a declining trajectory for both acutes
- The number of patients discharged using the 4 pathways – current performance showing:
    - An above target performance for P0 - non complex discharges
    - A below target performance for P1 - home with support discharges
    - A fluctuating performance around the target for both P2 - intermediate care and P3 - 24 hour care placement discharges
- The community waiting list performance which is showing significant pressure on waiting lists for community support.

There are also a few indicators relating to service provision which should help alleviate pressure on acute services and beds including:

- Virtual wards (which can play a role in both aiding discharge or reducing the need for admission) – use of these is gradually increasing but is still showing significant excess capacity
- Urgent community response service referral response within 2 hours – performance levels of 90% are significantly exceeding the target and help reduce the need for admissions.

When we look at how we compare with other systems the consensus was that we are middle of the pack around discharge.

Discussions also raised concerns regarding the availability of useful intelligence around discharge. It was noted that currently there are several sources of intelligence including BI, NECs & existing performance data, but that there could be advantages from more sophisticated, focused intelligence around discharge for the system as a whole.

Question for further exploration

Would it be helpful to have a clearer indicator around the delayed discharge position and a target within the operational plan?

Do we have the analytical capacity and BI support to enable us to understand system flow to help forecast and plan through intelligent capacity and demand modelling?

Are we sighted on what individual organisations are doing to address the delays in discharge that are down to internal hospital processes?

Appendix 1

Does the ICB have a holistic approach to discharge arrangements?

Whilst the ICB does not have a comprehensive strategic approach to discharge arrangements it has documented the different pathways and identified measures of success although these are not yet being measured in practice. Internal Audit's comparative work has highlighted that Derbyshire is more advanced in this area than others and so we are in a good place to develop this further.

Within the ICB it is recognised that this is an area for development and the system is looking more strategically at arrangements. Since June 23 the Strategic Discharge Group has been revamped under the leadership of Dean Wallace with a specific focus initially on discharge strategy for pathway 1 patients. This is an appropriate priority given the majority of delays are for patients on this pathway.

However, the resources available to lead this work are limited with part time input from Dean and Jo Warburton and it is unclear where responsibility for this will lie within the new ICB structure.

Questions for further exploration

Given the critical importance of effective discharge arrangements should this work be prioritised and appropriately resourced?
What would this involve and how would we fund it?

Does the ICB & partners understand how much money is being spent on discharge arrangements and whether they are getting best value from this money?

No but the Strategic Discharge Group is working on identifying the total quantum (thought to be circa £80m) and to be better sighted on how this is being spent. It was the intention to complete this work for end of Dec 23 so that it could be used to influence decisions re spending priorities for 2024/25. This work has not yet been completed.

Until this is known it is difficult to go on the subsequent question as to whether best value is being obtained from how this money is spent.

It has proved difficult to fully quantify in the past because of the number of different funding sources which feed into discharge arrangements and the number of organisations involved.

A considerable proportion of the funding flows through the Better Care Funds for both Derby City and Derbyshire County. In the current financial year decisions on spending were made by local authorities and NHS bodies independently and were then merged. For 2023/24 it is proposed that collective decisions will be made on spending priorities.

There is a risk that this review of spending is likely to identify several legacy programmes which may will need reassessing to determine their cost effectiveness against the benefits being realised. Capacity to undertake such reviews and to co-ordinate planning and prioritising is limited which makes it hard to achieve change at pace.

Questions for further exploration
Once the total quantum of funding has been identified how can the system be assured that the money is being spent effectively?

- What indicators of success exist and what are they showing?
- What else needs to be developed to enable the effectiveness of schemes to be assessed and to hold organisations and/or partnerships to account for delivery?
- How do we manage change where it is identified that resources could be better targeted?

Should all funding for discharge be channelled through the BCF to take advantage of the pool arrangements to provide flexibility around how the money can be spent?

- What changes would be necessary to enable this to happen?

How do we help move the focus from commissioning individual programmes to commissioning an integrated place based service?

Multidisciplinary discharge teams

Multidisciplinary discharge team based in Derby Royal is the most developed in that:

- It has a physical space within hospital – mini ward
- Acute, community and social services discuss individual cases and match support and staff each day – formal integration of staff is being consulted on
- The voluntary sector is involved to provide non care support to help people on the P0 pathway return home
- Links into PCNs are well established – this facilitates the handing off of patients to GPs and also enables GPs to identify vulnerable individuals who could benefit from early input.

Chesterfield Royal has similar plans but these are currently significantly affected by the County Council's transformation programme which involves a shift from in-house care provision to private providers. In the interim the hospital has set up its own bespoke discharge arrangement with a private provider which costs more but is cheaper than keeping people in hospital. It is hoped that progression to a more integrated team with the local authority will be possible from 2025.

Questions for further exploration
Is there a more cost effective interim solution for the County area?

Strength based assessments (SBAs)

The P1 pathway strategy makes reference to the use of strength based assessments which are intended to be undertaken by ward staff at the point of admission to determine 'what matters to me?', what citizens are able to manage themselves (or with existing carer support), and what support they require with tasks of daily living. This review should form the basis of the care plan for the citizen to focus on promoting independence for return home and should identify any complex issues, which may be a barrier to discharge, so that relevant agencies can be contacted to plan for discharge.

To date these assessments have only been introduced on a very small scale (one ward at UHDB). To scale up requires system wide commitment as to work effectively it requires input and leadership from not only the acute hospitals but also community health and local authority services.

Questions for further exploration
Do we agree that strength based assessments are a valuable tool to aid discharge?
If so, what can we do to influence engagement and action around further roll out?

Criteria based discharge

The adoption of criteria based discharge would enable non medical staff to identify patients ready for discharge and initiate discharge arrangements prior to medical sign off. This could reduce the mean discharge time by 2-3 hours which cumulatively could improve bed availability. If this were to be combined with 7 day per week discharge the impact would be significant not only in terms of bed availability but also for the patient experience.

Questions for further exploration
Do we agree that criteria based discharge and 7 day per week discharge would significantly improve bed availability and patient experience?
If so, what can we do to influence engagement and leadership around implementation?

Mental Capacity Act assessments (MCAs)

The current practice within Derbyshire in relation to MCAs is that they need to be undertaken before a decision is made regarding discharge and this leads to significant delays in discharge equivalent to 9200 bed days a year even though only 1 in 5 patients discharged need an MCA.

I understand that in other systems the MCA is not seen as a requirement for someone who is going into a P1 pathway as they are considered to be having ongoing assessments in the community of which the MCA could be one and that it is in the best interests of the person to be moved into the P1 pathway than remain in an acute bed. They therefore treat moving someone onto the P1 pathway in the same way as they would in moving someone between wards as they will continue to be assessed.

Whilst it is important that we are compliant with the Mental Capacity Act requirements the practice in other areas suggests that there are alternative compliant approaches which could not only reduce discharge delays but improve outcomes for patients. A system approach could help allay any concerns around compliance with the legislative requirements.

Questions for further exploration
Is there benefit in the system exploring whether MCAs need to be undertaken prior to discharge into the P1 pathway?
If so, how can we take this forward?

Appendix 1

Virtual wards

Virtual wards are a national initiative that is intended to enable patients to be monitored remotely by clinicians in their own home rather than in hospital. There has been considerable investment in establishing capacity and this capacity can be used both to step down patients from hospital as part of their discharge arrangements or to prevent admissions. An additional advantage of out of hospital care is that it should prevent the decompensation of individuals that is seen when hospital length of stay exceeds 72 hours.

The initial focus has been on step down discharge and whilst capacity has increased in line with plans utilisation has lagged significantly with current utilisation only at 58%.

Discussions as part of my review identified that it is likely to take much longer than originally anticipated for virtual wards to start to play their full role. However, it is important that the system persists in encouraging their use. Useful work has already been initiated to tackle early issues such as the initial lack of buy in from acute clinicians who were concerned about managing the risk around remote patients. A clinical senate session in September 2023 was intended to address these concerns. A digital enabler is now being rolled out which should also give clinicians more confidence.

Questions for further exploration
Is there anything further to be done to increase utilisation of virtual wards?

Team Up – admission prevention

Admission prevention whilst not directly linked to the effectiveness of discharge arrangements is the other significant element affecting the flow of patients through the acute sector.

Team up is the Derby & Derbyshire initiative for the provision of community urgent response primarily for people who are housebound. It is intended to build on what is already in place but with a greater focus on one team working and on teams working proactively on their own initiative to solve problems as they arise rather than waiting for central guidance. There is a central navigation hub through DHU but this lacks local detail and so it is intended that this is supported by local navigation hubs that should link into the individual places.

As a consequence whilst Team up is running across Derby & Derbyshire the focus and staffing varies between place and areas are at different levels of maturity and performance, for example:

- Amber Valley is focusing on a GP led team supported by HCAs, specialist nurses (chest & respiratory and palliative care), a seconded community care worker from social care and pharmacy technician
- High Peak has both health and social care staff based at the community hospital and focuses on discharge as well as preventing admissions

Discussion suggests that the variation is not necessarily driven by patient lead but by the local leadership's interests.

Appendix 1

GP engagement is variable with some seeing it as offering a valuable service whilst others see it as a threat to the GP model.

It is recognised that there are several barriers to further integration and joint projects have been established to review and address issues around:

- Workforce (including T&Cs)
- Digital
- Legal/regulatory – regulation of multifunctional teams
- Governance and assurance

Other issues that need to be addressed cover:

- Governance & assurance – consideration is being given as to how areas of quality, clinical and financial assurance are addressed
- Performance – there has been a rapid improvement in urgent care response over last 2 years and feedback from patients is that they like it. However it is harder to demonstrate the impact on for example reduced admissions
- Other issues raised
    - Too much focus on discharge rather than preventing admission
    - Discharge planning starts too late and is sometimes over prescriptive about what is needed at home
    - Priority need – rapid & short term adult social care – particular issue in County

Questions for further exploration

How do we get assurance that Team Up is delivering the right balance between locally lead initiatives and wider system priorities which are focused on the particular needs of the local population?

What needs to be done to address the issues identified above and who is responsible for taking a lead?

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Integrated Care Board

Holistic Discharge

Sue Sunderland
NED

Multi-disciplinary discharge teams

Question for further exploration

- Is there a more cost effective interim solution for the County area?

Strength based assessments

Questions for further exploration

- Do we agree that strength based assessments are a valuable tool to aid discharge?
- If so, what can we do to influence engagement and action around further roll out?

Criteria based discharge

Questions for further exploration

- Do we agree that criteria based discharge and 7 day per week discharge would significantly improve bed availability and patient experience?
- If so, what can we do to influence engagement and leadership around implementation?

Mental Capacity Act assessments (MCAs)

Questions for further exploration

- Is there benefit in the system exploring whether MCAs need to be undertaken prior to discharge into the P1 pathway?
- If so, how can we take this forward?

Contact Details

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NHS
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Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: 155

Report Title	Audit and Governance Committee Assurance Report – February and March 2024							
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 (February 2024) Appendix 2 – Committee Assurance Report (March 2024)							
Assurance Report agreed by:	Sue Sunderland, Non-Executive Member (Audit & Governance)							
Which committee has the subject matter been through?	Audit and Governance Committee – 8th February and 14th March 2024							

Recommendations
The ICB Board is recommended to **NOTE** the Audit and Governance Committee's Assurance Report for February and March 2024.
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 8th February and 14th March 2024.
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**	There is a risk that the system does not create and enable a health and care 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?

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

Better health outcomes	☐	Improved patient access and experience	☒

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

Appendix 1

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Audit & Governance Committee on 8th February 2024

Matters of concern or key risks to escalate	Decisions made
There were no matters of concern or key risks to escalate to the ICB Board.	We approved the following procedures & plans: • Information Governance framework policy • NHS Network, internet & electronic mail acceptable use policy • Records management policy • Subject access request policy • Confidentiality and data protection policy • Information security and incident management policy • Data protection impact assessment policy • Data security and protection toolkit policy • IAO, IAA and information flow mapping policy • Safe haven policy These policies were previously part of the three main policies but have been separated out into key standalone subject areas to facilitate access by staff. Further refinements for the future will be to separate out any procedures from within these policies.
Major actions commissioned or work underway	**Positive assurances received**
1. The Committee noted the update regarding the detailed review 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. 2. We received an update on the organisational restructure arrangements and progress to date.	1. Received internal audit progress report including reference to two final reports: • Financial ledger & reporting – substantial assurance • Head of Internal Audit stage 2 memo We also noted the improvement in implementation of IA recommendations following the concerns raised at the last meeting. 2. Received the digital and cyber security update which provided assurance that primary care and corporate IT services are being managed effectively. A concern around the results of a phishing exercise within primary care is to be followed up with further training.

	3. Received the information governance update which provided assurance around the steps being taken to prepare for the 23/24 data security and protection toolkit submission in June. 4. Received the ICB Corporate Risk Register report and the risks responsible to the Audit and Governance Committee. 5. Received a deep dive into the corporate risks noting the action being taken to mitigate the risks and the future likelihood of risk reduction as a consequence. 6. Received assurance from reviewing the regular reports on: • Conflicts of interest • Freedom of information 7. Received the ICS Green sustainability report which provided positive assurance around the progress against priorities as well as outlining the further work needed in key areas. 8. Received the Month 9 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. 9. Received updates on plans for the preparation of the 2023/24 annual accounts including the position re accounting policies and the accruals report for month 9. All of which provided assurance that we are well prepared for the challenge of producing the financial statements to the required deadlines.
Comments on the effectiveness of the meeting	
We had a good discussion around the key items on the agenda with positive actions agreed as a consequence.	

NHS
Derby and Derbyshire
Integrated Care Board

Board Assurance Report

Audit & Governance Committee on 14th March 2024

Matters of concern or key risks to escalate	Decisions made
We noted that there remains a significant amount of internal audit work to be completed including 4 core reviews and that the Internal Auditor is currently unable to give an interim opinion. ICB staff must be encouraged to facilitate the work of Internal Auditor and respond in a timely manner to requests and draft reports.	The Committee: 1. approved the External Audit plan for the financial year 2023/24; 2. approved the Internal Audit plan for 2024/25 subject to clarification of the system wide audit proposals; 3. reviewed and agreed the Committee Terms of Reference for recommendation to the Board for approval; 4. approved the Fit and Proper Person Test framework; and 5. approved the EPRR policy and Business continuity management system.
Major actions commissioned or work underway	**Positive assurances received**
We received an update on progress relating to the delegation of responsibility for specialised services from NHSE to the ICB, noting that the following outstanding matters: 1. NHSE needs to provide more detail as to how they will work with ICBs and manage these services in partnership; 2. A full pre-delegation pack has not yet been shared and therefore ICBs need clarity from NHSE ahead of transition in relation to any risks that may be present or might emerge in the 59 services to be transferred, along with a process for resolution of such risks; 3. Greater clarity is required from NHSE on the role and expectations of the lead ICB.	The Committee received: 1. the internal audit progress report including reference to the interim Head of Internal Audit Opinion and an ongoing improvement in implementation rate of agreed actions which is currently at 91% at first follow up; 2. the counter fraud progress report noting that all bar one assessments against the functional standards are green; 3. a self assessment of the ICB assurance framework with regard to delegated primary care functions which identified only one area as not fully compliant; 4. the ICB Board Assurance Framework, Corporate Risk Register report and the risks responsible to the Audit and Governance Committee which confirmed that risks are being monitored and managed on an ongoing basis and that all committees are in the process of reviewing the underlying threats and associated actions; 5. a deep dive into the strategy and planning risks noting in particular the development session held by PHSCC earlier today which recognised that further a further development session is

	needed to review the detail behind the threats and actions and how new risks are identified; 6. the annual complaints report which noted an increase in the number of complaints received and set out the learning and action taken where complaints were partially or fully upheld; 7. assurance from reviewing the regular reports on: a. Mandatory training compliance; b. EPRR & business continuity; c. Losses & special payments and write offs; 8. an early draft of the Annual Governance Statement; 9. the Month 10 financial position review along with an update on the most current position. We noted the change to the projected year end position but also that this improvement was linked to non-recurrent items that do not address the underlying deficit which will continue into 24/25; 10. a report confirming compliance with the Mental Health Investment Standard in 22/23 and heard that the external audit was being finalised with no issues identified from the testing to date; and 11. the Equality Deliver System return which scored each area as developing – subject to a review of the supporting evidence outside of the meeting we hope that this return will be approved virtually by the committee.
Comments on the effectiveness of the meeting	
We had a good discussion around the key items on the agenda with positive actions agreed as a consequence.	

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: 156

Report Title	Finance, Estates and Digital Committee Assurance Report – January and February 2024							
Author	Jill Dentith, Non-Executive Member – Finance and Estates							
Sponsor (Executive Director)	Keith Griffiths, Chief Finance Officer							
Presenter	Jill Dentith, Non-Executive Member – Finance and Estates							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report (January 2024) Appendix 2 – Committee Assurance Report (February 2024)							
Assurance Report agreed by:	Jill Dentith, Non-Executive Member – Finance and Estates							
Which committee has the subject matter been through?	Finance, Estates and Digital Committee – January and February 2024							

Recommendations
The ICB Board are recommended to **NOTE** the Finance, Estates and Digital Committee Assurance Report for January and February 2024.
Items to escalate to the ICB Board
The Board should be aware of the system financial, estates and digital positions as detailed in the attached reports. The Chief Finance Officer will give an oral update to the Board on the current financial position for 2023/24 and the projection for 2024/25 as this is moving at pace.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Finance, Estates and Digital Committee on the 23rd January 2024 and 27th February 2024.
Background
The Finance, Estates and Digital Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The Finance, Estates and Digital Committee's Assurance Reports (Appendix 1 and Appendix 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 £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**	There is a risk that the system does not create and enable a health and care 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

[To be completed by the Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

None 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.			

Derby and Derbyshire Integrated Care Board

Board Assurance Report

System Finance, Estates and Digital Committee on 24th January 2024

Matters of concern or key risks to escalate	Decisions made
• **Deficit against plan** - As of 31st December 2023, the JUCD year to date position is a £39.7m deficit against a £8.7m planned deficit, which represents a £31m 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. • **Unmitigated likely case year end forecast** for 2023/24 is a deficit of £47.7m which reflects pressures that were not known at the time of planning and pressures on delivering the agreed plan, including planned efficiencies and workforce costs. • **The worst-case scenario** of a £78.9m deficit includes additional risks related to not delivering the agreed JUCD Operational Plan, such as, health care assistant re-banding (possibly in the region of £20m, with subsequent recurrent implications), pressures on capacity and activity and drugs costs. • **Risk relating to Health Care Assistant claim for re-banding** – Locally this is the largest single risk of circa £20m relating to a national Health Care Assistant claim for re-banding. Currently each organisation is treating the situation individually and no national guidance on an approach has been received, however some national funding may be available to mitigate this risk. • **Delivery of the system efficiency** is £1.8m ahead of plan year to date, £21.9m behind plan on recurrent and £23.7m over plan on non-recurrent efficiencies. Unless planned levels of recurrent efficiencies can be delivered, it will impact in future years. • **Capital** - inflation and bad weather have resulted in Derbyshire Healthcare being £7.5m short in relation to the cost of the eradication of dormitories. It will not be possible to complete the project without additional resources being made available, resulting in an inability to achieve 100% eradication of	• **Risk Register** - Committee approved the decrease in risk score for risk 22, relating to the possibility of unfunded pay awards as there may be some mitigation relating to national funding.

dormitories. Additional funding is being requested via the Regional Team. • **Workforce -** JUCD is reporting an overspend of £31.7m to date with a year-end forecast of £57.6m over plan.	
Major actions commissioned or work underway	**Positive assurances received**
• **Delivery Board position** – a deep dive would be scheduled for early 2024-25, with monthly reports following. (Action KG). • **Forward planner 2024-25** - this would be reviewed to ensure that the planner accurately reflects the roles and responsibilities of the Committee as detailed in the Terms of Reference and to include the Delivery Board position as detailed above. (Action KG / DD / JED). • **Analysis of Recurrent / Non-Recurrent efficiencies** – a review of the classification of efficiencies to ensure that the correct accounting principles were being used. (Action – KG and Directors of Finance).	• The report on the **Committee Development Session, (**12 January 2024) to review the roles and responsibilities of the Committee and its effectiveness, was positively received. • **Most likely outturn** of £47.3m deficit may improve, and mitigations have been identified which may reduce the deficit to £44.7m. However, this is before any additional costs relating to further industrial action are considered. System leaders have agreed that every opportunity to improve the out-turn position will be identified and considered. • **Cash -** CRH and UHDB's applications for cash has been supported. An application for £30m additional cash over the cash limit has been made by the ICB due to the amount of non-recurrent balance sheet and other flexibilities used to achieve the financial position. This is currently being considered. • **ERF -** Based on the national data covering the period April to September 2023, the system has achieved 100.4% performance against a target of 100.0%; this reflects the impact of the agreed baseline changes submitted by JUCD providers. This means that NHSE will no longer withhold any ERF allocation for that period and could mean that if that performance continues or further improves, NHSE could make additional funding available to pay for the additional activity; currently, it has been assessed as a circa £1.3m benefit. However, there is a risk that performance could worsen over the winter months and the £1.3m benefit may not materialise.
Comments on the effectiveness of the meeting	
There were several apologies, however the meeting was quorate. There was good debate and discussion with contributions from all parts of the System.	

Derby and Derbyshire Integrated Care Board

Board Assurance Report

System Finance, Estates and Digital Committee on 27th February 2024

Matters of concern or key risks to escalate	Decisions made
• **Deficit against plan** – As at 31st January 2024, the JUCD year to date position is a £44.4m deficit against a £5.9m planned deficit, a £38.5m overspend against the plan. The main factors driving this are excess inflation and a reduction in income. • **Unmitigated likely case year end forecast -** NHSE recognised a forecast deficit of £44.7m as a genuine likely position for JUCD and based on year-to-date performance, the system is confident this will be achieved prior to the impact of industrial action. Additional costs relating to Junior Doctors industrial action have further increased this deficit by £3.5m to give a total forecast position of £48.3m. This reflects pressures that were not known at the time of planning and pressures on delivering the agreed plan, including planned efficiencies and workforce costs. It has been agreed as a System that every opportunity to improve the out-turn position will be identified and considered. • **The worst-case scenario** – The worst-case scenario of a £72.5m deficit includes additional risks related to not delivering the agreed JUCD Operational Plan, such as, health care assistant re-banding at an estimated cost of £20m, pressures on capacity and activity and drugs costs. • **Delivery of the system efficiency -** The system efficiency delivery is £1.4m ahead of plan year to date, split into £23.5m behind plan on recurrent efficiencies and £24.9m over plan on non-recurrent efficiencies. Unless planned levels of recurrent efficiencies can be delivered, it will impact in future years. • **Capital funding for the eradication of dormitories** - Inflation and bad weather have resulted in Derbyshire Healthcare being £7.5m short in relation to the cost of the eradication of dormitories. It will not be possible to complete the project without	• **Board Assurance Framework (BAF) and Risk Register** – It was agreed that there would be no changes proposed to the risks on the BAF or the Risk Register which related to this Committee.

additional resources being made available which would mean we would be unable able to achieve 100% eradication of dormitories. NHSE have indicated some support may be available for this work but a final decision has not been reached, therefore a reprioritisation of the systems 2024-25 capital plan may be required. • **Workforce -** JUCD is reporting an overspend of £41.8m to date with a year-end forecast of £57.4m overspend. • **Financial Planning 2024-25** – The Committee were advised of the work in hand to produce a balanced financial plan for 2024-25. The first cut was showing a significant planned deficit and further work was taking place to resolve this position.	
Major actions commissioned or work underway	**Positive assurances received**
• **Productivity, planning and financial recovery** – Committee agreed there would be a detailed review of the system position in relation to productivity and planning which would be an agender item for the March 2024 meeting. (KG to lead the work with Director of Finance colleagues).	• **Delivery of the system efficiency** - The system efficiency delivery is £1.4m ahead of plan year to date, however, the split between recurrent and non-recurrent efficiencies will have a significant impact in future years if remedial actions are not taken. • **Capital** – There is system slippage in year relating to delays in several developments, but plans are in place to manage this across the year end by bringing forward unavoidable 2024-25 commitments into this year. • **Cash** – Our two acute trusts have been successful in their applications for cash support for the fourth quarter. NHSE and the ICB are working to manage a £30m additional cash requirement relating to non-recurrent balance sheet and other flexibilities used to achieve the financial position. • **Estates** – work continues developing the system Estates Strategy which is due to be delivered by 31 March 2024. • **Efficiency workshop** – is being held shortly to consider estates, digital and workforce in relation to the wider efficiency agenda. • **Electronic Patient Record (Acute hospitals) (EPR)** - The finance case was presented to extraordinary meetings of both our acute trusts Finance and Performance Committees and has

	progressed to the national review process. Circa 600 staff have attended 'drop-in' sessions of the proposed system. • **Cyber Security Strategy –** for JUCD was presented and approved by D3B in November 2023 and published on the JUCD website. • **Cyber Improvement Programme** - In addition to the 2023-24 funding allocation, JUCD has been allocated £167,391. The funding will be available from April 2024 and is contingent upon some conditions as set out in an accompanying Memorandum of Understanding.
Comments on the effectiveness of the meeting	
There were helpful presentations and useful confirm and challenge discussions in relation to the current position relating to finance, estates, digital, workforce and efficiencies. There was also a detailed discussion about the first cut of the financial projections for 2024-25 noting the pressures and challenges.	

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: 157

Report Title	Derbyshire Public Partnership Committee Assurance Report – February 2024							
Author	Sean Thornton, Deputy Director Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Richard Wright, Acting ICB Chair and Chair of Public Partnership Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report (February 2024)							
Assurance Report agreed by:	Richard Wright, Acting ICB Chair and Chair of Public Partnership Committee							
Which committee has the subject matter been through?	Public Partnership Committee, 27th February 2024							

Recommendations
The ICB Board are recommended to **NOTE** the Public Partnership Committee Assurance Report.
Items to escalate to the ICB Board
No matters of concern or key risks to escalate.
Purpose
This report provides the ICB Board with highlights from the development meeting of the Public Partnership Committee on the 27th February 2023. The committee alternates its monthly meetings between business, through which project and programme schemes are reviewed for assurance, and development, where the committee discusses structural and process issues in greater depth to support committee establishment and role; the February meeting was a business meeting and this cycle will now be amended to reduce the frequency of development sessions. This report provides a summary of the items transacted for assurance.
Background
The Public Partnership Committee ensures that the ICB effectively delivers the statutory functions of the ICB in relation to patient and public involvement. The committee also seeks, through its terms of reference, to drive citizen engagement in all aspects of the ICB's work to ensure that local people are central to planning and decision-making processes.

Report Summary

The Derbyshire Public Partnership Committee Assurance Report (Appendix 1) highlights to the ICB Board any:

- matters of concern or key risks to escalate;
- decisions made;
- major actions commissioned or work underway;
- positive assurances received; and
- comments on the effectiveness of the meeting.

Identification of Key Risks

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

Has this report considered the financial impact on the ICB or wider Integrated Care System?

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None raised as a result of the items reviewed at these meetings.

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

Appendix 1

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Public Partnership Committee on 27th February 2024

Matters of concern or key risks to escalate	Decisions made
No matters of concern or risks to escalate.	<u>Board Assurance Framework (BAF)</u> The Committee reviewed the current risk rating applied to the BAF Strategic Risk 3 on public engagement with the design and development of services. Following discussion, and on the basis that the organisation and system continues to deploy a range of new and evolving systems and processes to seek to engage the public, the risk score was reduced from 4x4=16 to a 3x4=12. <u>Corporate Risks</u> The ratings for the Committee's corporate risks relating to communications and engagement team capacity and stakeholder engagement through a period of change were maintained at a 3x3=9 and 3x4=12 respectively. It was noted that the team's capacity would begin to stabilise following the outcome of the ICB's staff restructure. The Committee will continue to monitor these risks into 2024/25, and agreed to add a further risk to the corporate register. This relates to the introduction of the new provider selection regime, and the risk that existing processes to connect PPI governance into change programmes may weaken, resulting in services not meeting needs of patients, reduced PPI compliance, risk of legal challenge and damage to NHS and ICB reputation. This risk was given an initial rating of 3x4=12, but with mitigations in development could quickly reduce to a lower rating. <u>Primary Care Involvement Scope</u> PPC has reviewed its scope for assuring engagement in service changes led by provider organisations. It has been established that PPC has an assurance role in some but not all elements of primary care service change involvement. Contractual changes that are overseen by ICB Commissioners and are governed by the primary care subgroup, such as practice boundary changes and branch closures, new housing estates or change of management would be required to complete a PPI form to assess the level of involvement required.

	It is established that PPC does not have an assurance role in changes that GPs make to the services they provide when they are delivering their GP contract. This might include changes to the way patients are triaged. The ICB will continue to promote good practice in these areas and share guidance. Changes and reconfigurations that are taking place within the Primary Care Networks (PCNs) are covered by contractual requirements for PCNs which ensure they are adequately involving patients and members of the public in their service changes. This activity therefore is in the scope for PPC assurance. <u>Equality & Diversity System – Domain 1</u> PPC noted by the process planned to assess system progress within the Equality Delivery System (EDS). EDS is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. PPC heard of the collaborative approach to scoring a range of schemes seeking to evidence good practice, including those linked to CORE20PLUS5 priority areas identified by providers. These include weight management inequalities, early diagnosis of bowel cancer, perinatal services and tobacco dependency. Hypertension was the system-wide priority identified. The outcomes of the work and review were required to be published by 29 February. <u>Meeting Frequency</u> PPC would meet bi-monthly from April 2024 to enable progress with key schemes, with at least two develop sessions each year.
Major actions commissioned or work underway	**Positive assurances received**
• Board Assurance Framework action plan – ongoing delivery of mitigating actions • East Midlands Fertility Policy Review • Recruitment to committee lay member vacancies • Review of approach to committee/sub-group diversity. • Establishment of Lay Reference Group.	<u>Patient and Public Involvement Log</u> This log records the outcomes of all assessments of legal duty triggers where service changes are identified. The log is presented to PPC at each meeting, with the open opportunity for members to request deep dives on any schemes listed.

• Ongoing development of engagement frameworks
  ○ Insight Framework
  ○ Governance Framework
  ○ Evaluation Framework
  ○ Co-production Framework
  ○ Engagement Framework	

Comments on the effectiveness of the meeting
The committee reviewed a series of assurance questions and agreed that the meeting had been effective.

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NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: Item 158

Report Title	Population Health and Strategic Commissioning Committee Assurance Report – January and March 2024							
Author	Richard Wright, Acting ICB Chair and Chair of Population Health and Strategic Commissioning Committee							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Presenter	Richard Wright, Acting ICB Chair and Chair of Population Health and Strategic Commissioning Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☒
Appendices	Appendix 1 – Committee Assurance Report (January 2024) Appendix 2 – Committee Assurance Report (March 2024)							
Assurance Report agreed by:	Richard Wright, Acting ICB Chair and Chair of Population Health and Strategic Commissioning Committee							
Which committee has the subject matter been through?	Population Health and Strategic Commissioning Committee – 11th January and 14th March 2024							

Recommendations
The ICB Board is recommended to **NOTE** the Population Health and Strategic Commissioning Committee's: Assurance Report for January and March 2024
Items to escalate to the ICB Board
As detailed within the report.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Population Health and Strategic Commissioning Committee on the 11th January and 14th March 2024.
Background
The Population Health and Strategic Commissioning Committee ensures that the ICB effectively delivers the statutory functions of the ICB. It is a requirement for Committees of the ICB to produce an assurance report as set out in the Committee's Terms of Reference.

Report Summary

The Population Health and Strategic Commissioning Committee Assurance Report (Appendix 1) highlights to the ICB Board any:

- matters of concern or key risks to escalate;
- decisions made;
- major actions commissioned or work underway;
- positive assurances received; and
- comments on the effectiveness of the meeting.

Identification of Key Risks

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

Has this report considered the financial impact on the ICB or wider Integrated Care System?

[To be complete by the Finance Team ONLY]

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 raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Appendix 1

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Population Health & Strategic Commissioning Committee on 11th January 2024

Matters of concern or key risks to escalate	Decisions made
None to report.	All decisions were confidential.
Major actions commissioned or work underway	**Positive assurances received**
None to report.	**Risk Register** Received and discussed the risks responsible to the Committee. **Board Assurance Framework (BAF)** Noted the BAF risks and risk scores and the changes relating to Strategic Risk 9. The following items were received for information: • CPAG updates • Derbyshire Prescribing Group report/minutes • JAPC Bulletin, Aug & Sept • CPLG minutes Sept 2023
Comments on the effectiveness of the meeting	
The meeting was effective, with sufficient opportunity for discussion and the papers presented were appropriate.	

Appendix 2

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Population Health & Strategic Commissioning Committee on 14th March 2024

Matters of concern or key risks to escalate	Decisions made
None to report.	All decisions were confidential.
Major actions commissioned or work underway	**Positive assurances received**
Committee Effectiveness Review including TOR review and forward plan review.	**Risk Register** Received and discussed the risks responsible to the Committee. Approved closure of risk 18 relating to patients accessing their health records. Did not approved three new confidential risks/ Requested a new confidential risk be developed. **Board Assurance Framework (BAF)** Discussed the Board Assurance Framework Strategic Risks 7, 8 and 9 for quarter 4 to date. Reviewed the risk score for each Strategic Risk 7, 8 and 9 for quarter 4 to date. **The following items were received for information:** • Derbyshire Prescribing Group report/minutes • JAPC Bulletin • CPLG minutes **Other items:** The Committee DISCUSSED and APPROVED two confidential items.
Comments on the effectiveness of the meeting	
The meeting was also a development session to review the effectiveness of the committee. A committee effectiveness report will be produced following this meeting.	

NHS DERBY AND DERBYSHIRE ICB BOARD

PUBLIC SESSION

21st March 2024

Item: 159

Report Title	Quality and Performance Committee Assurance Report – December 2023 and January 2024							
Author	Jo Hunter, Director of Quality							
Sponsor (Executive Director)	Dean Howells, Chief Nurse 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 (December 2023) Appendix 2 – Committee Assurance Report (January 2024)							
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 – 21/12/24 and 25/01/24							

Recommendations
The ICB Board are recommended to **NOTE** the Quality and Performance Committee Assurance Report for December 2023 and January 2024.
Purpose
This report provides the Board with a brief summary of the items transacted at the Quality and Performance Committee on 21/12/24 and 25/01/24. As reported in previous reports 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.
Background
This report provides the Board with a brief summary of the items transacted at the meeting of the Quality and Performance Committee on 21/12/24 and 25/01/24.
Report Summary
The System Quality and Performance Committee Assurance Report (Appendices) 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**	There is a risk that the system does not create and enable a health and care 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.	☐

ICB Risk Register risks 01, 03, 09, 19, 20.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

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

Derby and Derbyshire Integrated Care Board

ICB Board Assurance Report

ICB Quality and Performance Committee on 21st December 2023

Matters of concern or key risks to escalate	Decisions made
• The ICB is currently not compliant with any statutory operational targets relating to the urgent care and planned care & cancer programme. The 2023/24 NHS Operational Plan developed by the Derby and Derbyshire System addresses these issues of underperformance. • CQC rating progress update – UBDB Maternity services: Stephen Posey, CEO of UHDB is attending the ICB Board meeting on 18th January 2024 to close to circle on the flow through all of the governance structures in relation to the CQC rating and report.	The following items were approved by the Group: • Discharge and Flow Deep Dive: The Committee agreed that the discharge and flow work should be driven through System Quality Group in terms of progress and improvements. This will be fed back into Quality and Performance Committee and a report submitted at a suitable time after Q4. • Integrated Performance Report: The Committee agreed that a better understanding on the UTCs was required and asked for a report, detailing the effectiveness and efficiency of the UTCs as well as a forward look to come to be presented to the meeting in April 2024. • Deep Dives: It was proposed that to prevent duplication of effort the deep dives will be presented first at Q&P Committee, and should there be additional operational work or wider system work required then it will be referred to System Quality Group. The Committee agreed with the proposal which will commence in February 2024.
Major actions commissioned or work underway	**Positive assurances received**
The following pieces of work will be regularly presented to the Committee: • Deep Dives as per the Committee forward plan.	The following papers were presented for assurance: • Deep Dive into Discharge and Flow • Integrated Performance Report • Board Assurance Framework • System Quality Group Assurance Report
Comments on the effectiveness of the meeting	
Those present agreed that the meeting had been effective, with sufficient opportunity for discussion and that the papers presented were appropriate.	

Derby and Derbyshire Integrated Care Board

ICB Board Assurance Report

ICB Quality and Performance Committee on 25th January 2024

Matters of concern or key risks to escalate	Decisions made
• The ICB is currently not compliant with any statutory operational targets relating to the urgent care and planned care & cancer programme. The 2023/24 NHS Operational Plan developed by the Derby and Derbyshire System addresses these issues of underperformance. • Integrated Performance Report: The fragility of stroke services across JUCD was noted recognising that these services are increasingly fragile both regionally and nationally. Stroke services in large parts of the country is fragile and it is important that is recognised as offers of support from other areas is limited.	The Board Assurance Framework for Quarter 3 was approved. The Committee was asked to consider the risk scores given the pressures the system has experienced. • Strategic Risk 1 - There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to delivery consistently safe services with appropriate levels of care. Current score is 16. • Strategic Risk 2 - There is a risk that short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy. Current score is 16. Committee members discussed and supported the current scores. They felt the scores were rated correctly.
Major actions commissioned or work underway	**Positive assurances received**
The following pieces of work will be regularly presented to the Committee: • Deep Dives as per the Committee forward plan.	The following papers were presented for assurance: • Deep Dive – Safeguarding Adults and Safeguarding Children • Integrated Performance Report • CQC rating progress update – UBDB Maternity services • Serious Violence Strategy • NHS Oversight Framework (NOF) Segmentation – Q3 23/24 • Schedule of Deep Dives and update on process • System Quality Group Assurance Report
Comments on the effectiveness of the meeting	
Those present agreed that the meeting had been effective, with sufficient opportunity for discussion and that the papers presented were appropriate.	

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: 160

Report Title	People and Culture Committee Assurance Report – February 2024							
Author	Lucinda Frearson, Executive Assistant							
Sponsor (Executive Director)	Linda Garnett, Interim ICB Chief People Officer							
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 – 22 February 2024							

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 22 February 2024.
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**	There is a risk that the system does not create and enable a health and care 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 People and Culture Committee will be linked to the ICB's Board Assurance Framework and Risk Register.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

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 raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

Better health outcomes	☒	Improved patient access and experience	☒

A representative and supported workforce	☒	Inclusive leadership	☒

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

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

Details/Findings
Not applicable to this report.

Appendix 1

NHS
Derby and Derbyshire
Integrated Care Board

Board Assurance Report

People and Culture Committee on 22nd February 2024

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	Terms of Reference were accepted and agreed by the Committee with an amendment to the attendance percentage due to frequency of the meetings.
Major actions commissioned or work underway	**Positive assurances received**
A new group has been established following the standing down of the Workforce Advisory Group (WAG) which had been replaced by the Academy. The Health & Care Workforce Partnership Group (HCWPG) was established as there was felt to be a gap in terms of the work alongside the Local Authority and other external partners. The Committee's role in the 24/25 Workforce Plan with a real challenge this year thinking about what can be done differently and what was driving spend. The M9 Workforce position was presented to members. Freedom To Speak Up (FTSU) Assurance, the paper was to provide assurance that partner organisations have appropriate arrangements in place to implement the recommendations from the Lucy Letby letter received from the Secretary of State.	• Members noted the TORs for the HCWPG meeting suggesting there be at least 50% of the membership and one officer should be in attendance at the meeting so that administration was complete with a feedback loop. • Everyone was involved in the discussion which provided assurance that people were truly sighted on the challenges flagged along with a commitment from organisations to work together and make a difference by focusing on the areas we can change and continuing to work on those changes. • The forecast showed we will end 380WTE above the revised forecast outturn plan position at M12. All organisations have put measures in place to limit the substantive workforce growth and reduce agency usage for the remainder of this year. • There was limited assurance on this month's position, but some comfort was taken from the number of actions in place and as we grow as a system. • It was questioned how to support organisations in the primary care arrangements, as there was funding for a post at the moment that was non recurrent, the risk had been included on the Primary Care Delivery Board risk register. It was noted that Primary Care had been given funding through the People Promise Exemplar Programme so there was possibility there.
Comments on the effectiveness of the meeting	
The meeting was well attended and generated a lot of discussion covering several topics.	

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st March 2024

Item: 161

Report Title	Fit and Proper Person Test Framework							
Author	Fran Palmer, Corporate Governance Manager							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1 – Fit and Proper Person Test Framework							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Audit & Governance Committee, 14th March 2024							

Recommendations
The ICB Board are recommended to **NOTE** the Fit and Proper Person Test Framework.
Purpose
The purpose of this paper is to make ICB Board members aware of the ICB's implementation of the Fit and Proper Personal Test Framework.
Background
On the 10th August 2023, the Audit and Governance Committee received a paper which provided an overview of the new Fit and Proper Person Test Framework guidance, which was published by NHS England on the 2nd August 2023. In response to this the ICB has developed a framework to assess the appropriateness of an individual to discharge their duties effectively in their capacity as a board member. The purpose is to strengthen/reinforce individual accountability and transparency for ICB Board members, thereby enhancing the quality of leadership within the NHS. The framework was approved by the Audit and Governance Committee on the 14th March 2024.
Report Summary
The framework aims to help ICB Board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit members will be prevented from moving between NHS organisations. The framework applies to ICB Board members who are ICB Executive Directors and Non-Executive Members.

The framework should be seen as a core element of a broader programme of board development, effective appraisals and values-based (as well as competency-based) appointments – all of which are part of the good practice required to build a 'healthy' board.

Ultimate accountability for adhering to this framework will reside with the ICB Chair, who will on an annual basis ensure a Fit and Proper Persons Test Assessment is completed for applicable ICB Board members. The process will also be followed throughout the recruitment process and upon appointment of new ICB Board members. Alongside this, it is expected that ICB Board members will complete a self-attestation, which forms part of the assessment.

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**	There is a risk that the system does not create and enable a health and care 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 nor 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

[To be completed by the Finance Team ONLY]

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 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?
Not applicable.

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

Details/Findings
Not applicable.

NHS Derby and Derbyshire Integrated Care Board

Fit and Proper Person Test Framework

KEY POLICY MESSAGES	
1.	To assess the appropriateness of an ICB Board Member in discharging their duties effectively.
2.	Aims to help ICB Board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit members will be prevented from moving between NHS organisations.
3.	This document should be read alongside NHS England's Fit and Proper Person Test Framework for Board Members.

VERSION CONTROL

Title:	NHS Derby and Derbyshire Integrated Care Board Fit and Proper Person Test Framework
Supersedes:	Not applicable
Description of Amendment(s):	Versions 0.1 and 0.2 – initial draft Version 0.3 – amendments made to paragraph 6.6 following feedback from Audit & Governance Committee
Financial Implications:	N/A
Policy Area:	Human Resources/Corporate
Version No:	Version 0.3
Author:	Corporate Governance Manager
Approved by:	Audit & Governance Committee, 14th March 2024
Effective Date:	March 2024
Review Date:	February 2026
List of Referenced Policies:	Disclosure and Barring Policy Fraud, Bribery and Corruption Policy Learning and Development Policy Recruitment and Selection Policy Subject Access Request Policy
Key Words section (metadata for search facility online):	Fit and Proper Person Test
Reference Number:	HR37
Target Audience:	This procedure applies to all Non-Executive ICB Board Members, and ICB Executives. Compliance with this procedure is a formal contractual requirement and failure to comply, including any arrangements which are put in place under it, will be investigated and may lead to disciplinary action being taken.

CONTENTS

1. INTRODUCTION

1.1 NHS Derby and Derbyshire Integrated Care Board (the "ICB") is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and are NHS bodies for the purposes of the 2006 Act. The main powers and duties of the ICB are to commission certain health services as set out in sections 3 and 3A of the 2006 Act.

1.2 In 2014, the government introduced a 'fit and proper person' regulation (the "regulation") via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which recognised that individuals who have authority in NHS organisations that deliver care are responsible for the overall quality and safety of that care.

1.3 The regulation sets out the requirement for a Fit and Proper Person Test (FPPT), which establishes a process to ensure all NHS Board members are suitable and fit to undertake the responsibilities of their role, and the Care Quality Commission (CQC) holds NHS organisations to account in relation to the regulation.

1.4 In 2019, the Kark Review was commissioned to review the scope, operation and purpose of the FPPT and the review highlighted improvement areas to strengthen the existing regime. One of the recommendations was to extend the scope of the FPPT to certain arm-length bodies.

1.5 In response to the recommendations and effective from the 30th September 2023, NHS England developed a Fit and Proper Person Test Framework. It also took into account the requirements of the Care Quality Commission (CQC) in relation to Board members being fit and proper for their roles.

2. PURPOSE

2.1 This document supports the ICB in the implementation of the recommendations from the Kark Review, and promotes the effectiveness of the underlying legal requirements by establishing a Fit and Proper Person Test Framework.

2.2 The purpose of having this framework in place is to strengthen and reinforce individual accountability and transparency for ICB Board members, thereby enhancing the quality of leadership within the NHS. It should be seen as a core element of a broader programme of board development, effective appraisals and values-based (as well as competency-based) appointments – all of which are part of the good practice required to build a 'healthy' board.

2.3 This framework will also help ICB Board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit members will be prevented from moving between NHS organisations. Ensuring that ICB Board members are demonstrating the right behaviours will help the NHS drive its cultural initiatives to foster a culture of compassion, respect and inclusion, and a feeling of belonging; as well as setting the tone at the top to encourage a listening and speaking up culture.

3. DEFINITIONS

"ESR"

refers to the NHS Electronic Staff Record, which is used by the ICB to store an employee's employment record electronically;

"Fit and Proper Person"

means a person who is suitable and fit to undertake the responsibilities of their role.

4. APPLICABILITY

4.1 The framework applies to ICB Board members, whereby the term 'Board member' is used to refer to:

4.1.1 both ICB Executive Directors and Non-Executive Members (NEMs), irrespective of voting rights; and

4.1.2 interim (all contractual forms) as well as permanent appointments.

4.2 Those individuals who by virtue of their profession are members of other professional registers, such as the General Medical Council (GMC) or Nursing and Midwifery Council (NMC), should still be assessed against this Framework if they are an ICB Board member.

4.3 The ICB Chair will need to consider FPPT assessment on a member-by-member basis and take into account assurance received from other recruiting/appointing organisations, for example, in the case of partner members. Ultimate accountability for adhering to this framework will reside with the ICB Chair.

5. PERSONAL DATA

5.1 Personal data relating to the FPPT assessment will be retained in local record systems and specific data fields in the NHS Electronic Staff Record (ESR). The information contained in these records will not routinely be accessible beyond an individual's own organisation. There will be no substantive change to the data controller arrangements from those already in place for ESR.

5.2 The aim of maintaining a record of FPPT outcomes in ESR is to significantly improve the management of the NHS, and ultimately the experience and outcomes for patients, and is therefore in the public interest and done as part of the exercise of the functions of the ICB.

5.3 In establishing this framework, NHS England has determined that:

5.3.1 it will not have day-to-day access to the system or its content and recognises that it may be considered a (joint) controller of the ESR fields because as the

commissioner of the ESR module and author of the Framework, it has a role in determining the nature and purposes of processing; and

5.3.2 the most relevant lawful basis for processing the FPPT data contained in ESR is set out in Article 6(1)(e) UK GDPR. This is on the basis that the processing of personal data is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller (that is, the employer, or indeed NHS England in connection with any role it fulfils as a joint controller).

5.4 When uploading the content (and determining what is said about each ICB Board member), both the ICB and NHS Business Services Authority (as the main commissioner of ESR), will also each be a data controller.

5.5 As special category data would be processed as part of the maintenance of the ESR FPPT data fields, controllers will also rely on one of the lawful bases for processing set out in Article 9 UK GDPR: Articles 9(2)(b) – employment; 9(2)(g) – statutory/public functions; and 9(2)(h) (read with Schedule 1, paragraph 2 of the Data Protection Act 2018). This covers processing that is 'necessary for the management of the health service.'

5.6 The ICB recognises the requirements of Article 5(1) UK GDPR, and that personal data should be processed lawfully, fairly and transparently. In line with all other ESR data fields, fair processing information will be available to the users of the ESR system. Current ESR fair processing information can be found in the NHS Electronic Staff Record (ESR) privacy notice. The Framework and related guidance documents also help discharge transparency-related obligations.

5.7 Information that is the personal data of the applicant is exempt from the Freedom of Information Act under section 40(1) and any request should be processed under section 7 of the DPA. Regulation 5(3) of the Environmental Information Regulations 2004 is the equivalent provision and has the same effect.

5.8 Arrangements for dispute resolution or request for review of content of data (in ESR and local records), or relating to the FPPT assessment outcome, are set out in the guidance document for chairs.

6. FIT AND PROPER PERSON TEST

6.1 Assessment

The ICB should consistently demonstrate on an annual basis that a formal assessment of fitness and properness for each ICB Board member has been undertaken. in the following circumstances:

6.1.1 new appointments in ICB Board member roles, whether permanent or temporary, where greater than six weeks, including:

(a) new appointments that have been promoted;

(b) temporary appointments (including secondments) involving acting up into an ICB Board member role on a non-permanent basis;

(c) existing board members at one NHS organisation who move to another NHS organisation in the role of a board member; or

(d) individuals who join the ICB in the role of an ICB Board member for the first time from an organisation that is outside the NHS[1];

6.1.2 when an individual ICB Board member changes role within their current NHS organisation (for instance, if an existing ICB Board member moves into a new ICB Board member role that requires a different skillset; and

6.1.3 within a 12-month period of the date of the previous FPPT to review for any changes in the previous 12 months[2].

6.2 Self-Attestation

Every ICB Board member will need to complete an annual self-attestation (see Appendix 2), to confirm that they are in adherence with the FPPT requirements. Self-attestations are a necessary step that forms a part of the full FPPT assessment.

6.3 New Appointments

6.3.1 The ICB should demonstrate that appointments of new ICB Board members are made through a robust and thorough appointment process. As such, no new appointments should be made to the post of an ICB Board member unless the appointee concerned can demonstrate they have met the FPPT requirements as detailed in paragraph 6.7 of this document.

6.3.2 As part of conducting the initial appointment process for an ICB Board member, an inter-authority transfer (IAT)[3] could be submitted to identify any of the applicant's previous or current NHS service/employment history. Alternatively, other arrangements could be made to collate the relevant information. This should also help identify any potential duplicate employment accounts for the appointee e.g. when someone has more than one NHS role on ESR.

6.3.3 For the initial appointment of ICB chairs and Non-Executive Members only, NHS England will obtain references and carry out initial social media checks. If satisfactory, NHS England will then send the appointment letter subject to the remaining elements of the fit and proper person assessment carried out by the ICB.

[1] For those detailed within paragraphs 6.1.1(a)–6.1.1(d) the full FPPT will also include an ICB Board member reference check.
[2] The ICB Board member reference check will not be needed in the circumstances referred to in paragraphs 6.1.1 and 6.1.3.
[3] An IAT is an electronic way of gathering information from an employer for an applicant's previous or current NHS service using the ESR system: How to complete an Inter Authority Transfer (IAT) check in NHS Jobs user guide (nhsbsa.nhs.uk)

6.4 **Additional Considerations**

There are additional considerations when applying the FPPT for joint appointments across NHS organisations, shared roles within the same NHS organisation and periods of temporary absence.

6.4.1 Joint appointments across different NHS organisations

(a) Additional considerations are needed where there are joint appointments to support closer working between the ICB and another NHS organisations in the health and care system. For instance, where joint appointments of an ICB Board member can help foster joint decision-making, enhance local leadership and improve the delivery of integrated care. Joint appointments may occur where:

(i) a combined role is created; and

(ii) an individual is needed to work across the ICB and a different NHS organisation in the same role.

(b) In the scenario of joint appointments, the full FPPT would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the Chair of the other contracting NHS organisation to ensure that the ICB Board member is fit and proper to perform both roles.

(c) The host/employing NHS organisation will then provide a 'letter of confirmation' (Appendix 3) to the other contracting NHS organisation to confirm that the ICB Board member in question has met the requirements of the FPPT.

(d) The chair of the other contracting NHS organisation has the responsibility to keep the host/employing NHS organisation abreast of changes and any matters that may impact the FPPT assessment of the ICB Board member. Where there is a joint appointment, the host/employing NHS organisation responsible for the FPPT should also lead on conducting the joint appraisal and ensure adequate input from the other contracting NHS organisation.

(e) Where the joint appointment results in a new board member (for the NHS organisation in question), it will constitute a new appointment and as such, the host/employing NHS organisation should provide a 'letter of confirmation' to the other NHS organisation.

(f) For the avoidance of doubt, where two or more organisations employ or appoint (in the case of a Chair or Non-Executive Member) an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the FPPT. If the FPPT assessment at one organisation finds an individual not to be 'fit and proper', the Chair should update their counterpart of any other NHS organisation(s) where the individual has a board-level role and explain the reason. To note, the issue at one organisation may be one of role-specific competence, which may not

necessarily mean the individual is not 'fit and proper' at the other organisation.

6.4.2 Shared roles within the ICB

Where two individuals share responsibility for the same ICB Board member role (e.g. a job share) within the ICB, both individuals should be assessed against the FPPT requirements in line with paragraphs 6.1 and 6.2.

6.4.3 Temporary absence

(a) For the purpose of the FPPT process, a temporary absence is defined as leave for a period of six consecutive weeks or less (e.g. sick leave, compassionate leave or parental leave) and where the NHS organisation is leaving the role open for the same ICB Board member. As such there is no requirement to approve another permanent individual for the role of ICB Board member.

(b) Where there is a temporary absence, it is expected that the Chief of Staff and Assistant Director of Human Resources and Organisational Development will liaise with the Chair and Chief Executive Officer to ensure temporary cover is provided; and to ensure that local internal systems are adequately updated to record the start and projected end date of the temporary absence.

(c) Where an individual is appointed as temporary/interim cover and is not already assessed as fit and proper, the ICB should ensure appropriate supervision by an existing ICB Board member.

(d) A full FPPT assessment should be undertaken for an individual in an interim cover role exceeding six weeks. Therefore, if the interim cover is expected to be in post for longer than six weeks, the ICB should look to commence the FPPT assessment as soon as possible. Where the period of temporary absence is extended beyond six weeks, the FPPT assessment should commence as soon as the ICB is aware of the extension. This FPPT assessment should be carried out in line with the requirements under paragraph 6.2.

6.5 Role of the ICB Chair in overseeing the FPPT

The ICB Chair is accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of the ICB is maintained to support an effective FPPT regime. As such, the ICB Chair's responsibilities are to ensure:

6.5.1 the ICB has proper systems and processes in place so it can make the robust assessments required by the FPPT;

6.5.2 the results of the full FPPT, including the annual self-attestations for each ICB Board member are retained by the ICB;

6.5.3 the FPPT data fields within ESR are accurately maintained in a timely manner;

6.5.4 the ICB Board member references/pre-employment checks (where relevant) and full FPPT (including the annual self-attestation) are complete and adequate for each ICB Board member;

6.5.5 an appropriate programme is in place to identify and monitor the training and development needs of ICB Board members;

6.5.6 on appointment of a new ICB Board member, the specific competence, skills and knowledge to carry out their activities has been considered, and how this fits with the overall ICB Board;

6.5.7 conclude whether the ICB Board member is fit and proper;

6.5.8 they complete an annual self-attestation themselves to ensure they are in continued adherence with the FPPT requirements; and

6.5.9 ensure that for any ICB Board member approved to commence work or continue in post despite there being concerns about a particular aspect of the FPPT, they document the reason(s) as to why there has been an issue about whether an ICB Board member might not be fit and proper and the measures taken to address this. A local record of this should be retained. A summary of this should also be included in the annual FPPT submission form (Appendix 4) to the relevant NHS England regional director.

6.6 Overseeing the role of the ICB Chair

6.6.1 The ICB Chair will be subject to the same FPPT requirement, as per paragraphs 6.1 and 6.2. In completing their own annual self-attestation, the ICB Chair will effectively be confirming that they have adequately addressed paragraphs 6.5.1–6.5.9.

6.6.2 Annually, the ICB's Vice-Chair will review and ensure that the ICB Chair is meeting the requirements of the FPPT. However, the accountability for ensuring that the ICB Chair meets the FPPT assessment criteria will reside with NHS England regional directors, as is also the case for the ICB Chair's annual appraisals.

6.6.3 If the ICB's Vice-Chair is ever unable to review the Chair's FPPT, then another NEM should be nominated to complete this.

6.6.4 Once the ICB has completed their annual FPPT assessment of the ICB Chair, they should sign this off within ESR. The annual FPPT submission, which summarises the results of the FPPT for all ICB Board members is then to be sent to the relevant NHS England regional director.

6.7 Core elements

6.7.1 The full FPPT assessment will constitute an assessment against each of the core elements detailed below and should be conducted in accordance with paragraph 6.1. ICB Board members should complete self-attestations to confirm they are fulfilling the core elements of the FPPT assessment.

6.7.2 NHS organisations should assess ICB Board members against the following three core elements[4] when considering whether they are a fit and proper person to perform a board member role. To encourage openness and transparency, these should not be considered as a strict checklist for compliance, but rather as points for a conversation between the ICB Chair (or Chief Executive Officer for Executive Director Board members) and a prospective ICB Board member during the appointment process. This will in turn emphasise the ongoing benefits of openness and transparency among members.

(a) Good Character

(i) When assessing whether a person is of good character, the ICB should follow robust processes to make sure that they gather appropriate information, and must have regard to the matters outlined in Part 1 and Part 2 of Schedule 4 of the regulation, namely:

- convictions of any offence in the UK;
- convictions of any offence abroad that constitutes an offence in the UK; and
- whether any regulator or professional body has made the decision to erase, remove or strike off the ICB Board member from its register, whether in the UK or abroad.

(ii) As such, the ICB should conduct:

- a search of the Companies House register to ensure that no ICB Board member is disqualified as a director;
- a search of the Charity Commission's register of removed trustees;
- a Disclosure and Barring Service (DBS) check in line with the ICB's Disclosure and Barring Policy; and
- a check with the relevant professional bodies, where appropriate.

(iii) It is expected that processes followed take account of a person's honesty, trustworthiness, reliability, integrity, openness (also referred to as transparency), respectfulness and ability to comply with the law. Furthermore, in considering that an ICB Board member is of 'good character,' the ICB should also consider the following in relation to the individual in question:

- compliance with the law and legal processes;
- employment tribunal judgements relevant to the ICB Board member's history;

[4] Note: the FPPT checks relating to these core elements will be in addition to standard employment checks, as per the ICB's Recruitment and Selection Policy and NHS Employers' pre-employment check standard. This can include CV checks, self-declarations, online searches, proof of qualifications, proof of identity, right to work, etc.

- settlement agreements relating to dismissal or departure from any healthcare-related service or NHS organisation for any reason other than redundancy;
- a person in whom the ICB, CQC, NHS England, people using services and the wider public can have confidence;
- adherence to the Nolan Principles of Standards in Public Life;
- the extent to which the ICB Board member has been open and honest with the ICB;
- whether the person has been the subject of any adverse finding or any settlement in civil proceedings, particularly in connection with investment or other financial business, misconduct, fraud or the formation or management of a body corporate;
- whether the person has been involved as a director, partner or concerned in management:
  - with a company, partnership or other organisation that has been refused registration, authorisation, membership or a licence to carry out a trade, business or profession;
  - of a business that has gone into insolvency, liquidation or administration while the person has been connected with that organisation or within one year of that connection;
  - of a company that has been investigated, disciplined, censured, suspended, or criticised by a regulatory or professional body, a court or tribunal, whether publicly or privately;
- any other information that may be relevant, such as an upheld/ongoing or discontinued (including where an ICB Board member has left the NHS organisation prior to an investigation being completed):
  - disciplinary finding;
  - grievance finding against the ICB Board member;
  - whistleblowing finding against the ICB Board member;
  - finding pursuant to any ICB policies or procedures concerning the ICB Board member behaviour.

(b) <u>Qualifications, competence, skills required and experience</u>

(i) The ICB needs to have appropriate processes for assessing and checking that the candidate holds the required qualifications and has the competence, skills and experience required. For instance, where possible, checking the websites of the professional bodies to confirm that where required the ICB Board member holds the relevant and stated qualification.

(ii) Where the ICB considers that an ICB Board member role requires specific qualifications they should make this clear and should only appoint those candidates who meet the required specification, including any requirements to be registered with a professional body.

(iii) As such, job descriptions and person specifications should be clear in detailing required skills and relevant qualifications and/or memberships. These should be reviewed to ensure that they are appropriate and tailored for each board role. In assessing competence, skills and experience for the purposes of the FPPT, the ICB should look to use the outcome of their appraisal processes for ICB Board members, which will be based on the NHS Leadership Competency Framework for board-level leaders. The Leadership Competency Framework covers the following six competence categories:

- setting strategy and delivering long term transformation;
- leading for equality;
- driving high quality, sustainable outcomes;
- providing robust governance and assurance;
- creating a compassionate and inclusive culture; and
- building trusted relationships with partners and communities.

(iv) In assessing whether an ICB Board member has the competence, skills and experience to be considered fit and proper, the FPPT assessment will:

- not just consider current abilities, but also have regard to the formal training and development the ICB Board member has undergone or is undergoing;
- take account of the ICB (its size and how it operates) and the activities the ICB Board member should perform; and
- consider whether the ICB Board member has adequate time to perform and meet the responsibilities associated with their role.

(v) Regarding formal training:

- the ICB should ensure any necessary training is undertaken by ICB Board members where gaps in competency have been identified. As such, a tailored learning development plan and training framework should support ICB Board members. Both the development plan and training should be updated and delivered respectively with an appropriate frequency; and
- training constitutes continued development for ICB Board members who are directly employed by the ICB. Those consistently failing to undergo required training in a timely manner should be deemed to have missed an important obligation, and appropriate action should be taken in line with the ICB's Learning and Development Policy. In turn, this may mean that an ICB Board member is not fit and proper.

(c) <u>Financial soundness</u>

The ICB must seek appropriate information to assure themselves that ICB Board members do not meet any of the elements of the unfit person test set out in Schedule 4 Part 1 of the regulation. Robust processes should be in

place to assess ICB Board members in relation to bankruptcy, sequestration, insolvency and arrangements with creditors. This, as a minimum, will include search of the insolvency and bankruptcy register and checks over county court judgement or high court judgement for debt.

6.7.3 Reasonable adjustments

(a) In assessing if an ICB Board member can properly perform tasks to the requisite level of competence and skill for the office or position for which they are appointed, consideration will be given to their physical and mental health in accordance with the demands of the role and good occupational health practice.

(b) All reasonable steps must be made to make adjustments for people to enable them to carry out their role. As a minimum, these must be in line with requirements to make reasonable adjustments for employees under the Equality Act 2010; to prevent discrimination as defined by the Act. Hence when appointing a person to a role, the ICB should have processes for considering their physical and mental health in line with the requirements of the role. As such, the ICB will undertake occupational health assessments (OHA) for potential new ICB Board member appointments, in circumstances where the individual in question has indicated a physical or mental health condition as part of pre-employment checks. The results of the OHA should be evaluated, and relevant reasonable adjustments should be made in line with the requirements under the Equality Act 2010, so an individual can carry out their role.

(c) While the OHA will not form part of the annual FPPT, it is an integral component of the recruitment process checks to ensure that the NHS organisation can demonstrate that they have taken account of and made any such reasonable adjustments for those in board member roles. This obligation is ongoing in relation to those with disabilities for the purposes of the Equality Act 2010.

(d) The statutory duty to make reasonable adjustments must be considered on an ongoing basis and applies where a disabled person is put at a substantial disadvantage.

6.8 **Breaches to the core elements**

6.8.1 Regulation 5 will be breached if:

(a) an ICB Board member is unfit on the grounds of character, such as:

(i) an undischarged conviction;

(ii) being erased, removed or struck-off a register of professionals maintained by a regulator of healthcare, social work professionals or other professional bodies across different industries;

(iii) being prohibited from holding a relevant office or position (see paragraph 6.7.2(a));

(b) an ICB Board member is also unfit on the grounds of character if they have been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity;

(c) an ICB Board member is unfit should they fail to meet the relevant qualifications or fail to have the relevant competence, skills and experience as deemed required for their role;

(d) an ICB Board member is unfit on grounds of financial soundness, such as a relevant undischarged bankruptcy or being placed under a debt relief order;

(e) the ICB does not have a proper process in place to make the robust assessments required by the Regulations;

(f) on receipt of information about an ICB Board member's fitness, a decision is reached on the ICB Board member that is not in the range of decisions a reasonable person would be expected to reach.

6.8.2 With regards to the above points, it is acknowledged that there could be circumstances where, for instance, ICB Board members are deemed competent but do not hold relevant qualifications. In such circumstances there should be a documented explanation, approved by the ICB Chair, as to why the individual in question is deemed fit to be appointed as an ICB Board member, or fit to continue in role if they are an existing ICB Board member. This should be recorded in the annual return to the NHS England regional director (Appendix 4 part 2).

6.8.3 Furthermore, there may be a limited number of exceptional cases where an ICB Board member is deemed unfit for a particular reason (other than qualifications) but the ICB appoints them or allows them to continue their current employment as an ICB Board member. In such circumstances there should be a documented explanation as to why the ICB Board member is unfit and the mitigations taken, which is approved by the ICB Chair. This should be submitted to the relevant NHS England regional director for review, either as part of the annual FPPT submission for the NHS organisation, or on an ad hoc basis as a case arises. The ICB shall determine breaches based on paragraphs 6.7.4(a)(i)-(iv), whereas any regulatory inspections, such as a CQC inspection will determine breaches of paragraphs 6.7.4(a)(v)-(vi).

6.9 ICB Board Member References

6.9.1 <u>Content of the references</u>

(a) The Leadership Competency Framework helps inform the 'fitness' assessment in FPPT. This is in line with the Kark Review's (2019) recommendations on professional standards. The Leadership Competency Framework references six competency domains (see paragraph 6.7.2(b)(iii)), which should be incorporated into all senior leader job descriptions and

recruitment processes. It will also form the core of ICB Board member appraisal frameworks, alongside the appraisal of delivery against personal and corporate objectives.

(b) The competency domains in the Leadership Competency Framework should be taken into account when an ICB Board member reference is written. It is recognised that no one will be able to demonstrate how they meet all the competencies in the framework. What is sought as part of the ICB Board member's reference is evidence of broad competence across each of the six competency domains, and to ensure there are no areas of significant lack of competence which may not be remedied through a development plan.

(c) ICB Board-level leaders will be asked to attest to whether they have the requisite experience and skills to fulfil minimum standards against the six competency domains. This attestation will be reviewed by the ICB Board member's line manager and overseen by the ICB Chair. The attestation record will be captured on ESR.

(d) The annual attestation by ICB Board members is expected to be undertaken at the same time as the annual appraisal process and assessment of competence against the six competency domains will also be used to guide the ICB Board member's development plan for the coming year. The line manager will also capture stakeholder feedback as part of the appraisal process and summarise competence against each of the six competency domains.

(e) The annual appraisals of the past three years will then be used to guide the ICB Board member's reference. The ICB is expected to request references, and store information relating to these references (see paragraph 6.10) so that it is available for future checks; and use it to support the full FPPT assessment on initial appointment.

(f) The ICB should maintain complete and accurate ICB Board member references at the point where the ICB Board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and ICB Board member references should be retained locally.

(g) References will apply as part of the FPPT assessment when there are new ICB Board member appointments, either internal to the ICB, or internal and external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

(i) new appointments that have been promoted within the ICB;

(ii) existing ICB Board members at one NHS organisation who move to another NHS organisation in the role of a board member;

(iii) individuals who join the ICB in the role of ICB Board member for the first time from an organisation that is outside of the NHS; and

(iv) individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

(h) It is important that ICB Board member references checks are carried out in accordance with the data protection principles, as set out within data protection law. In particular, the process should be undertaken fairly, and the information generated should be accurate and up to date.

(i) Requests for ICB Board member references should not ask for specific information on whether there is a settlement agreement/non-disclosure agreement in place. The ICB Board member reference request instead asks for any further information and concerns about an applicant's fitness and propriety, relevant to the FPPT to fulfil the role as a member, be it executive or non-executive.

(j) Information on settlement agreements should be retained locally (where applicable) and included in the overall consideration of the fit and proper status of the individual in question. If there is a historical settlement agreement/non-disclosure agreement already in place which includes a confidentiality clause, the ICB should seek permission from all parties prior to including any such information in an ICB Board member reference.

(k) The ICB should also consider inclusion of a term in any proposed settlement agreement to state that information about the settlement agreement can be included in ESR, and in doing so will not be a breach of confidence. The existence of a settlement agreement does not, in and of itself determine that a person is not fit or proper to be an ICB Board member. The reference is based on the standard NHS reference and includes additional requests for information as follows (relevant to the FPPT):

(i) information regarding any discontinued, outstanding, or upheld complaint(s) tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the organisation's policies and procedures;

(ii) confirmation of any discontinued, outstanding or upheld disciplinary actions under the ICB's disciplinary procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct; and

(iii) any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the FPPT to fulfil the role as a member, be it executive or non-executive.

(l) Discontinued investigations are included in the reference request to identify issues around serious misconduct and mismanagement and to deliberately separate them from issues around qualifications, competence, skills, and experience (which it is believed can be remedied) and health (which it is

believed can improve), unless such competence and/or health issues could potentially lead to an individual not meeting the requirements of the FPPT.

(m) Investigations (irrespective of reason for discontinuance) should be limited to those which are applicable and potentially relevant to the FPPT, and examples are as follows (this is not an exhaustive list and consideration will be needed on a case-by-case basis):

(i) relating to serious misconduct, behaviour and not being of good character (as described in the FPPT Framework);

(ii) reckless mismanagement which endangers patients;

(iii) deliberate or reckless behaviour (rather than inadvertent behaviour);

(iv) dishonesty;

(v) suppression of the ability of people to speak up about serious issues in the NHS, e.g. whether by allowing bullying or victimisation of those who speak up or blow the whistle, or any harassment of individuals; and

(vi) any behaviour contrary to the professional Duty of Candour which applies to health and care professionals e.g. falsification of records or relevant information.

The reason for discontinuing (including not commencing) an investigation should be recorded, including whether an investigation was not started or stopped because a compromise, confidentiality or settlement agreement was then put in place (recognising that such an agreement is not necessarily a conclusion that someone is not fit and proper for the purposes of the FPPT).

(n) It will be necessary as a matter of fairness for the employee to have had an opportunity to comment on information that is likely to be disclosed as part of any reference request i.e. as part of any disciplinary procedures/action.

(o) The ICB should also take any advice that they deem necessary in an individual case where they have assessed that the employee or prospective employer is likely to bring a claim.

6.9.2 Obtaining references

At least one reference should be obtained when the ICB is appointing an ICB Board member.

(a) For ICB Board members:

(i) a minimum of two references should be obtained (using the reference template at Appendix 1) where the individual is from outside the NHS, or from within the NHS but moving into the board role for the first time; and

(ii) these two references should come from different employers, where possible.

(b) For an individual who moves from one NHS board role to another NHS board role, across NHS organisations where possible one reference from a separate organisation in addition to the ICB Board member reference for the current board role will suffice. This is because their ICB Board member reference template should be completed in line with the requirements of the framework so that NHS organisations can maintain accurate references when an ICB Board member departs.

(c) For a person joining from another NHS organisation:

(i) the ICB should take reasonable steps to obtain the appropriate references from the person's current employer as well as previous employer(s) within the past six years; and

(ii) these references should establish the primary facts as per the ICB Board member reference template.

(d) Where an employee is entering the NHS for the first time or coming from a post which was not at board member-level the ICB should make every practical effort to obtain such a reference which fulfils the ICB Board member reference requirements.

(e) It is acknowledged that where the previous employer is not an NHS organisation, there may be greater difficulty in obtaining a standardised NHS board member reference. Nonetheless, for new appointments from outside of the NHS, the ICB should seek the necessary references to validate a period of six consecutive years of continuous employment (or provide an explanation for any gaps), or training immediately prior to the application being made. In such cases where references from previous employers are unattainable for the previous six years, additional character or personal references should be sought. Character and personal references should be sought from personal acquaintances who are not related to the applicant, and who do not hold any financial arrangements with that individual.

(f) References should never be used as the sole grounds for assessing an applicant's suitability for a post. Where negative issues are included in a reference, information should be carefully considered and weighed up against the wider range of evidence gathered as part of the recruitment process. The ICB should aim to investigate negative information by sensitively raising it with the individual concerned, giving them the opportunity to explain the situation in more detail and/or, where appropriate, give them a chance to outline any learning from past mistakes or experiences to obtain the necessary assurances about their suitability for a role. If a reference reveals something which is incompatible with the requirements of Regulation 5 of the Regulations, the individual should not be appointed to the role.

(g) The ICB should obtain references before the start of the ICB Board member's appointment. When requesting the reference it should be made clear that this is being requested in relation to a person being appointed to the role of ICB Board member, or for other purposes linked to their current employment.

(h) The obligation to obtain a reference for a potential candidate for employment/ appointment in the role of ICB Board member applies irrespective of how the previous employment ended, for instance, resignation, redundancy, dismissal or fixed term work or temporary work coming to an end.

(i) Where a potential candidate for employment/appointment in the role of ICB Board member has a gap between different employments, all reasonable efforts should be made to ensure that references covering those periods/gaps are obtained. References should be obtained in writing (either via hardcopy or email) and the ICB will need to satisfy themselves that both the referee and the organisation are bona fide.

(j) From time to time the information provided in a reference may contradict the information provided by ICB Board members. There may be a reasonable explanation for apparent discrepancies and the ICB should proceed sensitively to seek the necessary assurances directly with the ICB Board member.

(k) In exceptional circumstances where there is serious misdirection, employers may feel it appropriate to report their concerns to the NHS Counter Fraud Authority, in line with the ICB's Fraud, Bribery and Corruption Policy.

(l) Where an ICB is unable to fully evidence that the incoming ICB Board member is fit and proper because of gaps in their reference, they may continue to hire the individual but should clearly document within ESR the gaps in relation to the reference and the reasons/mitigations for being comfortable with employing/appointing them. In this scenario, the ICB should demonstrate that they have exercised all reasonable attempts to obtain the missing information.

6.9.3 Providing references

(a) The ICB should aim to provide a reference to another NHS organisation within a 14-day period, which starts from the date that the reference request was received. However, it should be acknowledged that there are occasions of exceptional circumstances, and references may take more than 14 days to provide.

(b) The references referred to above are for a request made in relation to the individual being appointed to the role of board member, or for other purposes linked to the ICB Board member's current employment. Where a current ICB Board member moves between different NHS organisations, a reference form following a standard format (Appendix 1) should be completed by the

ICB and signed off by the ICB Chair. The ICB should provide information in relation to that which occurred:

(i) in the six years before the request for a reference;

(ii) between the date of the request for the reference and the date the reference is given;

(iii) in the case of disciplinary action, serious misconduct and/or mismanagement at any time (where known).

(c) The ICB should also consider when providing the reference:

(i) that the process captures accurate, complete, open, honest and fair information about the ICB Board member concerned. As such, references should not conceal facts from the NHS organisation offering employment;

(ii) references should give established facts that are part of the history of the person. It is unfair to give partial facts if those result in the offer being withdrawn, for example where this causes the recipient NHS organisation to assume the information is missing because it is negative, so the offer is withdrawn. Views can be expressed but only after taking reasonable steps to verify factual accuracy and should be based on documented facts;

(iii) the reference should be fair, such that the employee concerned should have the right to note a challenge to the fairness of the mandatory reference and provide such explanation as they wish to in writing. This does not mean that they can comment on the reference itself; rather, that the ICB has provided the individual with a reasonable opportunity to respond to allegations or judgements upon which the reference is based. Hence an ICB Board member's opinions are not required to be included within the reference, but should be appropriately considered when drafting them. Where the NHS organisation providing the reference has not offered the employee the opportunity to previously (at the time the matter occurred) comment on the allegation, they ought to do so before including that allegation within the reference, rather than leaving the allegation out of the reference;

(iv) where the reference provides information about an applicant's health or disability this must be in line with the provisions outlined in the Equality Act 2010 and be relevant, necessary, and up to date, for the purposes of data protection law.

6.9.4 Revising references

(a) If the ICB provides a reference to another NHS organisation about an employee or former employee, and subsequently:

(i) becomes aware of matters or circumstances that would require them to draft the reference differently;

(ii) determines that there are matters arising relating to serious misconduct or mismanagement;

(iii) determines that there are matters arising which would require them to take disciplinary action; or

(iv) concluded there are matters arising that would deem the person not to be 'fit or proper' for the purposes of Regulation 5 of the Regulations,

the ICB should make reasonable attempts to identify if the person's[5] current employer is an NHS organisation and, if so, provide an updated reference/additional detail within a reasonable timeframe. Where the employee was an ICB Board member at the ICB or is a board member at the current NHS organisation, the updates should be reflected within their reference.

(b) Revised references should cover a six-year period from the date the initial reference was provided, or the date the person ceased employment with the ICB, whichever is later. The exception to this are matters that constitute serious misconduct or mismanagement: details of such events should be provided irrespective of time period.

6.9.5 ICB Board member reference template

(a) This framework, along with the ICB Board member reference template (Appendix 1), sets out the minimum requirements for a reference. The ICB can provide information in relation to additional matters if it deems it necessary to do so.

(b) If references are provided for the role of ICB Board member, or for other purposes linked to their current employment, the ICB should look to complete all sections of the template even where the NHS organisation requesting the reference does not specifically ask for it.

(c) The template should be completed, and retained locally in an accessible archive, for departing ICB Board members even where they have indicated they are moving onto a non-NHS role and/or performing a role that is not on the board, or where they have indicated they are to retire. Often in these circumstances the individual may go on to act in the capacity of a board member at a future date, even if it is just on a temporary basis.

[5] For the avoidance of doubt, this refers to Executive ICB Board members employed by the ICB and Non-Executive Board members who have been appointed.

6.10 Electronic Staff Record

6.10.1 NHS Business Services Authority (NHSBSA) hosts ESR on behalf of the NHS, as commissioned by the Department for Health and Social Care.

6.10.2 Within ESR, individual FPPT information for all ICB Board members will be used to support recruitment referencing and their ongoing development. The FPPT information within ESR is only accessible within the ICB Board member's own organisation and there is no public register.

6.10.3 It is reasonably expected that the following individuals have access to the FPPT fields in ESR:

(a) ICB Chair;

(b) Chief Executive Officer;

(c) Senior Independent Director;

(d) Deputy Chair;

(e) Chief of Staff;

(f) Assistant Director of Human Resources and Organisational Development.

6.10.4 Access will also be provided to relevant individuals within the CQC at a local level, where this information is necessary for their roles, noting the CQC's ability to require information to be provided to it under Regulation 5(5) of the Regulations.

6.10.5 The ESR FPPT data fields need to be maintained to ensure information about the serving ICB Board member is current. This will mean that ESR is specifically updated for:

(a) all ICB Board members;

(b) new ICB Board members upon appointment;

(c) whenever there has been a relevant change to one of the fields of FPPT information held in ESR (as per paragraph 6.10.8 below);

(d) updates for annual completion of the full FPPT; and

(e) annual completion of FPPT confirmed by the ICB Chair.

6.10.6 It will be the responsibility of the ICB Chair to ensure that ESR remains current and is updated for relevant changes in a timely manner. As a minimum the ICB will conduct an annual review to verify that ESR is appropriately maintained.

6.10.7 NHS organisations will need to establish a process for individuals to access and exercise their rights in connection with the information held about them, in accordance with the requirements of data protection law (see paragraph 5).

6.10.8 Information held in ESR

The information that ESR will hold about ICB Board members is summarised in the FPPT checklist (Appendix 6).

6.11 Record retention

6.11.1 The ESR FPPT data fields will retain records of completed tests to support the FPPT assessments. All supporting documents/records in relation to the FPPT will be held locally by the ICB.

6.11.2 As such, the ICB's Records Management Policy is to be adhered to. However, when retaining documents/records in relation to disciplinary and similar cases, the ICB should make an assessment as to the severity of the misconduct and/or mismanagement and its impact to the FPPT. The more serious the issue the longer the retention period should be.

6.11.3 In relation to ESR, the information and accompanying references should be kept career long, which at a minimum should be until the 75th birthday of the ICB Board member.

6.12 Dispute resolution

6.12.1 Data and information

(a) Where an ICB Board member identifies an issue with data held about them in relation to the FPPT, they should request a review which should be conducted in accordance with the ICB's Subject Access Request Policy.

(b) Where this does not lead to a satisfactory resolution for the ICB Board member, the following options are available for:

(i) NHS England-appointed ICB Board members (e.g. ICB Chair) – the matter should be escalated to the NHS England Appointments Team; or

(ii) ICB-appointed Board members:

- referring the matter to the ICO;
- taking the matter to an employment tribunal[6]; or
- instigating civil proceedings.

[6] For Executive Director roles only. Chair and Non-Executive Board members cannot take their organisation to ET unless in relation to discrimination, but they can instigate civil proceedings.

6.12.2 Outcome of FPPT assessment

Where an ICB Board member disagrees with the outcome of the FPPT assessment and they have been deemed 'not fit and proper,' the following options are available for:

(a) NHS England-appointed ICB Board member roles – the matter should be escalated to the NHS England Appointments Team for investigation in accordance with policy and procedure. Where this results in an ICB Board member being terminated from their appointed role, a BMR[7]must be completed and retained by the local organisation in accordance with the Framework; and

(b) ICB-appointed Board members – local policy and constitution arrangements should be followed first.

7. QUALITY ASSURANCE AND GOVERNANCE

To ensure that the FPPT is being adequately embedded within the ICB there will need to be quality assurance checks conducted by the CQC, NHS England and an external/independent review. The quality assurance checks over the various parts of the FPPT Framework have been detailed below.

7.1 CQC Quality Assurance

7.1.1 The CQC's role is to ensure NHS organisations have robust processes in place to adequately perform the FPPT assessments, and to adhere to the requirements of Regulation 5 of the Regulations. As such, as part of the Well Led reviews, CQC will consider the:

(a) quality of processes and controls supporting the FPPT;

(b) quality of individual FPPT assessments;

(c) ICB Board member references;

(d) collation and quality of data within the database and local FPPT records.

7.1.2 In doing so the CQC will have regard to the evidence that exists as to whether the ICB Board members meet the FPPT. For example, this includes, but is not limited to, checking the following forms of evidence:

(a) that the ICB is aware of the various guidelines on recruiting board members and that they have implemented procedures in line with this best practice;

(b) personnel files of recently appointed ICB Board members (including internal appointments of existing staff);

[7] Exit BMR to be drafted by local chair for Non-Executive Board Members (with support from the NHS England Appointments Team), and by the NHS England Appointments Team for the ICB Chair.

(c) information or records relating to appraisals for ICB Board members; and

(d) references and personal development plans.

7.1.3 The CQC may intervene where there is evidence that proper processes have not been followed or are not in place for FPPT. While the CQC does not investigate individual board members, it will pass on all information of concern that is received about the fitness of an ICB Board member to the relevant NHS organisation.

7.1.4 The CQC will notify NHS organisations of all concerns relating to ICB Board members and ask them to assess the information received. The ICB Board member to whom the case refers will also be informed. The ICB should clearly detail the steps taken to assure the fitness of the ICB Board member and provide the CQC with a full response within 10 days. The CQC will then carefully review and consider all information.

7.1.5 Where the CQC finds that the ICB's processes are not robust, or an unreasonable decision has been made, they will either:

(a) contact the ICB for further discussion;

(b) schedule a focused inspection; or

(c) take regulatory action in line with their enforcement policy and decision tree if a clear breach of regulation is identified.

7.2 NHS England Quality Assurance

NHS England will have oversight through receipt and review of the annual FPPT submissions to the relevant NHS England regional director from NHS organisations.

7.3 Internal audit/external review

7.3.1 Every three years, the ICB should have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments.

7.3.2 The internal audit should include sample testing of FPPT assessment and associated documentation. The ICB should consider inclusion of FPPT process and testing in the specification for any commissioned board effectiveness reviews.

7.4 Governance

7.4.1 For good governance, and to be clear about the reporting arrangements across the FPPT cycle, the ICB will:

(a) provide an annual update to the ICB Board in public to confirm that the requirements for FPPT assessment have been satisfied; and

(b) provide updates to the Audit and Governance Committee through any internal or external audit reviews included in the audit programme.

8. SUPPORTING DOCUMENTS

- NHS Constitution
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Fit and Proper Person Test (FPPT) Framework (NHS England)
- Nolan Principles of Standards in Public Life
- NHS Records Management Code of Practice
- Data Protection Act 2014
- ICB Standards of Business Conduct Policy
- ICB Records Management Policy
- ICB Disclosure and Barring Policy
- ICB Learning and Development Policy
- ICB Subject Access Request Policy
- ICB Recruitment and Selection Policy

Appendix 1 – Board Member Reference Template

BOARD MEMBER REFERENCE

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

Date:			
HR Officer/name of referee:		Recruitment officer:	
External/NHS organisation receiving request		HR department initiating request:	

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [ICB Board Member position]

The above-named person has been offered the board member position of [post title] at NHS Derby and Derbyshire Integrated Care Board. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants: To be used only AFTER a conditional offer of appointment has been made. Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.	
Name of the applicant	
National Insurance number or date of birth	
Please confirm employment start and termination dates in each previous role *A: If you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)* *B: As part of exit reference and all relevant information held in ESR under Employment History to be entered)*	
Job Title:	
From:	
To:	
Job Title:	
From:	
To:	
Job Title:	
From:	
To:	
Job Title:	
From:	
To:	
Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as an appendix): *(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)*	
Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	**Starting:**
	Current:

Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		
How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? *(only applicable if being requested after a conditional offer of employment)*	**Days Absent:**	
	Absence Episodes:	
Confirmation of reason for leaving:		
Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) *(this question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)*		
Date DBS check was last completed:		
Level of DBS check undertaken (basic/standard/ enhanced without barred list/or enhanced with barred list):		

If an enhanced with barred list check was undertaken, please indicate which barred list this applies to:	Adults ☐ Children ☐ Both ☐	
Did the check return any information that required further investigation?	Yes ☐	No ☐
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
Please confirm if all annual appraisals have been undertaken and completed *(This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)*	Yes ☐	No ☐
Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the ICB's policies and procedures? *(For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)*	Yes ☐	No ☐

If yes, please provide a summary of the position and (where relevant) any findings and any remedial actions and resolution of those actions:		
Is there any outstanding, upheld or discontinued disciplinary action under the ICB's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS; • dishonesty; • bullying; • discrimination, harassment, or victimization; • sexual harassment; • suppression of speaking up; or • accumulative misconduct. *(For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)*	Yes ☐	No ☐
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		

Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state 'Not Applicable'. *(Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12)* *Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)* *The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)*
The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief. Referee name (please print): ..... Signature: ..... Referee Position Held: ..... Email address: ..... Telephone number: ..... Date: .....
Data Protection: This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Appendix 2 – Fit and Proper Person Test Annual Self-Attestation

This attestation should be completed annually by new and existing ICB Board members and submitted to ddicb.hr@nhs.net on behalf of the ICB Chair.

NHS Derby and Derbyshire Integrated Care Board Fit and Proper Person Test Annual Self-Attestation	

I declare that I am a fit and proper person to carry out my role. I:
• am of good character;
• have the qualifications, competence, skills and experience which are necessary for me to carry out my duties;
• where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals;
• am capable by reason of health of properly performing tasks which are intrinsic to the position;
• am not prohibited from holding office (e.g. directors disqualification order);
• within the last five years:
  ○ I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more;
  ○ been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged;
  ○ nor is on any 'barred' list; and
• have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.
 	
The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, and if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.
 	
Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.	

Name and job title/role:	
Professional registrations held (including reference number):	
Date of DBS check/re-check (including reference number):	
Date of last appraisal:	
Last appraisal conducted by:	

Signature of ICB Board member:	
Date signed:	
For ICB Chair to complete:	
Signature of ICB Chair to confirm receipt:	
Date signed:	

Appendix 3 – Letter of Confirmation

The following wording is given as an example. It may not be applicable in every case and may consequently be amended.

NHS
Derby and Derbyshire
Integrated Care Board

1st Floor North
Cardinal Square
10 Nottingham Road
Derby
DE1 3QT

Tel: 01332 981601
www.derbyandderbyshireicb.nhs.uk [8]

Reference

Date

Contact details
Address 1
Address 2
Address 3
Postcode

Dear [Chair Name[9]]

Fit and Proper Person Test

This confirmation letter is provided in connection with [name of board member, job title of board member, organisations that the joint board member post covers] for [financial year of test] as at [date of conclusion of annual FPPT for the individual] for the purpose of the Fit and Proper Person Test.

As Chair of [lead employer], I confirm that I have carried out the Fit and Proper Person Test for [name of board member].

The process and the evidence used by me in carrying out the Fit and Proper Person Test and in being able to reach a conclusion as to whether [name of board member] is fit and proper, is appropriate to reach that conclusion in the context of the Fit and Proper Person Framework.

In accordance with the Fit and Proper Person Test Framework requirements and in reaching my conclusion that [name of board member] is fit and proper as at [date of conclusion of test], I have assumed that you know no reason that this is not an appropriate conclusion to reach.

Please would you sign and return this letter as confirmation of receipt and that there are no further matters which should be taken into consideration.

[8] This is the organisation which holds the contract/employs the board member who works jointly across more than one organisation.
[9] This is the name of the chair of the other organisation that the joint board appointment is made with.

Yours sincerely,

Chair of [lead employer]

I confirm that I have received the outcome for the FPPT for [name of board member] and that I have provided any necessary information for you to reach this conclusion.

…….. (Signature)

…….. (Name)

Date……..

Please return to the ICB Chair and ddicb.hr@nhs.net for a copy to be retained on file.

Appendix 4 – Annual NHS FPPT submission reporting template

Name of Organisation	Name of Chair	Fit and Proper Person Test Period/ Date of Ad hoc Test
NHS Derby and Derbyshire Integrated Care Board		

PART 1: FPPT OUTCOME FOR BOARD MEMBERS INCLUDING STARTERS AND LEAVERS IN PERIOD

Name	Date of appointment	Position	Confirmed as fit and proper?		Leavers only	
			Yes/No	Add 'Yes' only if issues have been identified and an action plan and timescale to complete it has been agreed	Date of leaving and reason	Board member reference completed and retained? Yes/No

PART 2: FPPT REVIEWS/INSPECTIONS

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews etc.

Reviewer/Inspector	Date	Outcome	Outline of key actions required	Date actions completed

PART 3: DECLARATIONS

DECLARATION FOR NHS DERBY AND DERBYSHIRE INTEGRATED CARE BOARD [year]				
For the SID/Deputy Chair to complete:				
FPPT for the ICB Chair (as ICB Board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No

For the ICB Chair to complete:		
Have all ICB Board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
Are any issues arising from the FPPT being managed for any ICB Board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:
As ICB Chair of NHS Derby and Derbyshire Integrated Care Board I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.		
ICB Chair signature:		
Date signed:		

For the regional director to complete:	
Name:	
Signature:	
Date:	

Appendix 5 – ICB Board Member FPPT Privacy Notice

NHS Derby and Derbyshire Integrated Care Board is required to provide you with details on the type of personal information which we collect and process. In addition to any other privacy notice which we may have provided to you, this notice relates to the information collected and processed in relation to the FPPT.

The type of personal information we collect is in relation to the FPPT for ICB Board members and is described below, much of which is already collected and processed for other purposes than the FPPT:

1. Name, position title (unless this changes).
2. Employment history – this includes details of all job titles, organisations, departments, dates, and role descriptions.
3. References.
4. Job description and person specification in their previous role.
5. Date of medical clearance.
6. Qualifications.
7. Record of training and development in application/CV.
8. Training and development in the last year.
9. Appraisal incorporating the leadership competency framework has been completed.
10. Record of any upheld, ongoing or discontinued disciplinary, complaint, grievance, adverse employee behaviour or whistle-blow findings.
11. DBS status.
12. Registration/revalidation status where required.
13. Insolvency check.
14. A search of the Companies House register to ensure that no board member is disqualified as a director.
15. A search of the Charity Commission's register of removed trustees.
16. A check with the CQC, NHS England and relevant professional bodies where appropriate.
17. Social media check.
18. Employment tribunal judgement check.
19. Exit reference completed (where applicable).

20. Annual self-attestation signed, including confirmation (as appropriate) that there have been no changes.

Processing of this data is necessary on the lawful basis set out in Article 6(1)(e) UK GDPR as the foundation for the database. This is because it relates to the processing of personal data which is necessary for the performance of the fit and proper person test which is carried out in the public interest and/or in the exercise of official authority vested in the controller.

For CQC-registered providers, ensuring directors are fit and proper is a legal requirement for the purposes of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and organisations are required to make information available connected with compliance to the CQC.

How we get the personal information and why we have it

Most of the personal information we process is provided to us directly by you as part of your application form and recruitment to satisfy recruitment checks and the FPPT requirements.

We may also receive personal information indirectly, from the following sources in the following scenarios:

- references when we have made a conditional offer to you;
- publicly accessible registers and websites for our FPPT;
- professional bodies for FPPT to test registration and or any other 'fitness' matters shared between organisations; and
- regulatory bodies e.g. CQC and NHS England.

We use the information that you have given us to:

- conclude whether or not you are fit and proper to carry out the role of board director; and
- inform the regulators of our assessment outcome.

We may share this information with NHS England, CQC, future employers (particularly where they themselves are subject to the FPP requirements), and professional bodies.

Under the UK General Data Protection Regulation (UK GDPR), the lawful bases we rely on for processing this information are that we need it to perform a public task.

How we store your personal information

Your information is securely stored. We keep the ESR FPPT information including the board member reference, for a career long period. We will then dispose of your information in accordance with our Records Management Policy.

Your data protection rights

Under data protection law, you have rights including your right:

- of access – You have the right to ask us for copies of your personal information;
- to rectification – You have the right to ask us to rectify personal information you think is inaccurate. You also have the right to ask us to complete information you think is incomplete;

- to erasure – You have the right to ask us to erase your personal information in certain circumstances;
- to restriction of processing – You have the right to ask us to restrict the processing of your personal information in certain circumstances;
- to object to processing – You have the right to object to the processing of your personal information in certain circumstances; and
- to data portability – You have the right to ask that we transfer the personal information you gave us to another organisation, or to you, in certain circumstances.

You are not required to pay any charge for exercising your rights. If you make a request, we have one month to respond to you.

Please contact us at ddicb.sars@nhs.net if you wish to make a request.

How to complain

If you have any concerns about our use of your personal information, you can make a complaint to us at [Insert your organisation's contact details for data protection queries].

You can also complain to the Information Commissioner's Officer if you are unhappy with how we have used your data:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Helpline number: 0303 123 1113 ICO website: https://www.ico.org.uk

Appendix 6 – FPPT Checklist

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	Executive Director	NEM	Source	Notes
First name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process	HR team to populate ESR For NHS-to-NHS moves via ESR / Inter-Authority Transfer/ NHS Jobs For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency
Second name/surname	✓	✓	✓	x – unless change	✓	✓		
Organisation (i.e. current employer)	✓	x	✓	N/A	✓	✓		
Staff group	✓	x	✓	x – unless change	✓	✓		
Job title Current Job Description	✓	✓	✓	x – unless change	✓	✓		
Occupation code	✓	x	✓	x – unless change	✓	✓		
Position title	✓	x	✓	x – unless change	✓	✓		
Employment history Including: • job titles • organisations/ departments • dates and role descriptions • gaps in employment	✓	x	✓	x	✓	✓	Application, recruitment process, CV etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	Executive Director	NEM	Source	Notes
Training and development	✓	✓	✓	✓	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	*Non-Executive Member recruitment often refers to a particular skillset/experience preferred e.g. clinical, financial etc, but a general appointment letter for NEMs may not then reference the skills/experience requested. Some NEMs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all ICB Board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (eg professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers	✓	✓	✓	x	✓	✓	Recruitment process	Including references where the individual resigned or retired from a previous role.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	Executive Director	NEM	Source	Notes
Last appraisal and date	✓	✓	✓	✓	✓	*	Recruitment process and annual update following appraisal	*For NEMs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.
Disciplinary findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	✓	✓	✓	Reference request (question on the new Board Member Reference). ESR record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT. This question is applicable to board members recruited both from inside and outside the NHS.
Grievance against the board member	✓	✓	✓	✓	✓	✓		
Whistleblowing claim(s) against the board member	✓	✓	✓	✓	✓	✓		
Behaviour not in accordance with organisational values and behaviours or related local policies	✓	✓	✓	✓	✓	✓		
Type of DBS disclosed	✓	✓	✓	✓	✓	✓	ESR and DBS response.	Frequency and level of DBS in accordance with local policy for board members. Check annually whether the DBS needs to be reapplied for. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.
Date DBS received	✓	✓	✓	✓	✓	✓	ESR	

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	Executive Director	NEM	Source	Notes
Date of medical clearance* (including confirmation of OHA)	✓	x	✓	x – unless change	✓	✓	Local arrangements	
Date of professional register check (e.g. membership of professional bodies	✓	x	✓	✓	✓	x	e.g. NMC, GMC, accountancy bodies	
Insolvency check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.
Disqualified Directors Register check	✓	✓	✓	✓	✓	✓	Companies House	
Disqualification from being a charity trustee check	✓	✓	✓	✓	✓	✓	Charities Commission	
Employment Tribunal Judgement check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decisions	
Social media check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram etc.	
Self-attestation form signed	✓	✓	✓	✓	✓	✓	Template self-attestation form	Appendix 2 in Framework.
Sign-off by Chair/CEO	✓	x	✓	✓	✓	✓	ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidence locally.
Other templates to be completed								
Board Member Reference	✓	✓	x	x	✓	✓	Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday, whichever latest (Appendix 1 in Framework).
Letter of Confirmation	x	✓	✓	✓	✓	✓	Template	For joint appointments only (Appendix 3 in Framework).
Annual Submission Form	x	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director – (Appendix 4 in Framework).

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	Executive Director	NEM	Source	Notes
Privacy Notice	x	✓	x	x	✓	✓	Template	Board members should be made aware of the proposed use of their data for FPPT (Appendix 5 of Framework).
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.

Time Commenced: 13:00pm
Time Finished: 15.00pm

Health and Wellbeing Board
09 November 2023

Present:

Statutory Members Chair: Councillor Martin (Chair), Robyn Dewis, Director of Public Health, Andy Smith, Director of Peoples Services, Richard Wright (Chair of ICB),

Elected members: Councillors Ashby and Care

Appointees of other organisations: (Amjad Ashraf (Community Action Derby), Denise Baker (PV and Dean College of Health Psychology and Social Care University of Derby) Paul Brookhouse (Derby Poverty Commission), Chris Clayton (CEO Derby & Derbyshire ICB), Lucy Cocker (Derbyshire Community Healthcare Services), Gino Distefano (Director of Strategy Derby Hospitals), James Duffield (Derby Poverty Action), Maherul Hassan (Derbyshire Healthcare United), Vikki Taylor, Derbyshire Healthcare NHS Trust, Jenny Watson, (Housing Management Trainer DCC)

Non board members in attendance: Heather Greenan (Director of Corporate Management DCC), Kirsty McMillan (Director of NHS Integration & Prevention), Lewis Talbot (NHS DDICB), Alison Wynn (Assistant Director of Public Health).

18/23 Apologies for Absence

Apologies were received from Cllr Lonsdale, Emma Aldred (Derbyshire Constabulary), Stephen Bateman (CEO Derbyshire Healthcare United), Sue Cowlishaw (Derby Healthwatch), Angelique Foster (Derbyshire Police & Crime Commissioner), Margaret Gildea (ICB), Dean Howells (Chief Nurse Officer DDICB), James Joyce (Head of Housing and Homelessness & rep for Clare Mehrbani), Clare Mehrbani (Director of Housing Services, Derby Homes Ltd), Rachel North (Director of Communities & Place), Stephen Posey (CEX Derby Hospitals NHS Foundation Trust), Mark Powell, (CEO Derbyshire Healthcare NHS Trust), Perveez Sadiq (Director Adult Social Care Services), Doug Walkman (Head of Regulatory Services).

19/23 Late Items

There were none.

20/23 Declarations of Interest

There were none.

21/23 Minutes of the meeting held on 27 July 2023

The minutes of the meeting on 27 July 2023 were noted and agreed.

22/22a Partnership Winter Pressures

The Board received a report from the Director of Public Health, Derby. The report was presented by the Director of Corporate Management and provided the HWB with an overview of current and emerging issues across the Derby health and wellbeing system. It also set out the activity in the city to to mitigate pressures and risks identified.

The officer explained that significant challenges had been faced during winter over many years. The pressures are becoming more acute and challenging and have been made worse by issues like the COVID-19 pandemic, and the cost of living crisis. Some of the key issues currently being faced in Derby city were:

Risk of flooding – the River Derwent reached it highest recorded level on 21st October. Surface water from heavy rainfall and river flood meant there was significant travel disruption and some homes and businesses were flooded.

Health and Social Care – the NHS and social care services faced significant pressures during winter. Derby & Derbyshire ICB published an operational plan for the system earlier this year. Adult social care contributes to the plan. Some of the expectations of social care during winter included:

- Increased support for weekend and out of hours social care hospital discharges.
- Support for residential and nursing providers for patients with complex needs.
- Ensuring that the Carelink general and rapid response falls service was responsive to avoid hospital admission and ambulance journeys.

Flu and COVID-19 – the prevalence of seasonal respiratory viruses like flu and COVID 19 increase in the autumn and winter. A new variant of COVID was circulating recently, but vaccination was likely to provide continued protection especially for vulnerable people.

Poverty and the cost of living – In Derby city there are significant populations with existing health conditions who will be more at risk during winter particulary those with heart and respiratory conditions. Their physical and mental health risks are worsened due to the increasing challenges and living costs. A Cost of Living Coordination Group was established and a range of interventions like the Community Hub, Food 4 Thought, The Holiday Activity Fund and Household Support Fund are in place to support communities across the city.

Housing and Homelessness – there was a range of support available all year for the homeless or those about to become homeless. There services include the Council's Housing Options service, the city's street outreach teams and the Safe Space initiative amongst many others. Rough sleeping numbers are increasing. Between June and September 2023 the average number on any night was 10. Sleeping rough also increases the risk of cold-related illness and death. A Severe Weather Emergency Protocol (SWEP) was in place in the City.

Emerging Threats – more issues emerged as threats at a winter pressures partnership workshop in October.

- Homecare and access to homecare – the market was affected by recruitment and retention of staff.
- Debt and length of time for debt advice.
- Warm Hubs – look at availability for areas that most need this provision.
- Increased demand for temporary accommodation – this risk was increasing and there was limited capabililty available to mitigate.
- Identifying and reaching out to the most vulnerable individuals and communities

A councillor was concerned about preventing falls and also if advice on the benefits of Vitimin D available was circulating as there was a lack of recognition of the benefits of taking Vitamin D. The officer explained that the Warm Welcome Hubs would circulate leaflets on Vitimin D benefits if available. The Director of Public Health explained there was a health strategy in place and children and pregnant women in a low income bracket were eligible for free Vitimin D supplements. Health visitors promote this as well as vouchers for free milk and vegetables. It was recognised that there was not enough sunshine between September and March to provide sufficient Vitimin D and supplements were important.

The councillor asked if there was a debt advice strategy in place for next winter, the officer explained that work on providing debt advice was ongoing, but there was a lack of qualified debt advisers. It was suggested using a network of local churches who were offering debt advice. However, it was clarified that organisations giving debt advice must be registered and there was legislation surrounding debt advice. Community Action Derby provide Food and Debt Advice and Guidance and information was available on cost of living on their website. There were advisers in community centres and posters with contact information had been circulated, but the message was not always getting through to people, because of language or hearing difficulties.

A Board member highlighted the work of Derbyshire Community Health Services on child poverty and mental health. Unfortunately the work on mental health could end in March 2024 unless more funding was made available.

The officer was thanked for a comprehensive report. It was heartening and reassuring that risks are recognised and were being addressed.

The HWB Board:

- **Noted the report.**
- **Identified and considered further winter risks and challenges and further action that could be undertaken to reduce and mitigate those risks.**

22/22b NHS Operational Plan – October 2023 – March 2024

The Board received a report of the Chief Executive NHS Derby & Derbyshire Integrated Care Board (DDICB)/Joined Up Care Derbyshire (JUCD). The report provided the HWB with a briefing on the status of the NHS' operational plan over the next six months (October 23 – March 24).

In May 2023 Derby and Derbyshire ICB submitted the health system's operational plan for the financial year 2023/24. The plan set out it's aims for the year ahead, mainly to improve access to care across the acute planned, cancer, emergency care, mental health, autism and

learning disability portfolio.

In late July 2023, NHS England published its approach to winter and asked that systems review their operational plans looking at actual year to date delivery and any new risks emerging. All health systems were asked to make sure that the 10 high impact areas to reduce hospital A&E demand and to improve acute flow would be in place over the winter period.

A task and finish group was set up with the input of NHS Delivery Board Leadership and Provider organisations. It's aim was to:

- Review performance in relation to the operational targets for planned care, cancer and urgent and emergency care
- Establish a forecast delivery position for the targets for October 23 to March 24.
- Summarise the key actions necessary to meet the forecasts.

A presentation was provided by officers to show how performance went in the first six months and the focus for the next six months.

- A&E 4 hours, both Acute Trust are delivering their plan
- Long Acute stay, fewer beds occupied by people staying longer
- Ambulance Turnaround, 1,980 fewer hours lost to handover delays
- GP Appointments, overall output has been 2.1% higher than planned
- Urgent community response, over 80% of referrals for older people in crisis were responded to within 2 hours.
- Faster cancer diagnosis, 7% more people were treated in the process of ruling out or diagnosing cancer.

However, waiting lists were not on track.

- Referral to Treatment (RTT) waiting list (overall size) at the end of August 2023 the RTT waiting list was 12% larger than originally expected and 10% larger than it was in August 2022.

- RTT long waits (65+weeks) The number of people waiting longer than 6 weeks was 15% lower at the end of August 23 compared to August 22. However, there are 1,263 patients waiting longer than 65 weeks than was expected.

- The number of patients waiting longer than 62 days for their cancer treatment has deteriorated during the last two months and is not on track, behind by about 50 patients.

- 999 response (category 2 incident) the average response time from 999 call to the arrival of an ambulance at the scene. The performance for EMAS entire operation is currently higher than the 30 minute (mean) target level, the local position was reasonable with performance operating within plan.

A councillor suggested there should be less jargon and initials used in report. She suggested the plan was dependent on achieving improvement in areas and managing demand. Some areas depended on recruitment of more staff, community care was one example. Also what

were virtual wards and who would administer virtual wards.

The officer apologised for the jargon and use of initials in the report and explained that virtual wards were a means of looking after patients outside of the hospital bed, they would be booked in and monitored in their own homes. There were different types of virtual wards but the main one was specialist care.

The risks in the plan, such as recruitment were acknowledged. However, there was a need to set assumptions, and recognise there would be variables. Assumptions were made around the levels of Covid, Flu, also industrial action. The plan was predicated on there being no further industrial action. Trends are looked at year on year and assumptions made as to what will happen. Advice and guidance and feedback from the Board was welcomed. Work was ongoing to improve the mechanism to connect GP and specialist care, to seek advice, and create a dialogue between them. The aim of the plan was to support and manage demand. Work was being undertaken on the primary and secondary care interface to enable GPs and consultants to work together to reduce bureaucracy.

The DoPH highlighted that national waiting list figures were at 7.5m and were increasing over time, the trend was upwards. All work had a preventative focus, operations and procedures, but the list had increased so there was a need for a different approach to reduce the number of people on waiting lists. It was a health burden, the waiting list had to be prioritised and health inequalities must be thought about. The longer a patient stayed on a waiting list the more their health would deteriorate.

The Chair stated that waiting lists were an area of public concern, she suggested there did seem to be an improvement in terms of communication with patients on the waiting lists. The Board were concerned about GPs picking up the care of patients on a waiting list. It was good that GP output had improved, but there was a need for action on the numerous pressures on the GP workforce. The officer was also concerned about GP Practices. The issue of supporting primary care was one that he would discuss with the HWB. The long term workforce plan was about recruitment and retention.

The Board noted the improvement to speed and experience of using Accident & Emergency Departments but were concerned that the figures for waiting times now included Urgent Treatment Centres (UTCs). The officer explained that Urgent and Emergency Care was a broad criteria, the figures included all data on urgent emergency care activity on hospital sites. UTCs are a GP led service but form part of the urgent response. Work was ongoing with the public to help them to choose the right service, there were a lot of options ranging from a conversation with the Pharmacist, to Emergency Departments.

The Chair invited the officer to comment on the Cancer Care figures. The officer explained there were many different types of cancer. The report highlights the figures for two pathways, lower gastrointestinal and urological. The delays were linked to the availibility of specialists and industrial action. The position was challenging at the beginning of the year but improvements were made, but the position deteriorated, efforts to recover and get back on course were being made.

The HWB Board noted the work that the NHS was doing to deliver operational performance with regard to urgent emergency care and planned cancer care.

22/22c COVID and Flu Autumn/Winter Programme 2023/24

The Board received a report of the Director of Public Health DCC. The report provided the HWB with an overview of the delivery of the COVID and Flu/Autumn/Winter Programme 2023/24 in Derby to support the HWB in delivering its responsibilities in protecting the health of local people.

The Board were informed that respiratory diseases are a major factor in the winter pressures faced by the NHS, and double in number in the winter. The potentially serious impacts of flu ahead of winter had been set out in a recent winter briefing by the UK Health Security Agency. The flu and COVID-19 vaccination programmes help to protect vulnerable people from severe illness and also help with the pressures faced by the NHS and social care during winter. Vulnerable groups are urged to take up the flu vaccine.

There are currently 21 vaccination sites across Derby, 18 community pharmacies, 1 primary care network and 2 hospital hubs. A further 2 community pharmacies will go live by November. All Community Pharmacy, General Practice and Hospital Sites have opted into the flu programme in Derbyshire.

Uptake for the Autumn Winter COVID Programme progess and 2023/24 Flu Vaccination Season were highlighted:

- 232,577 (52.94%) Covid-19 vaccinations undertaken from 11/9 to 06/11
- 278,847 (44.58%) Flu vaccinations from 11/09 to 06/11

The areas of concern and mitigating actions were detailed.

- A new School Aged Immunisation Services provider started in September. They are building relationships with schools and have begun providing flu vaccinations.

- Additional payments were made to providers for the Autumn/Winter COVID progamme to support an earlier start to the programme. The payments finished at the end of October which could mean providers are unable vaccinate due to financial viability. The local JUCD Vaccination Operation Cell (VOC) will review expected provision after October. Any gaps in provision will be reviewed individually.

- As part of the accelerated programme for Covid there was a need to vaccinate all care homes by the 22/10/2023, at first care home completion was slower than other systems in the midlands however it has now caught up and vaccinations are above the national and regional average percentages.

- Due to several issues some of the new sites have not yet begun vaccinating. The JUCD VOC team are working with these sites to ensure they are operation as soon as possible.

A Board member asked about vaccination take up data for ethnic commuities. The officer confirmed that work was ongoing with Community Action and communities to understand the cultural issues surrounding take-up of vaccinations, but there was no data available yet. The Board member asked if information for child flu vaccinations was available ? The officer would review and share any information. Another Board member explained there was a huge

variation in vaccination uptake. Within flu vaccinations there were historically good results for vaccinating those with long term and chronic disease but there were issues around vaccinnating those who were pregnant. This information could be shared with the HWB, Health Inequalities Group. A councillor asked about the hospital hubs and whether it was possible for people to use them as drop in centres for vaccinations. It was explained that hubs were not the right setting for drop-in clinics. They were being used for hospital staff and some eligible patients.

Another councillor asked about the option to have Flu and Covid vaccination at the same time. It was explained that several GP practices did not offer this as they would not be financially recompensed. It was explained that the Flu programme was on a five year contract, whereas with the Covid it was a reactive programme and providers have the option to sign up or opt out. A councillor asked about the table of vaccination sites, and raised concern about the quantity of sites available. The officer explained that areas of concern are looked at and if necessary temporary pop-up clinics would be provided. The Board members were asked to encourage people in their wards to come forward for vaccinnations. One Board member felt there was issues around trust and confidence in people and that vaccination programmes should be looked at strategically.

The HWB noted the contents of the report

23/23 Better Care Fund Review

The Board received a report and presentation from the Strategic Director of Peoples Services which gave which detailed proposed plans to review the Derby Better Care Fund (BCF). The report was presented by the Director NHS (Integration and Prevention).

The Board were informed that a report had been brought to the HWB as the statutory body responsible for the BCF and the HWB had approved the City's BCF Plan for 2023-25. Since then the NHS England (NHSE) led Assurance process had ended and Derby City's BCF Plan had been approved.

In Derby the fund was £17.4 million per year in 2015 but this had risen to £39.2m because of additional funding streams and priorities being incorporated within the BCF, and inflationary uplifts.

The officer informed the Board about the proposed review. It was explained that the BCF was a nationally authorised pooled budget and partnership agreement between the NHS and local authorities. In 2015 a partnership agreement was made between DCC and the NHS and a pooled budget was created. The arrangement was to ensure local authorities, Health and Wellbeing Boards, and NHS worked together to agree a joint area plan to bring health and care services together and to access BCF income.

The BCF Programme in Derbyshire and Derby City were subject to oversight by the BCF Programme Board, a subgroup of both HWBs. When the Integrated Care System was formed under the Health and Care Act 2022, there was more national and legal emphasis on delivering integrated care to improve support for local people. The HWB still holds the responsibility for the BCF but there are more opportunities now to align the BCF to the objectives of the new Integrated Care Strategy

It was proposed that the HWB agree that the BCF be reviewed. The NHSE BCF support team would be asked for assistance to undertake the review, members of the HWB the Integrated Care Partnership/Integrated Place Executive would be engaged and involved. As the HWB was the statutory body responsible for the BCF any proposed changes to how the pooled budget was spent would need to be considered and approved by the HWB. However, the HWB may think that a review would not be necessary at this time, given the capacity needed from partner organisations and because the current 2023-25 plans had been approved by the recent DHSC BCF Planning round.

The Board welcomed the proposed review. A councillor asked if there were any opportunities to bring in teams from other areas perhaps to integrate the need for more exercise and clear messaging which could encourage people to change their behaviour. The officer confirmed there would be more opportunities with a pooled budget, preventative work would be a part of that, however there are tight returns and restrictions on the funding.

The Chair noted that the funding had been agreed in July and that a review and interim report ahead of final recommendations would be welcomed by the Board.

The Board:

1. **Approved the review of the local Better Care Fund processes and arrangements to ensure it matched with local health, social care and housing system priorities.**

2. **Agreed that the review would be overseen by the BCF Programme Board on behalf of the Health and Wellbeing Board, and that any proposals following the review would return for consideration. This would include an interim report ahead of final recommendations.**

Items for Information

24/23 Update from the Derbyshire Health Protection Board

The Board received a report of the Director of Public Health which provided an update and overview of the key discussions and messages from the Derbyshire Health Protection Board (DHPB). The report was to ensure that the HWB was kept updated on the work of the Derbyshire Health Protection Board and the health protection issues which affected the population of Derby.

The Board were informed that the DHPB met on the 8th September 2023. The key items discussed included:

- A draft Health Protection Strategy for Derby and Derbyshire. It was planned to approve the final strategy on 10th November and to bring to the HWB for discussion and awareness.

- An update on the Infection Prevention and Control (IPC) audit pilot was given.

- The Tuberculosis (TB) services were discussed in particular with challenges to capisity and staffing. A subgroup of the DHPB was to be established to undertake in depth work and report back to the DHPB.

- An update was given on the screening and immunisation service. There are significant system changes and work was progressing to delegate responsibility for commissioning to Integrated Care Boards (ICBs).

- A new school aged immunisation provider was now in place, work was ongoing to ensure increased uptake of immunisations.

- A MMR elimination plan had been established by the ICS Vaccination and Immunisation Board. Progress would be monitored by DHPB.

- The Air Quality Medium Term Annual Report was presented for the DHPB's assurance. It would be reviewed at the November meeting of the DHPB, and will come to a future HWB meeting.

The HWB Board noted the update report.

Private Items

None were submitted.

MINUTES END

MINUTES OF THE AUDIT AND GOVERNANCE COMMITTEE

HELD ON 11 DECEMBER 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
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)
Donna Johnson	DJ	Acting Assistant Chief Finance Officer
Chris Leach	CL	Head of EPRR
James Lunn	JL	Assistant Director of Human Resources and Organisational Development
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
Rosalie Whitehead	RW	Risk Management & Legal Assurance Manager
Apologies:		
Craig Cook	CC	Director of Acute Commissioning Contracting and Performance/JUCD Chief Data Analyst

Item No.	Item	Action
AG/2324/271	**Welcome, introductions and apologies.** Sue Sunderland as Chair welcomed all members to the meeting. Apologies were received from Craig Cook.	
AG/2324/272	**Confirmation of Quoracy** The Chair declared the meeting quorate.	
AG/2324/273	**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/2324/274	**External Audit** Andrew Cardoza gave a verbal update and highlighted the following: • The planning process had commenced. Initial conversations had been undertaken with Keith Griffiths, Darran Green and Donna Johnson. • KPMG would work with 360 Assurance to understand the work that they would be undertaking. • It would be a very difficult year, again, for the NHS. Providers across Derbyshire System were under pressure, and it would be difficult to deliver the services that residents in Derbyshire required within the funding envelopes. • KPMG expected the 23/24 Audit to go well; there would only be one Audit this year. • Timothy Wakefield reported that risk assessment conversations had commenced with Donna Johnson and her team. • Keith Griffiths reported that we were going through unprecedented times; there would be conversations regarding stopping activity to deliver financial balance, the impact this would have on every System would be huge, particularly for the Derbyshire System. DDICB had significant relationships with non-Derbyshire partners who were looking at their own bottom line given the pressures they were under. It was noted that there was real evidence of inconsistency and inequity appearing across the ICB and across organisations and it was testing relationships. • It was noted that when we get to final accounts and agreements in balances there would be bigger risks than ever with those non-Derbyshire partners, and we may need to have some very difficult conversations because of the environment that we were all being driven to. • The Chair reported that both Andrew Cardoza and Timothy Wakefield had been sighted on the level of out of area relationships around finance. The deep dive that had come to the last Committee regarding Finance had been helpful, and the Chair reported that if KPMG needed any more detail to flag this with the finance team. **The Audit and Governance Committee thanked Andrew Cardoza for his verbal update.**	
AUDIT		
AG/2324/275	**Internal Audit** **Progress Report:**	

	Usman Niazi presented their progress report, and since the last Audit and Governance Committee, they had issued the final reports resulting from the following reviews: : This was issued with limited assurance and included two medium risk recommendations. The reason for the limited assurance opinion was that currently there was no formal mechanism within the ICB for the provision of robust assurance from the local authorities, namely Derbyshire County Council and Derby City Council, about the verification process that was followed within the local authorities, in order to ensure that the claims were accurately reflective of the activity that had been undertaken. There was a need for some further checks to be undertaken to reduce the risk of claims being made which did not accurately reflect a completed Mental Health Act assessment. **Data Quality and Performance Management Framework**: This was issued with a limited assurance opinion and included two medium risks and two low risk recommendations. There was a need for the ICB to develop a formally documented performance management framework which sets out the reporting structures and the accountabilities across both Board and Committee levels. That framework needed to include guidance which sets out how the quality of the data that the ICB received from organisations within the System, and its own internally generated data, was quality assured. There was also a need for the ICB to strengthen its integrated assurance and performance report received by the ICB Board and by the Quality and Performance Committee. Within the report 360 Assurance had outlined several areas that could be incorporated into the report to enable that to happen. **Developed and agreed the Terms of Reference for the following reviews**: • Financial Systems: Fieldwork was currently under way. • Delegated primary care functions: Was due to commence in February 2024. • Health Inequalities: Would commence when requested evidence was received. **Status of Agreed Actions**: Usman Niazi reported that at the time of writing this progress report, the current first follow up rate stood at 68% and the overall implementation rate was 89%. There was a total of fifteen actions that became due between 1st of April and 30th of November. Eleven of these were implemented within the original due date. Two further actions were implemented ahead of their due date of 31st of March and four actions were implemented outside of the original due date. This puts the ICB in the Moderate Assurance category in terms of the Head of Internal Audit Opinion (HOIAO) in respect of the follow up of actions.	

	It was noted that there was a medium risk action from the Committee Effectiveness Report, which became due at the end of November. This action required future presentations of the BAF to Committees to include an update on how the implementation of actions recorded in the BAF had impacted on the profile of each risk. 360 Assurance were originally expecting a report to be submitted to each Committee to comment on whether the implementation of actions detailed in the BAF had impacted on the risk score. However, 360 Assurance had done some further reflection on their evidence expectation for this action, and they had recognised that it was more to do with the articulation of actions than it was about the process of feeding back on the impact of each completed action. For that reason, they had reclassified this action as superseded on their action tracking system. It was noted that there was to be a forthcoming Audit of the Committee Risk Management Development which would cover the essence of what that original action was trying to target. The Chair referred to the overall performance and noticed that was still quite a lot of work to be done before year end, she asked whether 360 Assurance were confident that they had the resources to deliver that. Usman Niazi reported that he was confident that they had the resources in place and work had sufficiently progressed to enable them to provide an Opinion at year end. Jill Dentith reported that she was disappointed that the ICB had received a limited assurance on some of the reviews. Regarding the follow up actions and the HOAIO, Jill Dentith asked whether we were agreeing to dates that were not achievable or were we agreeing to dates and not delivering on them? With reference to the BAF and the rethink by 360 Assurance, Jill Dentith asked whether this was impacting on the moderate score, or had that been taken into account? Usman Niazi reported that the percentage quoted in the report was up to end of November, 360 Assurance were still in the process of having discussions with the ICB regarding the BAF, therefore had not been incorporated into the figures reported, so this would have a slightly more positive impact on the overall score. It was noted that it would be up to ICB colleagues to consider when they were signing off Audit reports to set realistic timescales for actions versus ability to deliver. Keith Griffiths reported that he had had a conversation with Elaine Dower in relation to the draft Mental Health Report; a couple of helpful things came out of that conversation. Keith Griffiths reported that the number of reviews undertaken (based on our population), we would have expected us to have had about 2,100 reviews a year and we actually had 3,238; he wondered why we were such a big user of these Mental Health assessments, it might be that we had two clinicians attending the same patient, but even so that was a massive increase compared to the average expected for our population size. He reported that he had asked Elaine	

	Dower to review this to see if there was any intelligence coming out from our volume which was worthy of a further review. It was also noted that the ICB was paying slightly higher than the average rate in Derbyshire; Elaine Dower was asked to find out what others were paying so that we could take a measured view about whether we needed to change things in the future. It was also noted that we were paying for assessments that had not taken place; the patient might refuse entry and allied to that we had evidence from the data that four or five visits were taking place on the same day, and we might be getting charged for each of those occasions. We needed to ensure that we were getting what we were paying for at an appropriate rate. Keith Griffiths reported that he had agreed for Elaine Dower to spend more time on this, even though it may be beyond the scope of what was originally within the report. Keith Griffiths also reported that looking at the data from this report, it appeared that one supplier got most of the ICB's business, we needed to check that we had the correct stewardship around this. It was noted that this report would come back at a future date. The Chair highlighted the fact that there did not appear to be a management response to Mental Health Assessment Claims report and asked Usman Niazi whether this was the case? Usman Niazi confirmed that there had been an opportunity to respond to this report, but that no response had been received. The Chair referred to the second report, Performance Management, and Jill Dentith's comments regarding timescales being achievable for follow ups; she found the timelines on these recommendations to be very generous. She asked Usman Niazi whether he was happy with the timelines; she appreciated that a lot of work had to be done on these recommendations? Usman Niazi reported that the lengthy timelines specifically for the main two actions around the development of the Performance Management Framework and guidance were mainly down to the new ICB organisational structures and the need to allow time for those new structures to embed. The timescale assigned to the Quality Committee ToR for end of May tied in with when the next review of the ToR would be due. The Chair asked Chrissy Tucker for some interim milestones on this, as having an effective Performance Management Framework was not something, as a Board member, she would want to wait until April 2025 to get. Chrissy Tucker agreed to speak to Helen Dillistone outside of this meeting as to how we could take this forward. **Audit and Governance Committee NOTED the Internal Audit.**	CT/HD

AG/2324/276	**Internal Audit Recommendations Report** Chrissy Tucker presented the Internal Audit Recommendations Tracker and highlighted the following: • This report was presented to Committee for assurance. • Action 4 on the tracker re PLACE – an extension for this action was given until end of March 2024. This action relating to having a formal process for risk in place with PLACE. They were involved in our BAF, and our Risk Manager regularly spoke with the PLACE lead to ensure that PLACE was helping mitigate against our BAF and strategic risks, but we did not have a formal structure within PLACE to escalate any of their risks to us. It was noted that those discussions happened as part of the catch up with the Risk Manager, but this was an outstanding action. • Action 5 on the tracker re the forward planner for People and Culture Committee. The planner would be redrafted by the end of the month, which was the target date; that work was in progress and would be delivered by end of December 2023. • Action 6 was amber; the due date had been changed from November 2023 to March 2024. • Action 9 on the tracker was around Risks and linking them to change in risk profile by the actions that were undertaken. This had now been superseded. The Chair reported that a lot of the actions related to the Governance review, and the time it had taken to get through the various Committees. Margaret Gildea reported that rather than going through each individual action, she wanted to ask the generic question as to whether there was some root cause of why we were late with these actions. Was it because we take unrealistic dates or was it because we were overloaded. She felt that our overall ranking at 68% did not feel quite right. Usman Niazi reported that scores over 75% gave significant assurance, between 60% and 75% was moderate assurance and between 40% and 59% was limited assurance. It was noted that the percentage would potentially affect the Head of Internal Audit Opinion, but the percentage on its own was relatively meaningless. The ICB did not have many medium risks, a lot of them were low risks, although the ones that were overdue were medium risks. Helen Dillistone referred to the root causes of why actions had been delayed, she felt it was a mixture of reasons. She reported that in some instances there would be a case-by-case reason depending on the nature of the issue, the dates may also not be realistic and too ambitious when originally set. This should be learning for all of us to take forward to try and be more realistic. It was also noted that other reasons for late completion of actions were volumes of	

	work and other urgent distractions; this needed to be worked through by the Directors and their teams. Jill Dentith reported that the outstanding actions may be of low risk, but that they were still impacting on the HOIAO; she asked whether we would be able to recoup that position or whether we would be rated at moderate assurance at the end of the year? The Chair responded that was only part of the overall assessment, there would be other factors that take part in that. We had seven recommendations that were not yet due; if we got those implemented in time, they would up the percentages. The Chair reported that there was a need to encourage Executives to ensure that they were completed as four were medium priority recommendations. Keith Griffiths agreed that 2/3 compliant was not good enough; he requested that Usman Niazi send him a monthly report detailing the outstanding actions, and he would liaise with/follow up with colleagues to ensure that actions were given priority. **The Audit and Governance Committee NOTED the Internal Audit Recommendations Tracker.**	UN/KG
FOR DECISION		
AG/2324/277	**Sight Test Procedure for Display Screen Equipment Users** Chrissy Tucker presented the updated Sight Test Procedure for Display Screen Equipment Users and reported that the ICB was implementing a small increase to the reimbursement costs that staff could claim for their sight test, as High Street prices had increased. Chrissy Tucker reported that the ICB was making a £5 increase available to staff from the 1st of April 2024 for their sight test, but other than that, there were no material differences to this procedure. **The Audit and Governance Committee:** • **NOTED and APPROVED the ICB Sight Test Procedure for Display Screen users, and** • **NOTED the increase in eye test reimbursement costs for ICB employees.**	
PROCUREMENT		
AG/2324/278	**Procurement Review Update** Chrissy Tucker reported that following presentations of procurement reports to the Committee and questions raised around some of the procurements, Committee had requested a review of the ICB's processes. Committee had also requested that an agreement on realistic timescales be agreed at the next agenda setting meeting between the Chair and the Corporate team. It was	

	subsequently agreed with the Chair that the end of the financial year would be a realistic target to complete this work. This report sets out the progress and proposals to date. Chrissy Tucker reported that a Procurement Review Group comprising Governance, Finance, Commissioning and Contracting colleagues had been established and met on 21st November to introduce the group to the feedback from the Committee, discuss the current status from a variety of perspectives and agree actions. The group felt the implementation of changes and dissemination of information should be via the ICB Delivery Group (formerly SLT) but had also scheduled a second meeting of the Review Group for 5th January 2024. The meeting explored the experiences and thoughts of the attendees in relation to procurement and related processes and agreed that there were four main workstreams that would support this review: 1. Process Review 2. Future model of work with the CSU 3. No PO No Pay 4. SoRD/Governance Review It was agreed that a full programme plan would be pulled together incorporating all four areas of work, actions agreed, owners and timescales and that the plan would be delivered by the end of the financial year. The programme plan would be brought back to this Committee's February meeting. Chrissy Tucker reported that circulated in addition to this report was a document showing the scope of the procurements including those which were due before the end of March, and those which were due before the end of September next year. It was noted that one of the key pieces of work that Craig Cook was leading on was working through all our procurements to look at whether there were any that we could do differently, how they would be treated under PSR, and what our work plan was for the next 12 months. The Chair reported that this was something that Committee was very interested in seeing the progression on, and what it was going to cover; she felt the spreadsheets were quite alarming in terms of the number of contracts that needed to be let before the end of March 2024, and asked whether we had looked at the feasibility of meeting those deadlines? Chrissy Tucker reported that there was a meeting this evening to review the feasibility of those deadlines. It was noted that a large proportion of the primary care contracts were already in hand. Jill Dentith reported that this report had been a good start, but she was anxious about timescales; there was a need to ensure that we	

	were getting the quality we needed and that we also got value for money. Margaret Gildea reported that she felt assured now this work was happening, but asked whether there were things we needed to do in the meantime whilst the work streams were progressing? Chrissy Tucker reported that we would get the full picture of the whole organisation of clinical and non-clinical procurements, and actions would be taken as soon as they were identified rather than waiting until the end of the piece of work. The Chair asked whether Chrissy Tucker would be prioritising the actions? She was particularly concerned for those ones raised by this Committee where the ICB had elected to go at risk. Chrissy Tucker reported that where that had been stated, the governance around that decision would be reviewed and whether we had made the relevant people aware of those risks and whether we had an audit trail of that and what the impacts were would be gathered. The Chair assumed that the plan due to come back to the next Committee would have more timetabling around it, so that it could be reviewed by members. The Chair reported that this was an important step forward and requested that this be a standing item on Committee's agenda until we were more assured in this area. **The Audit and Governance Committee NOTED the contents of this report and the plans outlined.**	CT/SP
AG/2324/279	**Procurement Highlight Report** Lisa Innes explained that the highlight report only detailed the in-progress procurement and transactional services. The reason for that was that Craig Cook and his team had taken all the in-progress projects to look at the re-prioritisation of work. Since the last Committee meeting, the number of Ambers and Reds had reduced significantly and there were only two at risk projects with Medium/High risk for the ICB, which were: **Clinical In-progress** Wheelchair Services – This was at risk in terms of a compliance point of view; it had a 7.5-month extension under the direct award, which had been discussed at the last meeting. It was noted that we had a plan in place to recommission those services next year. **Transactional In-progress** Advice and Guidance Platform – this was subject to legal negotiations, and we were not able to progress with that until that	

	issue had been resolved, which was hoped to be by Christmas. We would then be able to go out to market in January 2024 for the re-procurement of that service. The Chair reported that the SRO for quite a few of these schemes were people who had now left the organisation and asked that this be reviewed. The Chair highlighted the phlebotomy re-procurement, which was showing green, but with an anticipation completion date of March 2024. The last sentence suggested that we were waiting for a procurement update from the Commissioner regarding what the outcome and next steps were; she asked that if a procurement exercise was needed at this stage, had we got time to do that before the end of March? Lisa Innes reported that regarding phlebotomy services, this was potentially being looked at as a wider pathway. She added that in terms of re-procuring phlebotomy (from the 1st of January), nothing had been published to the market currently for this and would fall under PSR. It was noted that there was a mechanism under PSR to be able to recommission for phlebotomy if need be. Jill Dentith assumed that Craig Cook and his colleagues would make sure we were timelining these re-procurement process to fit with any longer-term strategic conversations about changes to pathways because if not, we would miss an opportunity and then find ourselves being tied into 1–5-year contracts. Lisa Innes reported we had a couple of contracts eg MSK triage pathways, and occupational therapies that would be looked at on a pathway redesign model rather than independently. She went on to add that likewise we had a number of services to do with eyes in terms of ophthalmology and we were looking to try to commission in a more effective and efficient manner in terms of pathways. The Chair had a minor query regarding page 81, in relation to Mental Health peer support and recovery. She referred to the soft market testing which had not resulted in any bids being received. Effectively we had tried but had not been successful, however, we still had a contract that had not been let, but it was showing green. Lisa Innes reported that under the PCR15 regulations where we had been out to market and been unable to identify a suitable or qualified provider, we could go out to direct award (Regulation 32). Keith Griffiths reported that one of the learnings that we had all picked up from the 111 service was the question about affordability. He wondered how that played into Arden and Gem CSU's normal approach to contract negotiations and sign off? It had been noted from the 111 re-procurement that the process was legally secure, but the output was totally unaffordable. He wanted to make sure that the complete suite of issues was driving the procurement	LI

	process, not just the legal conformity. It was noted that we were in a difficult economic climate, and we needed to drive these contacts so that they cost us less for more; we needed a more tenacious approach than we had experienced in the past. Lisa Innes reported that the 111 contract, was a relatively unique service in terms of not wanting to publish a financial envelope threshold; that was something that Arden and Gem CSU had advised against. In terms of a commissioning point of view, it was difficult at the time for that service to quantify what it would be, as it was going to be a different delivery model including additional services, for which there was not a financial value for. Lisa Innes noted Keith Griffiths point and reported that going forward Arden and GEM CSU would do that test and challenge in terms of the financial modelling and how they could support that moving forwards. It was noted that to meet the change into PSR, she felt that they had all the quality, social value, the financial and economic rationale and reasoning to look at and support Commissioners moving forward, and to develop those templates, hopefully, more appropriately. Keith Griffiths reported that the financial outlook for next year was going to be more difficult than this year; we would have less income in the System not more. It was noted that anything we did with Arden and GEM CSU needed to be supporting breakeven in that environment, and that we would not be paying more for someone's contracts than we were able to give proportionally to our own NHS partners; Keith Griffiths felt the discipline and scrutiny in this area was going to grow. It was noted that we needed more support in managing expectations with our potential partners; we wanted the right quality of service, but we could not afford what we had been paying in the past unless we decided to prioritise proportionally. **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.**	
AG/2324/280	**Provider Selection Regime Changes and Challenges** Lisa Innes highlighted the presentation attached to the agenda papers and reported that currently Healthcare services were completed under the PPCC13 and PCR15 Regulations. From 1st January 2024, PCR15 would remove Healthcare provision from Schedule 3 and would be replaced by the Provider Selection Regime (PSR). Non-healthcare services would remain under PCR15 until the implementation of the Procurement Bill expected in October 2024. Key factors to consider were the changes to the	

	Regulations and the potential impacts and challenges the ICB may face during the transition of the new Regulations. The slide deck had been designed to provide the Committee with a high-level overview of PSR, the key changes and challenges. Future training would be delivered to ICB staff through dedicated training sessions, lunch and learns and via Commissioning Team Directorate Meeting, which were being scheduled during December 2023. The following was highlighted: • PSR would give us more flexibility and make it easier to award contracts. • The key changes from a commissioning point of view was the transparency element. • There were 5 ways in which we could award a contract, and there were 3 direct award processes (A, B or C). • The new guidance and guidelines included key and basic criteria. • We would have to publish an annual report covering all the award making decisions. • The ICB would have to log decision making, by whom and when. Therefore, conflicts of interest would pay a key part moving forwards and in terms of the governance arrangements for those decision-making processes. • The Chair asked whether we had governance arrangements in place for this as it would commence in January 2024? • It was noted that Arden and GEM CSU were putting together a toolkit, which would help with some of the templates, rather than starting from scratch. It was noted that Chrissy Tucker was in dialogue with Arden and GEM CSU. • Keith Griffiths referred to the representations process, as he felt it could be deemed to be subjective in terms of our decision making, and there was still a right to legal claim at the end of it. He liked the flexibility, but asked what we needed to be doing to prevent ourselves being open to a material amount of litigation at the end of it? • Lisa Innes explained that it was a really difficult question to answer. We wanted to make sure that we were following the new regulations and that we were being open and transparent in the publishing of our notices, but likewise, we did not really want to be the first one to do everything and then people start challenging on what we had done and why we had done it. • The process offered flexibility, if a representation did come in, we could look back at our decision making, to see whether we had made an error. If we had not and we were happy with the process, then it should be escalated up to NHSE. It did give us the flexibility to be able to review and stand by our decision. Lisa Innes reported that the work that we were doing with Craig Cook's team looking at the contracts, and the most appropriate	

	route to market following PSR and the justifications for why we had done that, should mitigate quite a lot of that. • Legal advice taken had indicated that there was no right or wrong answer to some of these representations. It would be about how we could demonstrate the justification for why we had made the decision. • The Chair asked for an update to the February meeting on the governance arrangements in place for the Healthcare Competitive Tendering process. **The Audit and Governance Committee:** • **REVIEWED the Provider Selection Regime Changes and Challenges presentation.** • **NOTED challenges and changes to Healthcare Competitive Tendering process from 1st January 2024.**	LI/CT
CORPORATE ASSURANCE		
GOVERNANCE		
AG/2324/281	**Update on ICB Re-Structure** Helen Dillistone reported that the ICB had commenced a formal consultation with staff affected by the new restructure. It was launched in November and would run for 60 days to 7th January 2024. It was noted that all colleagues had been briefed, and every member of staff had received an individual letter setting out their individual circumstances that related to the proposed structure. Helen Dillistone reported that we were in the process of receiving feedback from staff 1:1's, and meetings were being held with staff affected. It was noted that Chris Clayton had commenced an engagement process with our key providers to get their thoughts and views and to discuss wider System issues where we worked collaboratively. It was noted that all the Unions had been fully briefed and discussions with them, in the main, had been positive. Helen Dillistone reported this verbal update was for Committee to note at this stage, but at the appropriate point post consultation, and further discussions at ICB Board in January, any issues would be brought back to this Committee who had the responsibility for overseeing draft policy. **Audit and Governance Committee NOTED this verbal update.**	
AG/2324/282	**ICB Corporate Risk Register Report – November 2023** Chrissy Tucker presented the ICB Corporate Risk Register Report and as at 30th November 2023, the Audit and Governance Committee are responsible for five ICB Corporate Risks, two of	

	which were scored high, which were the risks around climate change, and the other around staff well-being. The mitigating actions and updates on those were given in Appendix 1 to the report. Regarding the staff wellbeing risk, the consultation had commenced and was open until 7th of January 2024. Staff were encouraged to provide feedback and to discuss their thoughts or get any support they needed from various sources, including their line managers or their employee assistance programme. Chrissy Tucker reported work continued with the climate change risk and explained that we would not really reduce that risk until we had made more headway with the targets that we had in our action plans. It was noted that it would be a few months before we could achieve that; overall there was no movement in scores for this month. Margaret Gildea referred to the consultation process and asked about the effects it was having on staff wellbeing? Helen Dillistone reported that the vast majority of staff would slot into a role that appeared in the new structure. However, there were still differences in the way that staff would be working, some of them would be in different teams, and have different line managers; it was not a lift and drop from CCG to ICB. It had taken a while to work out what the ICB needed in terms of not just size, but also shape of the organisation. It was noted that we had a relatively small cohort of staff where there was not a natural slot, so for those individuals we would be offering support regarding suitable alternative vacancies in the proposed structure. As a result, there was a level of anxiety amongst staff, however, we were not seeing any increase in levels of sickness attributed to this; sickness levels would be monitored, and staff would be supported. Margaret Gildea asked whether a dip in morale had been noticed, particularly with the financial resetting as well as the restructure? Helen Dillistone replied that it was difficult to tell because this time of year was so busy with Winter planning/operational plans and volume of things that we got from the regional and national teams that came in. It was noted that Winter was always quite an anxious time. Keith Griffiths gave an update on morale from the perspective of the Finance Directorate. There had been a face-to-face Directorate meeting a couple of weeks ago to go through the structures. There were a small number of colleagues who were quite anxious and that was because they were going to be embedded into other teams in the new structure. It was noted that staff welcomed the honesty and the transparency with how the process had been handled; this was certainly a very clear message from their timeout.	

	Keith Griffiths reported on differences in bandings and grades, it was hoped the restructure would bring clarity on expectations and accountability of the different grades; there needed to be equal parity regardless of the organisation you were working in – this would be a chance to reset. Jill Dentith referred to the small amount of people that would be displaced whether there would be a chance of suitable alternative employment with partners across the patch and hopefully avoid redundancies at the end point? Helen Dillistone reported that there were conversations with partners at CEO and SRO levels around the System to try and work together. It was noted that there was an HRD network who would be looking at these things in the hope of mitigating compulsory redundancy. However, it was noted that all organisations had, to a lesser or greater extent, got recruitment freezes on currently; it was a trickly period for the NHS. **The Audit and Governance Committee:** • **RECEIVED the risks which are the responsibility of the Committee as detailed in Appendix 1.** • **NOTED and DISCUSSED Appendix 2 which details the full ICB Corporate Risk Register.**	
AG/2324/283	**Board Assurance Framework Quarter 2 2023/24** Chrissy Tucker presented the Board Assurance Framework for Q2 2023/24, and highlighted the following: • The ICB Board had this report presented to them in November and they had approved it. • There was a decrease in score for two of the risks. Both came down from 20 to 16 (Risks 1 and 2) owned by Quality and Performance Committee and relating to our ability to make the increasing needs in healthcare in an appropriate way and to the urgent operational requirements that might potentially hinder the scale and pace we could achieve this with. This was deemed to be as a result of the Integrated Care System maturing and all the work that had been carried out so far and progress made, hence the reduction in those scores. • Risk 8 had been split and the element related to the establishment of intelligence and analytical solutions for decision making had been transferred to the Population, Health, and Strategic Commissioning Committee. The element relating to the prioritisation of digital transformation was retained by Finance, Estates and Digital Committee. • There were no other changes to the risk scores in Quarter 2. • The Chair felt the report summarised, for Committee's assurance, that the risks were being actively considered by each Committee when they met.	

	• The Chair asked that the following be passed back to Committees – she felt there were a couple of areas where we had actions that were all being assessed as completed, and yet we were still saying that we were only partially assured. Eg Threat 2 in relation to SR1 was showing as complete and no outstanding actions. She requested that her challenge back to that Committee would be if they were still not assured, what else needed to be done? Another instance was Threat 3 on SR2 which was in a similar position. We needed to go back to Population Health and Strategic Commissioning Committee regarding that query. • Jill Dentith requested that Chrissy Tucker and Rosalie Whitehead bring the respective Committee's attention to the above in the summary report they produce for those Committees. It was noted that Finance, Estates and Digital Committee had amended its risk scores, which would appear in Q3, at its last meeting and detailed work was ongoing. • Helen Dillistone reported that she had asked 360 Assurance as part of a developmental review in Q4, to help us further push our development around the BAF. Draft ToR had been received for this review and Kevin Watkins would be leading this piece of work. **The Audit and Governance Committee NOTED the Quarter 2 BAF Strategic risks 1 to 10 approved by the ICB Board at the meeting held on 16th November 2023.** The ICB Board: • **APPROVED** the Quarter 2 BAF strategic risks 1 to 10. • **NOTED** the decrease in risk scores for Strategic Risk 1 and Strategic Risk 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 Finance, Estates and Digital Committee to the Population Health and Strategic Commissioning Committee.	CT/RW
AG/2324/284	**Mandatory Training Compliance Report** Chrissy Tucker explained this paper reported on our activities in relation to mandatory training, our compliance and what our current position was. The report now contained a slightly amended table which added in the expected and actual percentage completion and compliance against actual numbers of staff. It was noted that there appeared to be low compliance with Safeguarding Adults Training at level 2, but on investigation this was found to be an ESR issue. The Safeguarding Team were investigating this currently, and the amended results would appear in the next report.	

	The Chair reported that she was pleased that Chrissy Tucker was following up where there were anomalies within ESR data. Jill Dentith reported that Conflicts of Interest (COI) Level 1 had appeared to have dropped off mandatory training and she had been unable to complete it as a result. It was noted that currently there was no new training for COI, it had been taken down nationally and we were awaiting a new version. Chrissy Tucker reported that the new COI module should be with us by the end of this year and uploaded onto the system for completion. **The Audit and Governance Committee RECEIVED the Mandatory Training Compliance Report.**	
AG/2324/285	**EPRR and Business Continuity Report** The Chair reported that there were a lot of papers contained within this item; there were two plans that Committee needed to approve, namely the Incident Response Plan and the Adverse Weather Plan. The other important document was Appendix 9 the Annual Report which gave a summary of the testing. The Chair felt that Committee did not need to see the details of all the actual exercises that had taken place; what the Committee needed was assurance that they had happened and that they had been reviewed by the EPRR Assurance Group. It was noted that the detailed post exercise reports were more than Members needed, unless Committee had a particular concern and wanted to go into them in a bit more detail. With this as a background, Chris Leach was asked to lead Committee through the key highlights of his report: • The Annual Report had been generated to show what had been done during 2022-23 and had been orientated around the EPRR Standards. • A submission had been done to NHSE for this year and it had been validated and had achieved a partial compliance status. • There were a number of standards that we still needed to work on that were in development. A lot of those were around System working and not necessarily around what the ICB needs to develop. We had some robust plans in place for that and a number of working groups set out across the System that were managed by the Local Health Resilience Partnership and the Health Emergency Planning Officers Group, to ensure we would deliver those over the next 12 months. • The footnote with core standards/ the whole process this year had been inordinately challenging again with NHSE, and feedback had been provided on that. It was hoped that would change the process next year and make it a little bit easier for our Providers to articulate their EPRR arrangements. • The Incident Response Plan had been updated annually in line with the emergency planning cycle. There had been a huge change to the document this year. We had now moved into a more integrated process with planning, which meant most plans	

	would now form the instant response plan as opposed to having several separate documents. This now encompassed a lot of different aspects, which were listed in the report but most importantly it would now flow for our commanders, and it also showed the System what we needed to do together to respond to incidents, as opposed to it just being an ICB facing document. • The Chair reported that the document as written were very much with our Category 1 role in mind and focused on the roles that everybody needed to play within the System and the leadership role, we needed to play around coordinating that. She felt it was a more comprehensive plan than where we were this time last year, when we were getting to grips with the more enhanced role. • It was noted that as part of that there would be a full training programme. It was a huge change especially for 1st and 2nd on call in their roles as commanders. An intense training programme was planned over the next 12 months. • The Adverse Weather Plan – there were not many major changes in this document from last time. This plan needed to be updated every six months because the UKHSA changed the guidance ever so slightly every six months in the run up to cold and hot weather. This was the Winter update of the Adverse Weather Plan. It was noted that we had included a lot of learning from storm Babet recently. • The ICB had supported the System in responding to storm Babet flooding, and we have had multiple exercises, specifically around whether we had encompassed a lot of that learning into the plan; there was not many major changes to this plan. • Keith Griffiths referred to conversation he had recently with EMAS and what was expected of them as a consequence of the recent Manchester Arena bombing, and the report and recommendations that came out of that, and asked whether there was something material that they needed to change/incorporate in their operation? • Chris Leach reported that from the Manchester enquiry, the ambulance service had received a lot of recommendations in the Northwest, so that would be what EMAS was alluding to. They had a lot of work internally to do around training and hazardous area response team provision. The second element was Martins Law, which was in the process of being passed, which would change the way we dealt with some mass gathering sites, that would be guided by emergency services and the local authority. As a Health Service we would probably find in next year's iteration of the Incident Response Plan that it would be similar to how we deal with our control of a major accident hazard site, eg Rolls Royce in Derby as a radiation site, we may need to include a section around those mass gathering sites, because there was an increased risk around mass casualty elements there. • The other element would be around psychosocial support and mental health provision, this was a piece of work that had been rumbling on for years, and it had to be done from a national perspective because of how spread out the mental health	

	services were. But we were very closely linked in with Derbyshire Healthcare and had a work stream specifically for psychosocial support in emergency situations. It was hoped this would be included in the next 12 months and was led by Nottinghamshire Healthcare. As a region we were having to work with Nottinghamshire Healthcare via Derbyshire Healthcare to get some of these elements in place and Derbyshire was in a relatively good position with regards to the psychosocial support, purely because of the work Derbyshire Healthcare put in by themselves in response to a number of incidents they had seen over the years. • Jill Dentith referred to section regarding emergency incident report staff, and in particular the number of loggists required. She asked in terms of the ICB's reorganisation and 30% reduction in staffing, whether this would be a problem? Chris Leach reported that there was a plan in transit about how we were going to deal with the loggists required for meetings in the next 12 months. It had been calculated that we needed 18 loggists and currently we had 11, there were several more in the pipeline awaiting training. It was noted that a lot of our meetings were recorded now, and we were awaiting national guidance as to whether this was allowed. Up to date there had been no problem with loggist coverage of incidents. **The Audit and Governance Committee:** • **NOTED the EPRR and Business Continuity Update.** • **APPROVED the DDICB Incident Response Plan and the DDICB Adverse Weather Plan.**	
AG/2324/286	**ICB Equality, Diversity & Inclusion Report** James Lunn presented the ICB Equality, Diversity and Inclusion Report and highlighted the following: • As an employer, the ICB aimed to be inclusive and ensure staff were treated with equity. • The 2022 staff survey results suggested that the lived experiences of our Black, Asian, and ethnic minority colleagues and those with a disability and/or who identify as LGBTQ+ could be worse in some cases when compared to staff who identify themselves outside of these groups. For example, less likely to recommend the ICB as an employer, more likely to have experienced bullying, discrimination, and harassment, less likely to consider that the organisation acts fairly in relation to career progressions or values difference and more likely to leave. • On 7 June 2023, members of the Diversity and Inclusion Network (D&IN) and the Organisational Effectiveness and Improvement Group (OEIG) met to discuss the staff survey results with a view to recommending actions for consideration by SLT.	

	• The D&IN recommended some actions for the ICB, which were detailed within the report (Appendix 1) to help improve the lived experiences of often marginalised groups, stating that senior leaders needed to take ownership and drive forward equity within the ICB. • The report detailed how the ICB was performing in relation to the Workplace Race Equality Scheme. Key things highlighted from that was that we had a slight reduction in black and minority ethnic representation within the ICB and the data from recruitment told us that they were less likely to be successful in each stage of the recruitment and selection process and less likely to feel that we provided equality of opportunity for progression. • Regarding the Disability Equality Scheme, we had seen an increase in the number of staff declaring that they had a disability since we launched the Disability Policy and Reasonable Adjustment Guide. • In terms of the gender pay gap, this was the first report for the ICB, but we had previously done them in the CCG. Like most areas of the NHS, the majority of the workforce tended to be female, with a higher proportion of females in the lower banded positions, which did give us a gender pay gap, as detailed in the report. • In terms of bonus payments, which produced long service awards, there was no differential between male and female, so there was no bonus pay gap. • The last part of the report updated the Committee around the National Equality and Diversity Action Plan and the six high impact actions that they were asking all organisations to undertake with the aim of improving Equality, Diversity, Inclusion enhancing that sense of belonging for all staff within the NHS. Those six high impact actions set by NHSE were the ones that we were prioritising within the ICB. • An action plan was included within the report indicating a red, amber, and green status in terms of how the ICB was doing. The report also included details regarding: ◦ Workforce Race Equality Standard (WRES) ◦ Workforce Disability Equality Standard (WDES) ◦ Gender Pay Gap Report ◦ Staff survey outcomes for LGBTQ+ colleagues ◦ NHS Equality, Diversity, and Inclusion Improvement Plan • The Chair referred to the feedback from network colleagues around feeling the need to reset the culture of the organisation from the top down. It was noted that the ICB Board was going through quite a detailed building leadership for inclusion set of sessions, the Chair's understanding was there may be an opportunity to tailor how we take that forward. The Chair asked Helen Dillistone to take this as an action to ensure that we were actively considering this concern raised from network	HD

	colleagues as part of that training. We would need to go back to the networks regarding how we propose to address this. • Helen Dillistone briefed Committee on the work that was happening at Board level. The Board had acknowledged the importance of rolling that programme out to the wider SLT as well. It was noted that Helen Dillistone and Linda Garnet were in discussions about how this could be done including timelines; there was a suggestion that there could be some combined sessions with the Board. Helen Dillistone reported that she had emailed the network to see if she could attend some of the meetings to talk about the work that had been happening in that programme, and to engage more widely with the group. • Margaret Gildea reported that there were examples of best practice within the System. It was noted that some of the Trusts had completely overhauled their recruitment process to what they called 'disrupt' them and had seen beneficial results in terms of EDI. • Helen Dillistone reported that she would meet with James Lunn and Linda Garnet to map out where things needed to go to ensure we were taking the right conversations to the right Committee. • The Chair referred to the action plan and asked Helen Dillistone whether we were actively ensuring that any relevant actions were being applied to the restructuring process? • Helen Dillistone reported that as part of the restructure, we had undertaken an Equalities Impact Assessment to ensure that that was being considered as part of the work we had been doing to develop the structure and capture that from colleagues as we progressed through the consultation. **The Audit and Governance Committee:** • **NOTED the Equality, Diversity and Inclusion data and trends within the ICB, with reference to the:** ○ **Workforce Race Equality Standard** ○ **Workforce Disability Equality Standard** ○ **Gender Pay Gap Report** • **NOTED the requirements of the National NHS EDI Improvement Plan** • **RECEIVED assurance on progress made.**	
FINANCE		
AG/2324/287	**ICB Financial Position Review – Month 7** Darran Green presented the ICB Financial Position Review for M7 and highlighted the following: As of 31st October 2023, the ICB financial position was £5.1m overspent YTD and had a forecast breakeven position. However, this had been achieved by recognising the £6.0m Dental underspend and there was now a requirement to deliver a minimum	

£5.8m of additional savings due to the pressures we were currently experiencing and to mitigate potential further risk as the financial year progresses.

The following was highlighted:

- NHSE had made it clear that all NHS organisations should continue to report a breakeven forecast outturn for 31st of March 2024.
- However, at the time of writing the report, the most likely forecast outturn position for the ICB was a deficit of just shy of £22m. All of this was due to the impact of excess inflation, which was above the levels that were funded. Presenting the position in this way highlighted that issue to the Regulator. It was noted that some of the excess inflation was anticipated and funded in the plan that had been produced, and we also had some balance sheet benefits that had yet to be included into that position.
- In terms of efficiencies, the plan for the year was to deliver £44m and the current forecast was that we would achieve that £44m and an additional £1.5m against that plan.
- Since that position was finalised and reported, NHSE had required each System to provide what they had called a financial reset, which was a detailed analysis of what was genuinely expected to be the most likely outturn position.
- Included in this reset, but not in the M7 positions, was the receipt of an additional £12.2m for the impacts of industrial action to date, and the application of the elective Recovery Fund Guidance, which NHSE had been asking Systems to ignore up to M7.
- The inclusion of both of these would see an improvement to the ICB's position.
- It was noted that when we did the work on that reset, it gave the System a forecast £47.3m deficit and in reality, the ICB's share of this would become clearer when the £12.2m given for industrial action was distributed and the Elective Recovery Fund rules were applied.
- It was important to note that this reset requirement was very clearly laid out, and we had been told to assume that there would be no further industrial action. Clearly, we now know that there was going to be two significant periods of industrial action prior to Christmas and early in the New Year.
- There remained a significant level of uncertainty in the coming months for the whole of the NHS, making it difficult to predict what the ICB's final outturn position was going to be.
- In terms of delivery against the plan that we agreed at the start of 23/24, Darran Green was confident that we would be more or less as an ICB Statutory Body, very close to delivering that plan.
- Darran Green reported that there had been a considerable number of other issues that could not have been envisaged at the time of writing the plan, and some of these were going to have an impact, although every effort was being made to mitigate these.

	Jill Dentith thanked both Darren Green and Keith Griffiths for the way they had articulated the position; it had been made very clear where we stood and the actions that were being taken to get us to this point. It was noted that there were still factors unknown in terms of any future industrial action. The Chair agreed with Jill Dentith, she too felt that non-Executives were being kept very well informed of the difficult decisions that were having to be taken across the System to get to the position highlighted above. It was noted that it felt like we had got transparency across the System, and the Chair echoed her thanks for the hard work going on behind the scenes. **The Audit and Governance Committee NOTED the ICB Financial Position for M7.**	
AG/2324/288	**Losses and Special Payments/ Aged Debt/ Write Offs Report** Donna Johnson presented the Losses and Special Payments/Aged Debt/Write Off Report as at 30 September 2023 and highlighted the following: • There was a £1k risk relating to four credit notes, with a supplier. The ICB continued to be in contact with the organisation, recovery was expected in September; however, the sale of the property fell through, and it was now back on the market. The supplier continued to advise that when the property was sold, the ICB would be reimbursed. This had been deemed a low risk. • There was a second risk surrounding a loss totalling £4k, which was a suspected fraud. The ICB was following a recovery process, and the situation was being investigated by Local Counter Fraud Service. There had been a complete lack of response from the recipient, and hence this was considered a risk. • There had been one special payment; an ex-gratia payment for out an of court settlement, which was discussed at Confidential Audit & Governance Committee earlier this year. Formal agreement was in the final stages; the current expected cost was £120k. This would be shared with NHSE for approval. **The Audit and Governance Committee:** • **NOTED the quarterly report contents regarding the level of aged debt as at 30 September 2023.** • **October information had been reviewed; there were no significant changes and nothing of concern to note.**	
AG/2324/289	**Single Tender Waiver Report (STW)** Donna Johnson informed members that this paper included a report for the STWs received and approved following those	

	reported at the ICB's August 2023 Audit & Governance Committee up to 30th November 2023. The chart on page 2 of the cover sheet demonstrated the cumulative number of STWs across the current and previous years. The level of STWs was comparable up to August, however, there has been a spike in September and October; 70% of these related to complex patients. It was noted, therefore, that this did not indicate a failing in the ICB's procurement processes. Jill Dentith noted the fact that the volume of STWs was predominantly down to complex patients, but there also seemed to be a lot in relation to primary care as well. She asked whether we were making sure that we were using the correct procedures when we were going out to the market? Donna Johnson reported that this was where the ICB received SDF monies, we did not know when we were going to get them or indeed how much. Commissioners believed that there was a reduced number of possible providers in the market that could deliver these services. It was noted that Commissioners were working with Arden and GEM CSU to understand how we could procure for such contracts when we did not know how much funds were going to be made available. Donna Johnson reported we always gathered as much evidence as possible to demonstrate the GPs were really the ones in the best position to deliver some of those. Darran Green reported in a lot of these cases, the services had to go to GP's because to deliver the service you needed access to the patient notes, and it was only the practice that a patient was registered at would have access to those notes. There was usually quite a range of reasons why STWs were used through primary care. Jill Dentith asked whether we were confident that people were not using this route because they could not be bothered to go through the formal procurement process, and they were using STWs because it was the only mechanism, they had got available to them? Donna Johnson assured Jill Dentith that she and her team thoroughly challenged each STW when they came in, before recommending to the CFO/CEO for sign off. The Chair referred to St Andrews Healthcare STW which appeared to include capital and asked if there was a particular reason why we had a capital waiver? Donna Johnson reported that it would certainly not be the ICBs capital; it was a grant to a mental health provider to purchase capital equipment. The Chair then returned to the question about STWs for complex patients and reported that there appeared to be a lot placed with a small number of suppliers. She asked whether there were any	

	options for developing framework contracts for some of these specialist providers if we were using them a lot? Donna Johnson reported that we had got frameworks in place wherever possible. But explained that often with these places, because there was such a reduced number, we could not always find places within the framework. It was noted that each of these cases go through a number of panels, including the Commissioning for Individuals Panel, and they thoroughly challenged each one of those to make sure it was right for the patient, but also to make sure that the fees were reasonable, and they did compare them with what we had been charged historically with alternative providers. **The Audit and Governance Committee NOTED the report of Single Tender Waivers approved by the Chief Finance Officer, and Chief Executive Officer.**	
ITEMS FOR DISCUSSION		
AG/2324/290	**Audit & Governance Committee Effectiveness** The Chair reported that our Internal auditors had shared a report on ICB Committee effectiveness, and recommended all Committees undertake a review to include the following questions: **Reflect on the defined responsibilities of the Committee and whether adjustments were required, if so, update ToR:** • The ToR for this Committee were reviewed and updated in September 2023. • It was noted that in the shift from the CCG to the ICB, this Committee had been combined into the Audit and Governance Committee. • It was noted that members were content with the ToR for this Committee. **Ensure that the forward planner allowed for the defined responsibilities to be met:** • It was noted that this Committee had a very comprehensive forward planner which included all the policies and plans that were coming up for review, together with various scheduled deep dives. • Reports from subgroups were also included within the forward planner. **Include in ToRs the sub-groups that were established and any matters delegated to them, review whether additional sub-groups or delegations were required:** • The slide in the attached power point presentation showed the subgroups that existed. The Chair was happy with three out of the four subgroups, but asked what the Delegated Functions Programme Board did?	

	• Chrissy Tucker reported this Board looked after the functions that were coming to the ICB from NHSE regarding Pharmacy, Optom and Dental. • Helen Dillistone explained that this group would oversee the process of transition; it was about ensuring that we safely received them and that we had got our systems and processes in place to receive them. • The Committee was content with the subgroups that we had. • Chrissy Tucker suggested that the subgroup structure be included within the ToR. **Review membership and monitor attendance at least annually, also review frequency of meetings:** • The Chair felt we had the right people regularly attending this Committee. • It was noted that if Committee needed anyone specifically to attend in relation to any reports, it had not found this to be a problem. • Keith Griffiths reported that for the last couple of meetings we had not had anyone from the ICBs commissioning team attend. It was noted that Craig Cook had been requested to attend this Committee, but for various reasons he had given his apologies at the last minute. As a result, when Arden and GEM CSU were reporting here, there was no-one from the ICB to provide a Board level response into the commissioning arena. Keith Griffiths agreed to speak to Michelle Arrowsmith about how we could bridge that gap for future meetings.	KG
FOR INFORMATION		
AG/2324/291	**Non-Clinical Adverse Incidents** Chrissy Tucker reported that there had been no non-clinical adverse incidents. It was noted that there would be further Junior Doctor strikes scheduled from 20th to 23rd of December 2023 and from 3rd to the 9th of January 2024. **Audit and Governance Committee NOTED this verbal update.**	
MINUTES AND MATTERS ARISING		
AG/2324/292	**Minutes from the Audit and Governance Committee Meeting held on 12 October 2023** The minutes from the meeting held on 12 October 2023 were agreed as a true and accurate record.	
AG/2324/293	**Action Log from the Audit Committee Meeting held on 12 October 2023** The action log was reviewed and updated during the meeting.	

CLOSING ITEMS		
AG/2324/294	**Forward Planner** The Chair requested that a Forward Planner for next year be compiled and brought to February's meeting. **The Audit and Governance Committee NOTED the Forward Planner.**	CT/SP
AG/2324/295	**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? **NO**	
	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? **NONE**	
AG/2324/296	**Any Other Business** There was no further business.	

DATE AND TIME OF NEXT MEETING
Date: Wednesday 8 February 2024
Time: 2.00PM
Venue: MS Teams

Signed: …… Dated: ……..
(Chair)

MINUTES OF THE AUDIT AND GOVERNANCE COMMITTEE

HELD ON 8 FEBRUARY 2024 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 (part)
In Attendance:		
Sarraf Arpit	SA	Audit Manager, KPMG (part)
Andrew Cardoza	AC	Audit Director, KPMG
Ged Connolly-Thompson	GCT	Head of Digital Development & Digital Health Skills Development Network Lead (part)
Helen Dillistone	HD	Chief of Staff
Debbie Donaldson	DD	EA to Chief Finance Officer (note taker)
Darran Green	DG	Acting Operational Director of Finance
Lisa Innes	LI	Associate Director of Procurement – East (part)
Donna Johnson	DJ	Acting Assistant Chief Finance Officer
James Lunn	JL	Assistant Director of Human Resources and Organisational Development (part)
Usman Niazi	UN	Client Manager, 360 Assurance
Glynis Onley	GO	Assistant Director, 360 Assurance
Suzanne Pickering	SP	Head of Governance (part)
Chrissy Tucker	CT	Director of Corporate Delivery
Apologies:		
Craig Cook	CC	Director of Acute Commissioning Contracting and Performance/JUCD Chief Data Analyst
Keith Griffiths	KG	Chief Finance Officer

Item No.	Item	Action
AG/2324/297	**Welcome, introductions and apologies.** Sue Sunderland as Chair welcomed all members to the meeting. Apologies were received from Keith Griffiths, and Craig Cook.	
AG/2324/298	**Confirmation of Quoracy** The Chair declared the meeting quorate.	
AG/2324/299	**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/2324/300	**External Audit: 23-24 Work Plan** Andrew Cardoza highlighted the following: • The planning and risk assessment work was nearly complete, thanks to Donna Johnson and her team, ahead of time. • The final Audit Plan would be brought to the next Committee meeting on 14th March 2024.	
INTERNAL AUDIT		
AG/2324/301	**Internal Audit** **Progress Report:** Since the last Audit and Governance Committee 360 Assurance had: • Issued the final report resulting from the Financial Ledger and Reporting review (substantial assurance). 360 Assurance had found the ICBs controls in relation to the financial ledger reporting to be operating effectively, based on the sample testing of the specified controls, and no recommendations had been made. • Issued the final report resulting from the Accounts Payable, Treasury and Cash Management Review (substantial assurance). The sample testing of controls within the ICBs boundary found they were operating satisfactorily. 360 Assurance had raised one advisory action relating to the absence of cash reporting of the ICBs position. • Issued the final memo resulting from Stage 2 of their 2023/24 Head of Internal Audit Work Programme. No formal findings or actions had been raised. Since completing Stage 1, 360 Assurance had made a few observations in relation to the BAF; they felt it could be strengthened to include cross referencing of gaps in controls and gaps in assurances to the relevant actions. There was scope for further strengthening of the BAF, such as the addition of revised due dates for actions not implemented within their original time scale, and some of the controls being worded in a way that specifically addresses the risk areas. • 360 Assurance had attended November Board and the November meeting of the Finance, Estates and Digital Committee to observe the discussions held around the Risk Register and the BAF. It was noted that 360 Assurance had seen plenty of evidence in both of those meetings of scrutiny	

	and challenge by Non-Executive and Executive Directors of the BAF risks. • 360 Assurance had carried out a survey of Board Members to understand their views on the effectiveness of the governance and risk management arrangements. For the majority of questions that were asked as part of that survey, there had been a high proportion of positive responses on the use of the BAF and Risk Register. There had been a small number of Board Members who responded unsure, and one Board Member who disagreed with some of the questions in the survey. One of the questions in the survey was around whether there were clear and effective risk management and escalation processes followed throughout the organisation. Full results of the survey were attached as an appendix to the memo, for the ICB to reflect on the comments received as part of the survey. It was noted that some of those Board Member survey comments would be addressed with the Committee Chairs to enable the ICB to understand these in more detail. • Developed and agreed the Terms of Reference for the Risk Management Development review. • Made a start on the Stage 3 Head of Internal Audit Opinion Work Programme. • The Chair referred to the survey of Board Members, she suspected that the people who disagreed with this survey were not Committee members and were partner members of the Board. • Helen Dillistone agreed with the Chair, it appeared to be one individual who did not fully understand our risk processes, and looking at the narrative, it appeared to be a partner member from outside of the NHS. It was noted that we needed to do some further and targeted work with that individual to help engage them. • The Chair reported that she regularly meets with Audit Chairs across the system, and she had shared the BAF with them, and they had been pleasantly surprised that it reflected System risks and that it was targeted at System level, not just duplicating their risks. • Jill Dentith agreed with the above comments made by the Chair and Helen Dillistone, and reported that System Finance, Estates and Digital Committee had a conversation at every meeting specifically looking at the BAF and Risk Register and how it linked with the progress that we were making in terms of our financial position. She went on to add that if it was an external person who sits on the Board then they needed to be fully assured of the processes we use and be able to feel that they could get assurance from those processes. It was noted that Kevin Watkins was doing some work on system processes, and he had arranged to meet with her in the next couple of weeks which may help to triangulate this. • Jill Dentith reported that as a result of work done by 360 Assurance, each Committee had done a more detailed piece of work reviewing their ToRs and how they fitted in with their	

	Forward Planners and thinking about the Risk Register and BAF in that context. • Jill Dentith asked that her thanks be sent to the corporate team regarding the follow up rate on the actions; these were much improved since we had the conversation last time. • Margaret Gildea endorsed the comments made by Jill Dentith above. She reported that we had gone over in Committee many times how well we are handling the BAF, and she felt we could come to a point where we could irritate some of the System wide members by over analysing how we did things, rather than driving improvement forward. She felt there was a risk that bureaucracy may mean that these members will not be interested in continuing to attend these meetings; she reported that this was particularly true of those attending People and Culture Committee. • The Chair asked Helen Dillistone to give consideration of how we could ensure everyone on the Board (including System partners and people outside of the NHS), were fully briefed around the BAF and how it worked. Follow up of Actions: Usman Niazi reported that he and Glynis Only had met with Chrissy Tucker and Suzanne Pickering regarding the follow up of actions. As a result of that meeting, a couple of the low-risk actions had been re-marked as implemented on time, which had meant an increase in the first follow up rate, which at the time of writing this report, stood at 95%. It was noted that this now puts the ICB in the Significant Assurance category as far as the follow up of actions were concerned. Planning for 2024/25: 360 Assurance had commenced initial planning conversations for 2024/25 with the ICB. There had been some suggestions received from Executive Directors for reviews to be included in the 2024/25 Internal Audit Plan. A draft Plan had been shared with the Executive Directors which sets out the 'core' reviews proposed for 2024/25 alongside consideration of audits included in the three-year strategic plan and other risk-based work. 360 Assurance would attend the Executive Team meeting on 28 February 2024 to discuss the draft outline plan. It was proposed that the Internal Audit Plan be reported to the Audit and Governance Committee on 14 March 2024 for review, consideration, and approval. **The Audit and Governance Committee NOTED the Internal Audit Progress Report.**	HD
AG/2324/302	**Internal Audit Recommendations Report** Chrissy Tucker reported that the Internal Audit Recommendations Tracker detailed the recommendations required from the outcome of the individual audit reports. Responsible leads were required to upload evidence to demonstrate the completion of the required recommendations and actions. The online tracker also identified those that were outstanding, and the Corporate Delivery Team	

	were required to monitor and request updates on these to ensure that the ICB meets its aim of a 100% completion on all actions. This percentage was a key area of the Head of Internal Audit Opinion. Chrissy Tucker highlighted the following: • The report showed all the actions that had been implemented within the timescales on page 1. • Line 4, page 1 Place – this note had been superseded. There would be a further review on Committee risk management development, and Place risks would be considered by that process. Place would escalate any risks up to the ICB's corporate Risk Register. • Page 2, there were a number of actions yet to be completed which were under the Committee Effectiveness Review - they were due to be completed by the end of March. • Actions around Data Quality and Performance Management were not due until April or later. • Actions around Mental Health Assessment Claims were due end of February. An action plan had been developed by the team and shared with the Local Authority. No feedback had yet been received from the Local Authority and meetings were being set up to work through that with those colleagues. **The Audit and Governance Committee NOTED the Internal Audit Recommendations Tracker.**	
FOR DECISION		
AG/2324/303	**<u>Information Governance Policies</u>** • Information Governance Framework Policy • NHS Network, Internet, and Electronic Mail Acceptable Use Policy • Records Management Policy • Subject Access Request Policy • Confidentiality and Data Protection Policy • Information Security and Incident Management Policy • Data Protection Impact Assessment Policy • Data Security and Protection Toolkit Policy • IAO, IAA, and Information Flow Mapping Policy • Safe-Haven Policy Ged Connolly-Thompson presented the above Information Governance Policies and reported that there had been no material changes from when this Committee had reviewed them last year. It was noted that these had been through, and approved, at IGAF with the Caldicott Guardian. Jill Dentith suggested (if it had not already been done), for something to be included in the overarching document which described the difference between a policy and a procedure.	

	Members of the Audit and Governance Committee were content to approve each of the listed policies above. **The Audit and Governance Committee APPROVED the suite of ICB Information Governance policies.**	
PROCUREMENT		
AG/2324/304	**Procurement Highlight Report** Lisa Innes presented the Procurement Highlight Report and highlighted the following: • PSR had come into full force on 1 January 2024. • Lisa Innes had been working with Craig Cook and his team to ensure compliance moving forward and had offered support with the contract register. • Living Well Service (Amber status). ITT was due to close 21st December 2023; however, new information had come to light which suggested that published activity was likely to have been significantly underestimated. Due to the potential impact of this, the ICB made the decision to abandon the procurement process, robustly review activity, model and budget and re-procure ASAP in 2024. The new contract was initially due to commence 1st June 2024. • Wheelchair Service (Amber status). Commissioners were planning for a procurement to be undertaken in 2023 with a new contract to commence January 2024. However, the ICB extended the current contract by a period of 7.5 months to allow for a procurement process. The ICB were unable to comply with Reg 32 but proceeded with extension at their own risk. Commissioners were engaged in undertaking a new procurement process to help mitigate risks. New ITT was anticipated to be published in February 2024, with the new contract to commence September 2024. • The Chair expressed concern regarding the ICB deciding to go at risk with the extension of the procurement process for the wheelchair service, and asked why, and whether it was appropriate for the ICB to do so. It was noted that Craig Cook had not been able to attend this meeting to explain the reasoning behind this. • Lisa Innes explained that the original risk came in terms of the 7.5 months extension option and the date when the original contract was due to expire. The extension option did not comply under Reg 32 and for the material changes required, so that was where the ICB was proceeding at risk; this had been notified to the market. It was noted that we were intending to go out to procurement, so those risks had been mitigated. We needed to ensure that under PSR Regs that this was completed on time. • Lisa Innes reported that advice and guidance for projects pre-1 January had been given under PCR15; after 1 January PSR Regs applied. She was working with Craig Cook and his team to ensure that this transition was as seamless as possible.	

	• The Chair asked why the governance route for sign off for the wheelchair service was still to be confirmed when we were well into the procurement. • Lisa Innes apologised and confirmed that this was an omission. She agreed to get that updated before the next report to Audit and Governance Committee and ICB Board. • Transactional services – Advice and Guidance Service. The IT platform was currently being re-procured. Craig Cook was currently taking a paper through the Executive Team after half term. It was hoped that an action plan for this would be ready in the next two weeks. • Jill Dentith referred to the NEPTS service, it had been republished for the third time and asked why it was so difficult to get this contract let. • Lisa Innes reported that the NEPTS contract was currently in the evaluation stage, and it was hoped that it would be concluded soon with an outcome report due in the next week or two. The reason it had been abandoned on the previous two occasions was due to data and incorrect activity issues, which had been outside of the ICB's control. • The Chair asked about the Community VCS infrastructure and signposting which had a completion date of 31 March. It appeared that procurement had been awaiting a response from the ICB and that there could be potential risks and challenge, but it was still rag rated green. • Lisa Inness reported that regarding the VCS contracts, conversations had been held with commissioning leaders, but it was potentially going through some contractual levers in terms of modifications and existing contracts; there would not necessary be any procurements as a result of that because some of these were for grants or transaction services and we could do a modification under the PCR 15 Regs. This was why there was no procurement action, and through contractual levers, the ICB was going to be managing those services. • The Chair referred to Restorative Supervision, this flagged up some concerns that maybe there was a lack of communication between procurement and the ICB on the grounds that there were a lot of 'to be confirmed' and procurement had not had an update since November 22. • Lisa Innes reported that for transactional services, Procurement often found that transactional provisions were very reactive (they found out about them within weeks of them coming to fruition). It was noted that in terms of this update report, Procurement had a number where there had been no contact and no engagement with the ICB. Because the ICB were normally quite timely, Procurement would assume that if no contact had been made after March, then they would come off the report. Procurement was chasing up with the individual service leads, but in the absence of no response, chances were that another process had occurred, or a direct award had been made that Procurement were not sighted on. • The Chair asked from an assurance position, how could Committee be assured that something had happened and not	LI

	been forgotten about. It was noted that we needed some assurance from the ICB that this was being followed through. • Chrissy Tucker reported that the next report (Procurement Process Review) may help answer this. • Lisa Innes reported that from a Procurement point of view, they conversed with the individual service leads regularly to complete this highlight report (at least monthly for updates). However, if no updates were received over a period of six months, they assumed contracts could be added to their completed list until they were told otherwise. **The Audit and Governance Committee NOTED the status of projects, Current Clinical and Transactional Procurements, Future Clinical and Transactional Procurements and Completed projects contained within this report.**	
AG/2324/305	**Procurement Process Review and Provider Selection Regime Update** Chrissy Tucker presented the Procurement Process Review and Provider Selection Regime Update and highlighted the following: • Following various conversations at Committee, this update aimed to provide members with assurance regarding how the ICB was managing its procurements and how we could assure ourselves that the ICB were acting compliantly and if not, compliant we knew it was being appropriately governed. • Appended to this report was an action plan giving an outline plan of the main areas being worked on in relation to the work streams mentioned at the last committee. • The report also touched on some of the governance aspects of the PSR regulations. • Early last year we became aware of some new software known as Atamis, which had been seen previously in CCGs, but was now being offered by the Department of Health and Social Care (DCHS) gratis, which had the capability of managing contracts, provide alerts and reports. It would effectively enable us to put in our commissioning project plans, looking at all the stages of the plan; it would provide reports, dashboards, reminders of start dates, rag ratings etc, and provide a much better oversight and less manual way of reviewing contracts. • A paper was going to Executive Team next week, and once approved, we would be able to sign the Memorandum of Understanding with DHSC. • As part of the initial work, we already had the templates from Atamis to complete what contracts we had that were live currently and what transactional and clinical procurements we had got planned for 24/25. • An oversight and assurance group would be established with the following responsibilities: • Oversight and management of the annual commissioning/decommissioning plan.	

	• Discuss commissioning projects and intentions. • Oversight of procurement and contracting timescales. • Act as approval gateway for work to be undertaken by the CSU. • Oversight of performance of the CSU. • Link to the System Planning Group. • It was proposed the group would meet end Feb/early March and a proposal would be taken through PHSCC for the group to have delegated decision-making responsibilities for clinical commissioning activity, to an agreed budget. PHSCC would receive an annual commissioning plan for approval, which the oversight group would enact, reporting in to provide assurance on progress or by exception. Non-clinical procurement plans for 24/25 were being gathered and would go through their relevant governance processes in the same way. This group would also provide assurance on processes and compliance to this committee. • Draft ToR were going to the ICB Delivery Group next week for review and to get membership nominations. To support this, a commissioning cycle training programme would be sourced and tailored to suit the ICB, providing a refresher of the key elements of the cycle, including the contacts and teams that could support following the restructure and the Provider Selection Regime. The draft training outline would be shared with the ICB Delivery Group to gain input and feedback. • Future model of work with CSU - planning work was underway for 2024/25, was due to be completed by mid-February, to enable us to consider the likely volume of work and whether that could be completed within the current, or the desired reduced budget for next year. The outcomes would be presented to the Executive Team. • No PO, no pay - a small working group was in place to ensure the ICB was ready for the 1 April deadline. Exceptions to the rule had been agreed (eg commissioning for individuals); the project would be further informed by the outcome of the future model of work with the CSU, and the volume of purchase orders that the CSU would be required to process. • SoRD Governance Review - commissioning colleagues had supported this review by providing examples to work through using our existing SoRD. The work was not yet complete, and a paper would be taken through the Executive Team with any recommendations for change. The SoRD was also being reviewed for any changes needed in light of the Provider Selection Regime (PSR) requirements. • Provider Selection Regime (PSR) - in December the committee received an overview of the new regime. The ICB was working with AGEM CSU on a number of actions to support adherence to these new regulations. It was noted that AGEM CSU was guiding the ICB on any new clinical procurements to ensure compliance. Further progress on Atamis would provide an understanding as to how that system would support the required audit trail and compliance reporting.	

	• Helen Dillistone reported that she and Michelle Arrowsmith were fully sighted on what had been set out and the action plan related to PSR. • Helen Dillistone reported that for assurance purposes, she presented to the System Chief Executive Group that met monthly, to give a headline overview of what PSR was, what it contained and how it was going to potentially work. Feedback from that had been interesting, one of the areas of risk that they identified was that the 11 ICBs (particularly those Providers that might have arrangements or potential future arrangements with other ICBs), may be interpreting the risks and guidance slightly differently. There had been an action from this for Helen Dillistone and Chrissy Tucker to explore with other ICB colleagues regarding consistency. • The Chair highlighted the action plan, one of the actions had got a mid-February date, which was around reviewing contracts due to expire before March 24 and there was a question mark particularly with the clinical procurements that had a mid-February completion date. The Chair asked for an update, as she felt this could be a worry looking at the highlight report. • Chrissy Tucker reported that Craig Cook was dealing with this, and she agreed to speak to him outside of this meeting to check on progress. • The Chair asked Chrissy Tucker to flag any risks to Committee outside of this meeting once she had spoken to Craig Cook. In addition, the Committee had previously asked for a review of the 'going at risk' procurements, to include how the risk was established, mitigations, and who was responsible; Committee needed to understand how these were being managed and how they were proposed to be managed going forwards. This needed to be included on the action plan. **The Audit and Governance Committee NOTED the content of this report.**	CT/CC CT/CC
CORPORATE ASSURANCE		
GOVERNANCE		
AG/2324/306	**Update on ICB Re-Structure** Helen Dillistone gave an update on the ICB Re-Structure and highlighted the following: • The Consultation closed at the beginning of January 24. • There had been good levels of engagement from staff. • There had been an MS Teams meeting this morning Chaired by Chris Clayton, with support from HR and the Executive Team, to present back to the organisation the headlines and themes from our respective directorates and more broadly across the organisation. • 450 letters would subsequently be going out to individuals via email to confirm what this meant in terms of their status and their roles going forwards.	

	• The close of consultation document was ready along with detailed new structures.
	• Each Executive was in the process of holding/organising a whole directorate session where they could get into more detailed specifics for each of those directorates and enabling staff to raise any questions directly with their respective Executive.
	• There had been four areas of broad themes which had come out:
	
	  • The process itself – staff were quite naturally anxious about the degree of uncertainty. Lots of technical questions around the slotting process, the ring fencing of roles, vacancies and who could apply and when.
	  • Structures themselves – thoughts and feedback around some of the admin level roles and capacity – this was being picked up and addressed where appropriate and where relevant.
	  • Job Descriptions – some were too generic, and more detail was required around scope of roles. This was being picked up.
	  • How was this going to work, what did it mean in terms of matrix working, and how were we going to work differently as a team. This had been a top to bottom re-structure and more work was required on the OD Plan.
	
	• Helen Dillistone reported that she had been leading on the OD work with Linda Garnett, Interim CPO, and the Executive Team, on how we construct our OD plan, of which structures was one part of that.
	• We were now into the implementation stage, and it was noted that we would continue to support staff.
	• Helen Dillistone agreed to share the slides from the meeting this morning with Committee members together with the consultation document.
	• Jill Dentith asked whether there had been a base conversation at the meeting this morning.
	• Helen Dillistone confirmed that this had been part of the conversation this morning. The proposal to move the ICBs headquarters to Derby City Council premises in Derby was an important part of the running cost reduction element of this piece of work. It was noted that the proposal to move the headquarters had now been agreed, and significant savings would come as a consequence of that. It was noted that Chrissy Tucker and the Estates team were working through the mechanics of that. Feedback from staff, in the main, had been positive to the move.
	• Helen Dillistone reported that there had been some interest from parties wishing to take the ground floor at Cardinal Square which would give the ICB some income and help towards our running costs reduction.
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	• In terms of Scarsdale in Chesterfield, the ICB were taking a reduced footprint, again, making some significant savings in the north of the county. Some rooms were being taken by other partners in the System, as we did not need all the footprint that we currently held at Scarsdale. **Audit and Governance Committee thanked Helen Dillistone for her verbal update.**	
AG/2324/307	**ICB Corporate Risk Register Report – January 2024** Chrissy Tucker reported that as at 31st January 2024, the Audit and Governance Committee were responsible for five ICB Corporate risks (updates were given in Appendix 1); two of the risks were currently scored high. It was noted that one risk was recommended to be increased in risk score: Risk 15: *The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI.* This risk was recommended to be increased from a moderate score of 6 (probability 3 x impact 2) to a high score of 9 (probability 3 x impact 3), due to the complexity of services transferring and the lack of clarity as to the operational model. The Chair agreed that it was a sensible suggestion to increase the risk score at this stage, due to the complexity of the services transferring. **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.** • **APPROVED the increase in risk score for risk 15 relating to the ICB having sufficient resource and capacity to service the functions to be delegated by NHSEI.**	
AG/2324/308	**Risk Management Deep Dive – Corporate Affairs** Helen Dillistone presented the Risk Management Deep Drive for Corporate Affairs and highlighted the following: • There were five open risks that sat within the corporate teams, three risks had a high score, and two risks had a moderate score. • Risk 05 related to the ICB not having sufficient resource for EPRR and business continuity functions and responding to our change to a Category 1 Responder. This risk was currently scored at a moderate 6 (2 x 3). We had now confirmed the	

	structure for this part of the team, and we had been able to add in two additional posts, one being a senior role to lead us through the EPRR element of a Category 1 Responder (Chris Leach), and another Band 7 role to work with Chris Leach and the wider EPRR and Business Continuity teams. • The EPRR team had an integral important role to play in the coordination of responding to the recent industrial action activity. • The ICBs Control Centre Team sat within the urgent care team. • Plans were in place for the potential likelihood of continued industrial action as we go into 24/25. The term was well versed and established to be able to support that, and as a result we were not recommending any change in score to this risk at this point. • The Chair referred to the target for this risk, which was 2 x 2. She asked how were we going to be able to get to that position, or was that target not right? • Chrissy Tucker reported that we had left the score at 6 because at the time of writing we had not received confirmation of the final structure of the EPRR team; this had now been finalised so this would bring the score down. We needed to review what outstanding work there was, as the team had been involved with industrial action, they had not been able to take forward some of the work on the core standards. We had hoped to be in a better position by the time those were reviewed by NHSE than we actually would be, and that went for all of our Providers as well. • Before we had the next risk review, an assessment of outstanding work would be undertaken, we could then consider whether we needed to take Risk 05 score down. • Risk 07 related to the failure to hold accurate staff files securely, which could potentially result in an IG breach and inaccurate personal details. This was a legacy risk from CCG days. • It was recommended that this score was still appropriate at this time (2 x 3). Work was being carried out to examine the staff files, this would take a further few weeks to be completed. At that point consideration would be given to review the score of this risk. It was noted that staff leaver files would be forwarded to the ICB off site archiving service. • It had been suggested that a temporary member of staff may have to be appointed to help with this work, but at this time HR have been unable to find the time to do this due to the ICB restructure and staff consultation. • The risk score was felt to be appropriate at this time. • It was noted that the aim was to digitise the staff records rather than hold on to the paper files, and the HR team needed to go through the files to say which pieces of documentation needed to be retained and which ones did not. • Risk 11 linked to prioritising the importance of climate change and the work and targets that the NHS had in place around our collective contribution to the net carbon zero target. • Risk 11 was scored at a high 9 (3 x 3). We had a robust Derbyshire ICS wide Green Plan and Strategy in place which	

	was supported by a detailed action plan that each organisation contributed to. We were making good progress in some of the different work steam areas. • We had a quarterly performance assurance meeting with NHSE on the Green Plan two weeks ago. At the last meeting it was very much focused on the assessment of where they thought we were in terms of the tiering system; we had been awarded a Tier 3, which meant that we were a maturing organisation. By giving us this award, NHSE were confident that we had things in place, and we were starting to make a difference. • The Chair asked whether there were any risks around progress on the Green Plan from the financial pressures that the ICB were under? • Helen Dillistone responded that it was possible in terms of investment and accessing funding to invest in some of the areas of development. Frequently organisations were invited to bid for national or regional monies to help with schemes. CRH had just been awarded £200k for some LED and solar lighting work. • Helen Dillistone reported that there was always a risk that money that had been set aside to support the Green Plan may get used to help with financial balances. But equally organisations were supported and encouraged to access monies when they became available. • Donna Johnson reported that the impact of flooding and heatwaves could drive increased healthcare needs; we could see a drive on financial pressures from that increased healthcare need. • It was noted that carbon emissions directly affect people's health, and we knew that it often disproportionately affected some our most deprived vulnerable communities and widened health inequalities. We knew that some of the areas with the biggest emissions were often in the most built-up areas where people already had multiple health conditions and that just further exacerbates that. • The NHS, whilst we were a not an insignificant contributor to overall carbon emissions, had contributed around 1% of the overall national carbon emissions, and within that there were some really big contributors like anaesthetic gases and inhalers. Hence, we had some focused work being done here in Derbyshire on inhalers. • It was important that we connected this risk with the plan that Suzanne Pickering would be presenting in the next agenda item with a much broader agenda working with our partners, local authorities and big local employers and other sectors in our patch, about what we all do collectively to support this. • Darran Green reported that in these financially challenged times, often the greener option for us, our System partners and even for our population, tended to be more expensive. We needed to take that into account when making our decisions, that we may have to pay a premium to do the right thing. • Risk 15, the ICB may not have sufficient resource and capacity to service the functions being delegated by NHSEI. Scored at 16 (4 x 4).	

	• Currently there was nothing to suggest that we needed to increase the score of this risk, but equally we were not able to decrease it either. • Risk 16, this risk was currently scored at 12 and related to the ICB structure. It was noted that we would like to be able to reduce the score of this risk, given that work was now underway to start the implementation of the new structure. It was recognised that a period of uncertainty had been created for a small group of staff who may still be at risk of potential redundancy. It was noted that the ICB would do its utmost to support those individuals and look for redeployment as an alternative option where possible. • It was hoped that after the next round of updates to the Risk Register, we would start to see a reduction in score for this risk. **The Audit and Governance Committee NOTED the Corporate Affairs risks.**	
AG/2324/309	**Derbyshire ICS Green Sustainability Report** Helen Dillistone, SRO, introduced the ICS Green Sustainability paper and reported that Suzanne Pickering had been playing a key role in this area. It was noted that DDICB had been asked to be a peer support to other ICBs that had further work to do in this area by NHSE. Suzanne Pickering presented the Derbyshire ICS Green Sustainability Report and highlighted the following: • The purpose of this report was to inform the Committee of the ICS Green Programme and progress of the ICS Green Plan and Action Plan. • It was noted a report would come to Audit and Governance Committee on a quarterly basis going forwards. • We had robust arrangements for governance in place through NHS Midlands and our Derbyshire ICS Green Delivery Group. The ToR for this group was attached at Appendix 1 of this report. • Appendix 2 was a detailed action plan which was worked through at the ICS Delivery Group on a quarterly basis. • The table on p2 of the summary sheet identified the key priorities for 2023/24 from the action plan and from the System ambition document for 2023/24, which had been agreed with NHSE. • There were three key priorities around medicines; that was reducing nitrous oxide products by 19-23%. This would be a challenge across Derbyshire, and it was a risk on the Risk Register. The use of nitrous oxide products was reducing, and there were subgroups set up across CRH and UHDB to help do that. We needed to change some behaviours and practice to achieve that target.	

	• In terms of inhalers, the target for 2023/24 was a 25% reduction, and in 2022/23 we just missed that target. Across Derbyshire, the Medicines Management Team and the Acutes were doing some really good work in this area, and we were looking to surpass that target. It was noted that DDICB was the best performing ICB in the Midlands in terms of inhaler emission reductions. • It was noted that there was a target to reduce Desflurane to under 2% and currently across Derbyshire we were at 0.26%. Real progress had been made here. It was reported that we had struggled with some consultant anaesthetists in the north of the county (CRH) to change their culture and behaviour, but this seemed to have now been resolved and we had seen some real improvement. • All the Trusts and ICB adhere to the new policy and national guidance in terms of procurements. Where we had new procurements over £5m per annum they now included the Carbon Reduction Plan requirement aligning with PPN 06/21. • Trusts and the ICB would be supported to adopt PPN 06/20 so that 100% of new NHS procurements, where relevant and proportional, to include a minimum 10% net zero and social value weighting. The Atamis software would help support this for Derbyshire. • Another priority was to future proof low carbon heating systems, and currently across Derbyshire we were purchasing electricity from renewable sources. But from April 24, that would change because of new contracts and the increase in contracts. • CRH and UHDB had submitted an expression of interest for some funding for LED lighting and solar projects; CRH had been successful in their bid for £200k. • We were currently working across the whole of Derbyshire ICS in developing an adaptation plan; this was in line with new guidance. Hopefully we would have a Derbyshire ICB adaptation plan by mid-24/25. • In terms of training and leadership, Derbyshire ICB had implemented ESR as mandatory training and that was effective from the 1st October 2023 and we had got compliance of about 25% at the moment. It was hoped to see the full year effect in 24/25. • Moving on to the risk log attached as Appendix 3, we had four very high risks, which we were reporting through the ICS Green Delivery Group. • Risk 3 - There was no capital investment available to support green projects, risk score 16. • Risk 5 - The national target to reduce emissions from nitrous oxide (N_2O) and mixed nitrous oxide products by 19-23% in 2023/24 would not be achieved if changes in practice did not occur. Risk score 16. • Risk 9 - Due to capacity issues across the System and with partner delivery, there was structural limitation in the implementation and progress of schemes. Risk score 15.	

	• Risk 10 - Derbyshire does not currently have sufficient charging infrastructure to meet demand if we switched to LEV/ULEVs fleet vehicles. Risk score 16. • The 5-year plan and the joint forward plan had strong commitment across the whole of the Derbyshire ICS with all Trusts having approved Plans in place. We were developing the Adaptation Strategy and we would also be developing a Derbyshire wide ICS Travel and Transport Strategy for 2024/25. • The Chair thanked Suzanne Pickering for this paper, she felt it read overall as a positive report in terms of the actions that had been taken against the priorities that had been set. It was noted that there was more to do, but it felt like we were in quite a good position. • It was noted that Procurement posed a real challenge going forward. The Chair felt that we needed to be clear that there was a difference between net zero and social value, and we needed to make sure that it was not all focused on one bit of that. It was noted that we were picking up on the net zero bit, and that we were also requiring suppliers to confirm that they had got their own net zero plans - this was going to be a real challenge. • Jill Dentith echoed the Chairs comments above. She thanked Suzanne Pickering, and everyone involved in the work that was being done in the background. **The Audit and Governance Committee NOTED the Derbyshire ICS Green Sustainability Report for information and assurance.**	
AG/2324/310	**Conflict of Interest Report** Chrissy Tucker presented the Conflict-of-Interest Report and highlighted the following: • The new Conflicts of Interest training module was now working and was currently being installed on ESR. It was hoped that this could then be shared with staff for training soon. • The Chair asked whether we could include COI percentage compliance figures within this report; it was not clear how many people had not responded with either a nil or updated assessment. We would then know exactly where we were with compliance. Chrissy Tucker agreed to include this for the next report to Committee. • The Chair asked whether the new COI training module would be included in staff communications so that staff knew it was now available. Chrissy Tucker reported that once it was on ESR that would be included in staff communications. **The Audit and Governance Committee NOTED and RECEIVED assurance from the Conflicts of Interest Report.**	CT

AG/2324/311	**ICB Freedom of Information Act Report - Quarter 3** Chrissy Tucker presented the ICB Freedom of Information Act Report Q3 and highlighted the following: • FOI requests had increased significantly when measured against the same quarter last year. However, our statutory timescales for response had been maintained. • It was noted that there had been a slight increase in the number of hours worked by a team member to help absorb some of the work. • The increase in FOI queries was largely mixed and was not due to a single topic. Although there had been an increase in dentistry queries. **The Audit and Governance Committee RECEIVED the Q3 Freedom of Information Act Report describing the performance of the ICB against our statutory duties regarding responses sent to requests made under the Act.**	
AG/2324/312	**Digital and Cyber Security Update** Ged Connolly Thompson presented the Digital and Cyber Security Update and highlighted the following: • Cost Reduction: Representatives from the ICB and NECs had been working for a number of weeks with colleagues from the Local Medical Committee (LMC) and other groups to review and agree how to remove 20% of the value of the NECs contract from April 2024 with a further 10% reduction and service improvement plan to be implemented from April 2025. • Network Upgrade Programme: The ICB was currently working with NECS and other System partners on a number of infrastructure programmes to ensure protection of the Primary Care and Corporate networks whilst also seeking opportunities to collaborate and embed seamless working across JUCD partners wherever possible. • The ICB continued to receive regular updates from NECs on progress of these projects through the Contract Management Board and other informal operational meetings. • Primary Care email Phishing: As part of an ongoing programme to identify potential weaknesses within the various levels of cyber protection, the NECs compliance team recently undertook an email phishing exercise focussing upon Primary Care accounts – which account for 90% of the NHS Mail and network accounts managed by the ICB. The phishing email prompted the user to click on a link embedded within an NHS branded email template which indicated that the individual had received feedback from colleagues and encouraging them to click on the link. Those staff who clicked on the link were then taken to a web page where they were asked to enter their NHS Mail username and password. Any colleagues who subsequently provided their credentials were then taken to a training video to	

	increase their awareness of phishing attacks and sharing their secure credentials. • Another area of concern identified by the NECs compliance team were those devices which were not being regularly connected to the Primary Care or Corporate network and/or subsequently not being regularly updated or patched. While the ICB and Primary Care remained well below the national average of 87.6 for the risk score (as calculated by NHSE), the scores of 49.28 and 45.21 for Primary Care and ICB respectively indicated an upward trend. • In addition to a planned comms campaign, the Head of Digital Development would speak with colleagues within the cyber security arena across NHS and wider for future attendance at Team Talk, as it was vital that software was patched and updated to allow the organisations to be cyber secure, especially the installation of updates considered high priority by NHSE. • It was noted that discussions were underway with primary care SMT around what the GP practice agreement was going to be next year and hence the contract between the ICB and GP practices. That contract would allow the ICB to require GP practices to show us their training plan for their staff. The best way to assure ourselves may be to put some bespoke training courses on and to provide that training into primary care. • The KPI report attached to this paper was predominantly green and had been for a while. • GP Performance – Table 1.2.1 was highlighted which showed a problem during this period relating to Goyt Valley Surgery – there were issues with slowness on the dental PC that had been issued by the ICB and NECS under the GP-IT contract. Changes were made to certificate and routing which appeared to have resolved the issue. It was noted that there were delays in identifying the problem and a site visit was required as it was only affecting users who connected to this PC. • We had an ongoing issue with checkpoint and our VPN dialler (remote access) and some of the firewall services to protect ourselves from attacks on the Internet; they were safe and secure, but there were sometimes problems with overloading and hybrid working. Checkpoint was rolled out quite quickly in 2020 and there had been a number of iterations in terms of improvements, and there was now a contingency in place. This was a known issue and from time to time, typically around Microsoft update time, the capacity on those devices become swamped and it could sometimes cause network performance issues. It was noted that it was somewhat mitigated by the fact that we used Microsoft Teams in the cloud and other services were cloud based, so it primarily affected clinical systems and things like SBS, Oracle, and other things where we had a secure Internet connection. It was noted that we had agreed with NECs to put a contingency connection in place, that should the primary connection go down or have performance issues, we had a secondary backup connection that we could now switch to, so we could route all our secure internet traffic to a secondary one	

	to provide some mitigation. We were continuing to seek assurances around what was being done; there was an ongoing dialogue between the ICB and NECs regarding how we could shore this service up, and how we could improve it. It was hoped that when it came to contract renewal time, we could feed into that process as it was important to get end user engagement. NECs had agreed to this, and we were having an ongoing conversation. • The Chair expressed her concern at the high percentage of failings from the phishing exercise. It was suggested that Ged Connolly Thompson speak to Ian Morris (Fraud) or Tom Watson (who leads on IT) from 360 Assurance regarding the phishing issues as they may have some useful suggestions to put forward. **The Audit and Governance Committee NOTED the Digital & Cyber Assurance Report.**	
AG/2324/313	**Information Governance Update** Ged Conolly Thompson presented the Information Governance Update and highlighted the following: • This update provided an overview of the operational activities of the Information Governance team, and assurance of the steps in place to prepare for the 23/24 Data Security and Protection Toolkit submission in June 2024. • Work was being done around understanding what sensitive and confidential information the organisation owned, where it was situated and how it was managed. • An information asset register was being put together as well as supporting information asset owners and administrators in understanding what an information asset was. Work was also being done on management protocols and data flow mapping. If data were to be lost or compromised in some way, we needed to understand the risk to the organisation and individuals. This would become more prevalent as we had access to Microsoft Teams channels, OneDrive and Sharepoint; we needed to understand how those were being used and the information being stored in them. • Many staff were only completing (95%) Level 1 Data Security and Protection. • Executive Directors and staff on call needed to be aware of possible cyber issues as they were more likely to deal with sensitive or confidential information. • The IG team worked closely with the EPRR team to understand business continuity to manage any issues. • Risk Stratification – A lot of work was taking place in the wider system around risk stratification. We had obtained approval from the Confidentiality Advisory Group to allow us to do risk stratification under Section 251 of the Health and Social Care Act. It was noted that that a public engagement campaign had been undertaken, recorded, and shared with CAG in November.	

	• The Chair referred to Risk Stratification and the patient engagement activities, she asked whether we needed to take something on this to the Public Engagement Committee. Helen Dillistone agreed to escalate Risk Stratification to Public Engagement Committee. **The Audit and Governance Committee NOTED the Information Governance update for February 2024.**	HD
AG/2324/314	**Guidance for Dealing with Prospective Parliamentary Candidates** Helen Dillistone presented the Guidance for Dealing with Prospective Parliamentary Candidates (PPC) and highlighted the following: • The guidance sets out the ICB's approach to dealing with Prospective Parliamentary Candidates during this pre-election period. • The ICB should provide any parliamentary candidate, organisation, or member of the public with information in accordance with the FOI Act 2000. The ICB should deal similarly with straightforward enquiries. Other requests for information would range from enquiries about existing policy that were essentially factual in nature, to requests for justification and comment on existing policy. All requests for information held by departments must be dealt with in accordance with the requirements of the FOI Act 2000. • Where an enquiry concerns the day-to-day management and where the Chief Executive would normally reply, he or she should do so in the usual way, taking special care to avoid becoming involved in any matters of political controversy. • In the build up to a pre-election period, a similar policy should be adopted of not meeting PPCs due to constraints on officers' time. Access to information should be provided, in line with the principles set out above, but offers of meetings should be politely declined. • During the pre-election period, guidance advised that the ICB should decline invitations to events where they may be asked to respond on questions about future government policy or on matters of public controversy. In summary**:** • The ICB would seek to maintain a professional relationship with PPCs. • PPCs did not have the same rights of access as MPs until a General Election was called. • Requests for information should be handled in line with existing enquiries, complaints or FOIA policies. • Seeking appropriate consent was vital. • The ICB would not usually meet with PPCs given a requirement to be equitable and the resultant constraints on time.	

	The Audit and Governance Committee APPROVED the Guidance for Dealing with Prospective Parliamentary Candidates.	
	FINANCE	
AG/2324/315	**ICB Financial Position Review – M9** Darran Green reported that this paper presented the financial position of Derby and Derbyshire ICB for period end 31st December 2023. It highlighted the key areas where we had particular I&E challenges, as well as summarising the efficiencies position for Derby and Derbyshire ICB. As of 31st December 2023, the ICB financial position was £3.5m underspent year-to-date and has a forecast position of £9.6m underspent. This had been achieved by recognising the £8.8m Dental underspend and on non-recurrent balance sheet savings of £7.8m to offset the additional pressures the ICB was currently experiencing. Delegated Primary Care Co-Commissioning continued to forecast an overspend and therefore was not meeting the statutory duty to remain within the specific allocation. This was due to the national contracting arrangements committing the ICB to a level of expenditure greater than the delegated allocation. The ICB had held a meeting with NHS England (NHSE) to review the financial pressures across primary care medical services. They were currently investigating the causes of some of the pressures, and this had been followed up at other meetings held with NHSE. The ICB were continuing to ask the question but had not yet received any further feedback. The ICB efficiency delivery at the end of December 2023 was £4.3m over the YTD plan and current forecast outturn positions recorded on ePMO indicated the ICB would exceed its efficiency target by £4.2m. Plans with a red or amber Rag rating had a medium to high delivery risk and account for £6.6m (14%) of the expected delivery of £48.4m, a major improvement on confidence from M8. There would be an ongoing pressure into 2024/25 due to the delivery of only £22.3m of recurrent efficiencies against a plan of £33.2m. Work must continue to identify additional recurrent efficiencies or in year savings to reach a breakeven and improve the recurrent position. The forecast was a surplus of £9.6m as part of the system pathway to a £47.7m deficit. This was driven by the ICB receiving a share of the industrial action and excess inflation allocation of £3.0m non recurrent benefits of dental and balance sheet savings in addition to underspends in running costs and programme spending. This was offsetting the excess inflation pressures including GP prescribing, CHC and mental health care packages.	

	The surplus of £9.6m continues to carry risks which were illustrated by the worst-case scenario of a reduced underspend of £1.1m. Executive Directors, with support from their teams and financial colleagues, must continue taking on the responsibility for controlling the operational risks and identifying savings. To keep the ICB on track, operational risks needed to be continually addressed by the Executive Directors, and teams were expected to make sure additional efficiency opportunities were identified and progressed through the appropriate gateways to achieve the planned and additional savings required in the current year and moving into 2024/25. The Chair asked whether individual organisations were now able to formally declare their deficit positions, as up to now they were formally showing breakeven? Darran Green reported that there was a meeting taking place at the same time of this Committee, to ensure that the FOT for the System partners totalled £44m deficit; this had been agreed with NHSE. Margaret Gildea referred to the underspend on dentistry, which was unfortunate, given the pressures on dentistry in Derbyshire. Her understanding of the situation from the last ICB Board meeting was that it related to the difficulty in recruiting dentists. Darran Green reported that it was certainly unfortunate in terms of the impact it must be having on the dental health of the population. Dentists were out there, but a number of dentists were choosing more lucrative private work, as opposed to taking the NHS contracts. It was noted that of the £9.6m surplus that the ICB was reporting, £8.8m of that was dental underspend. Margaret Gildea reported that that was not a good reason for being underspent if we were failing to provide a vital service. Darran Green reported that unfortunately, it was likely to come back and bite us in a few years' time with massive oral health issues across Derbyshire. The Chair asked whether we would be able to keep the dental underspend this year? Darran Green reported that we would be able to keep the underspend as it was ring-fenced. It was noted that Pharmacy, Ophthalmology and Dental was delegated to ICBs from the 1st of April and there was a high degree of uncertainty to it, together with Specialised Commissioning coming in a couple of months' time. A risk share agreement was put in place, and there had been a lot of discussions across the Midlands patch as to how that risk could and should be implemented. It was noted that Keith Griffiths and Darran Green had formed a view that, everybody had an underspend and therefore there was not a risk. It was just that some	

	underspends in some Systems were much bigger than others. It seemed that we were being challenged to do an underspend share as opposed to a risk share. Both Keith Griffiths and Darran Green's view was that we should not sign up to an underspend share; we had signed up to a risk share and nobody was at risk. Jill Dentith felt that it was important how we shared this sort of information. We had talked about the underspend on the dental contract, and how unfortunate it was in terms of that demand versus our ability to provide the service collectively across the patch and the financial impact. Board papers would be reviewed by the public, and it may be worth making sure that in the narrative we articulated our commitment to continue provision, whilst also noting we had an underspend; the words needed crafting appropriately for the public arena. Darran Green reported that many organisations put in FOI around this, and Pharmacy, Ophthalmology, and Dental was still being dealt with under a hub basis across the Midlands region hosted by Nottinghamshire, and careful consideration was given to those responses, shared across the region, and agreed before being released. This ensured consistent messaging across the Midlands. Andrew Cardoza agreed with the comments on oral health and dentistry; an underspend was not a great place to be in on this occasion. This had been talked about within KPMG in terms of oral health being a massive indicator and a causal factor of bad health, and the worse your oral health was, the worse your outcomes were from a health perspective. As Darran Green reported, the ICB may be saving money now, but as a System in the future those costs would come back and double or triple extrapolated from where you were now. It was noted that this paper was very helpful for KPMG in terms of their Audit, and the summary provided by Darran Green was helpful in terms of taking that forward. **The Audit and Governance Committee NOTED the M9 ICB Financial Position.**	
AG/2324/316	**2023-24 Annual Accounts - Planning and Processes Assurance** Donna Johnson presented 2023-24 Annual Accounts – Planning and Process Assurance Report and highlighted the following: • The ICB had commissioned a Project Accountant, Joel Martin, who has previously worked with NHS Derby and Derbyshire CCG and its predecessor organisations, to project manage the year-end accounts processes. Joel Martin had considerable experience in coordinating production of year-end accounts for both CCGs and ICBs. • Interim accounts as at M9, had been compiled and submitted a day earlier than the given deadline. A review of the processes	

	and outcomes had been undertaken, to inform the year-end processes and identify lessons to be learned. • A detailed timetable was usually presented to Committee at this time, but unfortunately the national timetable had yet to be received. However, the ICB had been informed that the Ledger would close on 12 April and reopen on 17 June 24 for final audit adjustments. The detailed timetable would be shared once received with Committee. • Donna Johnson reported that there were no significant concerns around delivering the ICBs Annual Accounts. • It was noted that considerable preparation and planning had already been undertaken and would continue over the next few months, ensuring that the ICB was well placed to produce an accurate set of accounts for 2023-24 within the national deadlines. • The Chair was content with the decision to commission Joel Martin as Project Accountant. **The Audit and Governance Committee NOTED the 2023-24 Annual Accounts - Planning and Processes Assurance**	
AG/2324/317	**Accounting Policies** Donna Johnson reported that she would usually present the Accounting Policies to Committee around this time. However, we were trying to align with NHSE, and they presented their Accounting Policies relatively late. It was noted that there were no real changes to the Accounting Policies for the ICB this year, and Donna Johnson was happy that as a Finance Directorate we were treating all transactions correctly. She therefore proposed to Committee that she would bring the Accounting Policies to Committee in May at the same time as she presented the draft accounts. **Audit and Governance Committee were content with this suggestion.**	
AG/2324/318	**Accruals Report M9** Darran Green reported that the Year End Report 2019/20 produced by KPMG following their audit of the CCGs Annual Accounts, recommended that a sufficiently detailed review of the accruals should be undertaken annually to identify the accuracy of the historic accruals. This good practice had been carried over to the ICB. The report provided a comparison between the levels of accruals at Operating Cost Summary level on a quarterly basis from 31st March 2023, describing the major variances between quarters. M12 to M3 Comparison: The main decrease in the accruals from year end related to the change in the date of the JUCD payments	

	to the 1st of the month in 2023/24. To be able to pay on the 1st the processing had to be made the day before resulting in the transaction hitting the ledger in the previous month. This required a negative accrual to correct the in-month position. M3 to M6 Comparison: The accruals had decreased from M3 to M6 mainly relating to the reduction in prior year accruals. Monthly review meetings were held to assess whether the accruals were likely to be utilised and where it was believed that no further expenditure would be expected against the accruals these were released. M6 to M9 Comparison: The reduction in accruals to M9 was mainly due to prepayments for hospices, MHIS slippage and prior year releases along with reductions in Dental Services relating to an adjustment in contract performance. These were offset by accruals for additional funding for JUCD providers relating to Industrial Action. **The Audit and Governance Committee NOTED the quarterly accruals analysis from March 2023 to December 2023.**	
FOR INFORMATION		
AG/2324/319	**Non-Clinical Adverse Incidents** Chrissy Tucker reported that there were no non-clinical adverse incidents to report.	
MINUTES AND MATTERS ARISING		
AG/2324/320	**Minutes from the Audit and Governance Committee Meeting held on 11 December 2023** The minutes from the meeting held on 11 December 2023 were agreed as a true and accurate record.	
AG/2324/321	**Action Log from the Audit Committee Meeting held on 11 December 2023** The action log was reviewed and updated during the meeting.	
CLOSING ITEMS		
AG/2324/322	**Forward Planner** The forward planners for 2023/24 and 2024/25 were presented, and no amendments or additions were required. **The Audit and Governance Committee NOTED the two Forward Planners.**	
AG/2324/323	**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? **NO**	
	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? **NO**	
	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? **NONE**	
AG/2324/324	**Any Other Business** **SoRD Review** Donna Johnson reported that the current Scheme of Reservation and Delegation (SoRD) required a minimum number of quotations when commissioning goods and services up to £50k (formal tendering was required thereafter) – Detailed in Appendix A. Single Tender Waiver (STW) documentation was required and approved where the SoRD's minimum number of quotations had not been obtained. Colleagues often faced difficulties obtaining 5 quotations for small value contracts. On review of the STW process, and the difficulties often faced in obtaining 5 quotations for such small value contracts, a revision was proposed in Appendix A: requiring only 3 quotations for goods/services contracts up to £50k. It was noted that the revision would realise the following benefits: 1) Continue to ensure value for money by obtaining 3 competitive quotations. 2) Mitigate the difficulties staff often found in attempting to obtain 5 competitive quotations. 3) Reduce the need and number of STWs completed (with little impact on decision). The ICB Audit & Governance Committee were recommended to note the SoRD Revision outlined in Appendix A of this report. Donna Johnson reported that the impact of the new PSR Regulations on the STW process for clinical contract awards was being considered separately as part of the wider Procurement	

	Review Project. It was noted that the above proposal would impact non-clinical goods and services only. **The Audit and Governance Committee NOTED the SoRD Revision for Quotation Requirements.** There was no further business.	

DATE AND TIME OF NEXT MEETING
Date: Thursday 14 March 2024
Time: 2.00PM
Venue: MS Teams

Signed: …… Dated: ……..
(Chair)

NHS
Derby and Derbyshire
Integrated Care Board

MINUTES OF THE ICB PEOPLE & CULTURE COMMITTEE

06 DECEMBER 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
Booth, Lorraine	LB	Derbyshire County Council, Head of HR Operations - Deputising for Jen Skila
Dawson, Janet	JD	DCHS, Non-Executive Director and Chair of PCC
Dentith, Jill	JED	ICB, Non-Executive Director
Garnett, Linda	LG	JUCD Programme Director, People Services Collaborative
Lam, Billie	BL	Non-Executive Director UHDB, Chair of People Committee
Moore, Liz	LM	Derby City Council, Head of HR
Patel, Atul	AP	CRH Non-Executive Director and Chair of People Committee
Rawlings, Amanda	AR	UHDB, Chief People Officer
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:		
Fackler, Dominic	DF	Head of Community, DCHS
Mahil, Sukhi	SM	JUCD Assistant Director Workforce Strategy, Planning and Transformation
McMillan, Kirsty	KM	Director of NHS Integration, Derby City Council
Apologies:		
Ashby, Carmel (Cllr)	CA	Derby City Council
Blackwell, Penelope	PB	Place Board Chair and NHS Derby and Derbyshire CCG Governing Body GP
Clayton, Chris	CC	ICB, Chief Executive
Gulliver, Kerry	KG	EMAS, Director of Human Resources & Organisational Development
Knibbs, Ralph	RK	DHcFT Non-Executive Director and Chair of PCC
Leggatt, Zahra	ZL	DHU Healthcare, Director of People & Organisational Development
Oakley, Rebecca	RO	Acting Deputy Director People & Inclusion - Deputising for Jaki Lowe
Pearson, Sally	SP	Derbyshire County Council
Skila, Jen	JS	Derbyshire County Council, Assistant Director HR

Item No.	Item	Action
PCC/2324/013	**Welcome, introductions and apologies:** Margaret Gildea (MG) as Chair welcomed all to the meeting. Apologies were received from: Carmel Ashby, Penelope Blackwell, Chris Clayton, Kerry Gulliver, Ralph Knibbs, Zahra Leggatt, Rebecca Oakley, Sally Pearson, Jen Skila. Lucinda Frearson (LF) was unable to attend due to technical issues at Cardinal Square, therefore, the notes were prepared from the meeting recording.	

PCC/2324/014	**Confirmation of quoracy** The meeting was confirmed as quorate.	
PCC/2324/015	**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 DISCUSSION		
PCC/2324/016	**Section 75 – Derby City Integration Work – Update** This item was presented by Kirsty McMillan (KM), and Dominic Fackler (DF) who explained that Team Up was essentially the Joined-Up Care Derbyshire way of describing integrated care and working together in a particular locality to better the need of individuals, carers and families. All services are delivered by a number of separate teams but as far as individuals are concerned at some point all these come together at certain points in their life and includes non-NHS and care teams that the councils may provide, and could include leisure and culture, which makes a difference in peoples lives in terms of wellbeing. Derby City Council and Derbyshire Community Healthcare Services (DCHS) currently provide a number of these services separately with work underway to have one approach looking at those services that overlap to get people home from hospital, being flexible about whether people have health or social care needs. The name is Community First and will mean pooling funding as well as resources to effectively benefit the individuals and for them to have as seamless experience as possible, blurring the lines between health and social care doing the right thing for the person whilst tapping into a wider workforce. The Committee offered the following comments and questions: • It was questioned how to move forward in a safe and efficient way and how the 300 potential staff were going to impact on the workforce numbers agreeing that it was the right thing to do. • It was felt to be a really inspiring presentation with the project being something that needed to be done and should be doing. • Thinking about the longer term, if staff are TUPEd across where does any financial package sit if there are redundancy costs due	

	to the change, members suggested redeploying from other areas. • Members asked if there was a baseline of numbers, with benchmarking taking place along with the cost of the service to provide information later to show that this is a more efficient way of working and better for patients. • What would the patients get from this, what type of criteria is being planned to measure from the patients' point of view. There are many things that you cannot measure in numbers but can have a huge impact on people. Question: What should the system role be in supporting integration, flexible working models and organisational differences. • What can we learn from workforce integration whilst making sure that the kind of strategic objectives of the system academy take account of place-based care. • From a system perspective it is important that we look at delivering things differently as we often carry out a policing and monitoring role rather than a creative thinking role. LG believed the system role was about creating the conditions where the different parts of the system recognise that integration and flexible working is the way to go and encouragement and support between us can help that to happen. • Could the Committee be involved in promoting that creative thinking. It was thought as all providers at various levels were represented, some quite senior in some cases, embryonic ideas could be shared and discussed. Question: Can these opportunities take place without formal integration? • We have been talking about these challenges around HR for many years it brings real opportunities in regard to workforce planning and development so there are benefits. Each needs to be judged on case-by-case basis and the benefits that we are trying to achieve. Question: How well can resource gaps be addressed between organisations and enabled by system leads? • Joined-Up Care Derbyshire Careers has been tapped into, but it is about how we shape that. We would wish to see an entry point as a route into health or social care. • Agreement was given in terms of the entry route and apprenticeships to give career progression. The key driver is a quality service, but it is also efficiencies and where we can demonstrate efficiencies then we can start to justify the input	

	and the expense at the front end. It does need to be linked to some financial benefit also. Question: What is the potential scale up and inclusion of other functions? • DF suggested learning from this, forwarding as an agenda item to ensure we are looking at this topic. **Action: To be placed on the forward planner for a future meeting.** **The People and Culture Committee DISCUSSED and NOTED the paper.** **KM and DF left the meeting.**	**LF**
PCC/2324/017	**Freedom to Speak Up (FTSU) – New Arrangements** MG began by highlighting the letter received by all organisations from the Secretary of State regarding the Lucy Letby case and on behalf of the ICB Board had been asked to ensure all organisations had appropriate arrangements in place to feel assured that they will not encounter in times to come somebody saying I tried to speak, and I could not be heard. The Committee offered the following comments and questions: • Susie Bayley (SB) speaking on behalf of GPs outlined their difficulties, highlighting a pilot that had been running over the past year to have a guardian outside of the practice, but there was no funding beyond that point. Having a guardian directly through line management did not always work in general practice. She felt comfortable at the moment, 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. **Action: LG to place this risk on the risk register** • Amanda Rawlings (AR) advised that a paper had been taken to the University Hospitals Derby and Burton (UHDB) Board, a self-reflection tool was also being developed and put in the public domain which AR offered to bring to the next meeting. **Action: To be placed on the agenda for the next meeting.** • Looking at FTSU issues they are more often to do with patients' experiences, and it was about finding a mechanism which helps us to identify whether we have the appropriate structure in place. A short report from Board will only show that people are reporting not actually giving assurance. • It was suggested the People Services Delivery Board or the HRDs regular meetings would be the best forums for sharing ideas and practice.	**LG** **AR**

	• 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. **Action: LG to reach out to Guardians and Ambassadors** • GPs would like to be involved but do not have a Chief Nurse representative. **The People and Culture Committee NOTED the discussion.**	**LG**
CORPORATE ASSURANCE		
PCC/2324/018	**Latest Workforce Report** LG explained that there had been an incredible amount of scrutiny on finances, workforce numbers and growth so it was important that time was spent on the report and its influences moving forward in terms of planning, controls, and alignment with regard to finance. Sukhi Mahil (SM) firstly outlined that over many years we had been told to grow our workforce, the NHS workforce plan is predicated on workforce growth and increase in that training capacity, but we also need to have a better understanding of the workforce costs and change that. Secondly, we all know there were challenges with last year's planning ground and the plans as they were submitted so what we have started to do within the Derbyshire system is to make sure that we are monitoring opposition against our workforce plan because it is necessary to get a sense of where we are going but also trying to get that alignment between the pay bill and the numbers. The other part being presented today was around the increased level of scrutiny around agency costs and agency spend and agency usage with a piece of work starting to bring workforce and finance together but there was still a need to move forward with the activity side as the driver. Key Points: - • Total workforce substantive bank and agency was 1304 wte above plan. • M12 outturn position was above baseline planning position so the starting point was already above plan in the year. • There had been growth in substantive positions in registered nursing, midwifery and health visiting which was expected. • Workforce trend: Comparison to April 2022 we have grown by 8.3%, this year alone the growth equates to 5.5%. • Comparison of substantive growth for this year shows a growth of 3% without seeing a corresponding reduction in temporary staffing but in terms of percentage growth month on month and it is not that significant except EMAS who had a large TUPE transfer of	

staff in July of this year and DHcFT who have received a lot of mental health investment funding.

- Primary Care Plan: Further work is needed regarding the primary care position. This data is drawn from a different source and is less frequently updated.

- Work has begun to start to align our wtes to finance and pay bill from our Provider Finance Returns (PFR), Table 2a of the presentation demonstrates the differences. If we change how we record, we have overspent by £21.6m at M7 and on our pay bill with 831 hte it shows over established substantive bank and agency.

- 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%.

- We had a planned agency usage bill of £15.6m and we have spent £25.9m so again we have overspent on agency. Going back to 2019 levels, whilst agency usage has fluctuated, we have not seen a worsening position and have managed to maintain rather than increase agency usage.

One key reflection is the lack of a national requirement to have a funded establishment plan, there is also an argument around understanding the establishment and ensuring that it is adjusted and reflects based on needs. The story has to show how that workforce growth is supporting delivery.

One of the challenges is money that has been invested, we have grown our workforce, but the corresponding activity has not increased at the same time.

Another challenge is workforce plans are not done by service lines and service areas they are done by staff groups which makes it difficult to triangulate the activity, finance, and workforce information. MS has suggested if one or two priority areas were selected aligned to a service area, pull out the money and do some mapping in a more integrated planning perspective monitoring on an ongoing basis. What we then learn can be rolled out and scaled up for the next few years. Activity should be informing everything that we do but because of the planning process it feels like a parallel process so needs to be more sequential.

Committee was asked to consider, how do we tell the story more coherently, getting underneath the data and approaching specific lines of service in a different way so activity can really be tracked.

The Committee offered the following comments and questions:

- LG proposed another ask which was, could the Chairs of the People Committees give their assurance that they are looking at this in the same level of detail.

	• The importance of the presentation was highlighted, and thanks was given to MS for such a thorough piece of work, but it was commented that it would have been more helpful to have known the ask in advance to be given chance to prepare. • It was felt there was too much information and too many slides and would have been better more condensed with key information collated onto a summary sheet to help Chairs understand what was required from them and if communicated prior to the meeting may have been able to make a better contribution. It was agreed that the process did require a little more structure. **Action: SM to prepare a summary of highlighted sections and areas of importance from the slides.** • We cannot take assurance that we have got effective agency reduction in place because actually the evidence is that it had increased at M7. • It was 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. **Action: Deep Dive to be placed on a future agenda.** **The People and Culture Committee DISCUSSED and NOTED the report.** **Agency Reduction Plan** The paper was taken as read. No comments or questions were raised. **The People and Culture Committee NOTED the Plan.**	**SM** **LF**
PCC/2324/019	**Assurance Report from the People Services Delivery Board** The paper was taken as read. No comments or questions were raised. **The People and Culture Committee NOTED the report.**	
PCC/2324/020	**BAF (Board Assurance Framework) Risks** The purpose of the report is for Committee to discuss the BAF Strategic Risks which are their responsibility. Following the ICB Board and Internal Audit feedback further development and strengthening of the risks has been undertaken. Two strategic risks have been identified: - **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.** It is proposed the risk description for Strategic Risk 05 is reviewed by members of the committee as this risk also relates to funding.	

	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.** A slight change is proposed to the risk description for Risk 06 - *There is a risk that the system does not create and enable a health and care workforce to facilitate integrated care*. The change is to reflect the system is no longer using 'One Workforce' as a definition. Also, the removal of Threat 1 from Risk 06 to reflect that 'One Workforce' is no longer used as a definition. It had been decided that the phrase One Workforce leads into assumptions and ideas that are not deliverable and what is being discussed is the health and care workforce. The Committee offered the following comments and questions: • Questions were raised regarding Risk 06 and whether following discussions today the risk should increase slightly but it was suggested to leave it at its current level today. • Could affordability be added into Risk 05 as it may bring the two aspects together. **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 with a change in wording and the removal of Threat 1.**	
ITEMS FOR INFORMATION		
The following items are for information and will not be individually presented:		
PCC/2324/21	**Bi-Annual Committee Attendance Report** The report had been requested following an audit report of committees therefore any comments were appreciated to give steer. The report was taken at a point in time, and it was understood that there would be meeting clashes, people leaving and new starters. The Committee offered the following comments and questions: • A rolling attendance for the last 4 meetings was suggested to see if there were any patterns. • It was noted that Joy Street had left the Committee in March. **The People and Culture Committee NOTED the Bi-Annual Report.**	

MINUTES and MATTERS ARISING		
PCC/2324/022	**Minutes from the meeting held: 06 September 2023** The minutes of the meeting held on 06 September 2023 were accepted as a true and accurate record of the meeting. **The People and Culture Committee ACCEPTED the Minutes.**	
PCC/2324/023	**Action Log from the meeting held: 06 September 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/2324/024	**Forward Planner** **The People and Culture Committee ACCEPTED the Forward Planner.**	

	1.	Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? - **There were no attendees EMAS, DHcFT and DHU**
	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? - **Papers would be better if more specific on what was requested with a summary of the topic.**
	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, and further changes will be made.**
	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 a future meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? - **Deep dive on the drivers of pay bill spend and** - **FTSU guardian and how to address in a form with the guardians and Chief nurses.**

	8.	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? - **NONE**	
PCC/2324/025	**Any Other Business** No further items of business were raised.		
DATE AND TIME OF NEXT MEETING			
	Date: Thursday 01 February 2024 **Time:** 09:00 – 11:00 **Venue:** via Microsoft Teams		

Derby and Derbyshire
Integrated Care Board

MINUTES OF THE PUBLIC PARTNERSHIPS COMMITTEE

30 JANUARY 2024, 10:00 – 12:00

VIA MS TEAMS

Present:		
Richard Wright	RW	Interim Chair Derby & Derbyshire ICB Board **(Chair)**
Steven Bramley	SB	Lay Representative
Patricia Coleman	PC	Lay Member for the Derby and Derbyshire Patient and Public Partner Programme
Helen Dillistone	HD	Executive Director of Corporate Affairs, DDICB
Val Haylett	VH	Governor, University Hospitals of Derby and Burton NHS Foundation Trust - Deputising for MT
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
Lynn Walshaw	LW	Lead Governor, Derbyshire Community Health Services NHS Foundation Trust
Carol Warren	CW	Lead Governor, Chesterfield Royal Hospital
Neil Woodhead	NW	Derby City Council (Deputising for Sam Dennis)
In Attendance:		
Lucinda Frearson	LF	Executive Assistant, DDICB (**Admin)**
Andrea Kemp	AK	Engagement Specialist, DDICB
Apologies:		
Kim Harper	KH	Chief Executive Officer, Community Action Derbyshire
Karen Lloyd	KL	Head of Engagement, DDICB
Hazel Parkyn	HP	Governor, Derbyshire Healthcare NHS Foundation Trust
Sam Dennis	SD	Director of Communities, Derby City Council

Item No.	Item	Action
PPC/2324/087	**Welcome, Introductions and Apologies** Richard Wright (RW) as new Chair introduced himself and welcomed all to the meeting further introductions were then made around the virtual room. Apologies were received from: Kim Harper, Karen Lloyd, Hazel Parkyn, Sam Dennis.	
PPC/2324/088	**Confirmation of Quoracy** The meeting was confirmed as quorate.	

PPC/2324/089	**Declarations of Interest** RW reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the Integrated Care Board (ICB). Declarations declared by members of the Public Partnerships Committee (PPC) are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: www.derbyandderbyshire.icb.nhs.uk Declarations of interest from today's meeting: No declarations of interest were made during today's meeting.	
	MINUTES AND MATTERS ARISING	
PPC/2324/090	**Minutes from the meeting held on: 28 November 2023** The Public Partnerships Committee **ACCEPTED** the Minutes as a true and accurate record of the meeting.	
PPC/2324/091	**Action Log from the meeting held on: 28 November 2023** The action log was reviewed and will be updated for the next meeting.	
	CORPORATE ASSURANCE	
PPC/2324/092	**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 BAF Strategic Risk 03. The Public Partnerships Committee are recommended to discuss and agree the BAF Strategic Risk 03 which is the responsibility of the Public Partnerships Committee. 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 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 table in the report (page 14) sets out actions and completion date which provides the committee assurance that work is underway and steps in place to manage that risk. The Committee offered the following comments and questions: - • It was noted that there was a lot of actions and ongoing work, so it was proposed highlighting which steps were critical to help to start to reduce those risks.	

	• There has been concern for a long time that risk levels had been static, one reason being change was happening so quickly that there was not the scope to reduce but now coming out of that it was hoped to see some movement on the level of risk. • The question was asked, at what point do we feel we are reducing the risk. ST believed once the performance report was established then seeing where we are performing would assist the committee in feeling that we are reducing the risks. • The 16 rating was still being driven around the involvement in people setting out the plans and strategy and will be assisted by the Insight Framework but requires more involvement at the beginning of the process of local people, so whilst there can be some reduction of the threat scores that residual threat remains. • RW noted that for the next meeting he would like to think we could review and take forward. **The Public Partnerships Committee DISCUSSED and AGREED the Strategic Risk 03 level.**	
PPC/2324/093	**Risk Report January 2024** The purpose of the paper was to present the operational risk owned by the committee held on the ICB's Corporate Risk Register and ICB's Confidential Corporate Risk Register for review and to provide assurance that robust management actions were being taken to mitigate them. 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*. The structure has been reviewed as part of the organisation's restructure and changes are starting to be implemented. No resources have been lost within the team and the implementation of new employees will assist backfill and secondment roles. The aim is to stabilise the team and have it fully recruited to. 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*. The risk is around the pace of change and complexity and being able to keep on top of aligning the engagement approach with all the different	

	planning that will commence for 2024/25 and ensuring that we are engaging with any significant changes that may arise as a consequence of the planning round. It was recommended that the overall risk score remains at level 12. **The Public Partnerships Committee RECEIVED Risk 13 and Risk 17 assigned to them.**	
PPC/2324/094	**Identify Risks for 2024/25** The ICB Public Partnership Committee are recommended to note the continuation of risks from 2023/24 and approve the adoption of new risks highlighted for 2024/25. The Committee currently manages three risks on the Corporate Risk Register, and it is proposed that given the ongoing risk ratings that these are carried into 2024/25. RW asked for members to think about the risks in the spirit of the role of the Committee, assuring ourselves that the engagement is taking place as a system and in the context of not just NHS but the wider determinate of health, hence why it is felt the need to have some of our partners to join this Committee moving forward. The Committee offered the following comments and questions: - • Sue Sunderland (SS) queried risk 01, our concern around what the Trusts are doing and why it has ended up with such a high-risk score as Trusts have their own duties to consult on changes. Sean Thornton (ST) felt that it was not in scope but needed registering due to reputational risk and possible legal issues if we are fully complying with engagement of the community but one of the providers are not. **Action: SS/HD/RW to discuss the risk outside of the meeting.** • Steven Bramley (SB) added that at previous meetings the legal basis had been discussed and it had been decided it was not relevant to the ICB, providers have their own legal responsibilities and duties and if we are not involved, we are not part of the risk, and it is not for us to start policing. **Action: Any members who feel they identify a risk to contact the Chair with their proposal.** **The Public Partnerships Committee NOTED and APPROVED the report with an update being provided at the next meeting.**	**RW/SS/ HD** **ALL**
PPC/2324/095	**Performance Reporting** ST introduced members to the new performance reporting sharing a PowerPoint slide of the Public Partnerships Committee Performance Reporting principles. **Action: ST to share PowerPoint slide with members.**	**ST**

	The Committee offered the following comments and questions: - • Members agreed the principles made perfect sense and also gave clarity. There was still a lot of work to do but it was an important point, it has to be important to the public and they need to know they are listened to and involved. **The Public Partnerships Committee NOTED the Performance Reporting principles.**	
PPC/2324/096	**PPI Assessment Log** The ICB Public Partnerships Committee are recommended to note the PPI forms and take assurance that forms are being completed and actioned appropriately. The report 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. ST flagged the Tier 3 Weight Management Service paper advising that there was a need to involve people and likely to be a temporary issue ahead of a longer-term solution so currently assessing the temporary change and will be monitoring that temporary change. **The Public Partnerships Committee NOTED and took ASSURANCE from the report.**	
COMFORT BREAK		
ITEMS FOR DECISION		
PPC/2324/097	**Public Partnership Committee & Lay Reference Group Scope and Terms of Reference (TOR)** Amendments to the Committee TORs have been provided that reflect conversations that have taken place and to bring a phase 2 approach of the Committee to a conclusion. The first draft TORs for the Lay Reference Group have also been provided. **The Public Partnerships Committee ACCEPTED the Terms of Reference for both the Public Partnerships Committee and Lay Reference Group.**	
PPC/2324/098	**Engaging in our Operational Plan Priorities and Joint Forward Plan (JFP)** ST took the paper as read, explaining this was a reminder of the work done to inform the JFP for last year with regard to insight gathering and also sets out the timetable for the development of the 2024/25 planning for this year. Work is still ongoing around seeking engagement in developing the plan whilst continuing to seek to strengthen as there are things that can be better, and this will also manage the risk around getting the views of the population built into our planning. **Action: ST to bring an update to the next meeting.** **The Public Partnerships Committee NOTED the report.**	**ST**

PPC/2324/099	**New Powers for Secretary of State in Service Reconfiguration** The briefing note was shared for information, emphasising that we have a role to ensure we are flagging our reconfiguration into this process, and we will be reviewing how the requirement fits into the governance we already have so as not to generate more work. **The Public Partnerships Committee NOTED the briefing.**	
ITEMS FOR DISCUSSION		
PPC/2324/100	**Insight Framework Update** The Committee are recommended to note the Insight Framework Update, presented by Andrea Kemp (AK) of the Engagement Team. The paper is to inform Committee on progress made relating to the implementation of the Insights Framework, including community led insight and sustained engagement to address health inequalities and promote agency across Derbyshire and Derby, highlighting themes emerging from the work being done. The Committee offered the following comments and questions: - • The Committee felt good things were coming out of the work and was really exciting. It is good to see the bigger events happening but more open when it is a small group with honest feedback. • Committee particular liked the DCHS worry catcher scheme which was allowing patients and visitors to talk to anyone and informally say what their feelings are with their care and treatment. • People do get overwhelmed by surveys and this system insight is trying to get away from overwhelming people and addressing those issues. • The question is about trust and how often we are talking to groups, how do you bridge the hierarchal difference and how do people believe that this will lead to some change. • It was queried how we ensuring we do not have gaps and are speaking to everyone. AK added trust and feedback are the centre of this work and heart of the tool kit this is relational work and the way to trust is to be trustworthy with each other and do what we say we are going to do. Building a culture of trust through the work its about keeping going around the feedback loop and always getting back to the people. It is hard work, so we have to support each other and be honest about the challenges. **The Public Partnerships Committee NOTED and felt ASSURED.**	
CLOSING ITEMS		
PPC/2324/101	**Forward Planner 2023/24** The Forward Planner was **ACCEPTED** by the Committee.	

PPC/2324/102	**Any Other Business** Frequency of Meetings: - RW proposed the committee frequency to be changed to bi-monthly with two face to face development sessions a year. Members were asked to consider and bring their thoughts to the next meeting. **Action: Consideration to be given to the frequency of meetings moving forward.**	**ALL**
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 27 February 2024		
Time: 10:00 – 12:00		
Venue: MS Teams		

Derby and Derbyshire
Integrated Care Board

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON

2nd NOVEMBER 2023 AT 13:00PM

MS TEAMS

Present:		
Adedeji Okubadejo	AO	Chair and Non Exec Member
Chris Weiner	CW	Chief Medical Officer – DDICB
Jill Dentith	JED	Non-Exec Director – DDICB
Lynn Andrews	LA	Non-Exec Director – DHCFT
Michelle Arrowsmith	MA	Chief Strategy and Delivery Officer/Deputy CEO - DDICB
In Attendance:		
Jo Hunter	JH	Director of Quality - DDICB
Phil Sugden	PS	Assistant Director of Quality & Patient Safety Specialist - DDICB
Jo Pearce (minutes)	JP	EA to Dean Howells - DDICB
Craig Cook	CC	Director of Acute Commissioning, Contracting and Performance – DDICB
Dr Andy Mott	AM	GP and Medical Director for the GP Provider Board
Samuel Kabiswa	SK	Assistant Director of Planning & Performance
Lisa Coppinger	LC	LeDeR Local Coordinator – DDICB
Collette McDermott	CM	Quality Assurance Manager (999 & 111) – DDICB
Apologies:		
Gemma Poulter	GP	Assistant Director, Safeguarding, Performance and Quality- Derbyshire County Council
Kay Fawcett	KF	Non-Exec Director - DCHS
Dean Howells	DH	Chief Nursing Officer - DDICB
Robyn Dewis	RD	Director of Public Health – Derby City Council

Item No.	Item	Action
Q&P/2223 /079	**Welcome, Introductions and Apologies**	
Q&P/2223 /080	**Confirmation Of Quoracy** The quorum shall be one ICB Non-Executive Member, to include the Chair or Vice Chair, plus at least the Chief Nursing Officer, or Chief Medical Officer from the ICB (or deputy), and two provider representatives (to include one provider Non-Executive Director, with responsibility for Quality). Nominated deputies are invited to attend in place of the regular member as required. It was noted that the meeting was not quorate as there was only one provider representative in attendance.	
Q&P/2223 /081	**Declarations Of Interest**	

Approved

	AO reminded Committee members of their obligation to declare any interest they may have on any issues arising at Committee meetings which might conflict with the business of the ICB. Declarations declared by members of the ICB Quality and Performance Committee are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/?cn-reloaded=1 Declarations of interest from sub-Committees No declarations of interest were made. Declarations of interest from today's meeting No declarations of interest were made.	
QP/2223/082	**Deep Dive –** CM presented the deep dive to the committee members. EMAS Category 2 Improvement Plan.pp Questions and comments raised were: AO asked the reasons for not meeting the target for the CAT 2 trajectory. CM replied to say although recruitment had been successful EMAS has not been able to convert the recruited staff into operational staff, however there is no singular reason for the target being met. JED noted the prolonged recruitment process and asked if there is assurance that the target in relation to recruitment will be achieved. CM responded to say that the EMAS Director of HR had attended the 999 CQRG meeting to give reassurance in terms of the action n place regarding retention and conversion and how this can be speeded up. JED noted whilst there has been an improvement in handover times this is starting to reverse and asked what actions are in place to keep the position stable. CM conformed that EMAS have a critical safety plan which is activated when a certain number of calls are waiting. CW also noted there are systems in place which monitor local handover times. Acute trusts have recently escalated to OPEL 4 which has resulted in the stepping up of the tactical coordination groups across the system. JED how the presentation fits with the Derby and Derbyshire population. CM replied to say that the presentation is based on the whole EMAS footprint and offered to provide more detailed information specific to Derby and Derbyshire if required. JED noted the presentation has been presented to the System Quality Group and asked what the added value of it being presented at Quality	

Approved

	and Performance Committee. AO added that it would be useful to know what the outcome of the paper is when it has been presented at another meeting. LA referred to patient safety and asked how we can measure the impact of reduced time on site and ensure safety is maintained. CM confirmed that serious incidents increase when the acute trusts are in OPEL 4 due to patients waiting longer for ambulances. Some of the serious incidents have been around unsafe non conveyance regarding cardiac presentations and misinterpretation of ECGs. EMAS are looking into circulating an education package to all frontline responders around ECG interpretation and cardiac presentations. JH noted the role of the Clinical Quality Review Group (CQRG) in monitoring the quality and safety of EMAS services. As host commissioner DDICB chair the meeting and the serious incident data and the data relating to non-conveyance is considered and discussed in this meeting. If there are areas for concern these are escalated to the Urgent Care Delivery Board. CC raised a comment about the use of NHS pathways by EMAS and the unintended consequences to other services and the need to understand the scale to ensure there is a connection to operational planning. **The Committee the deep dive and were assured by its contents.**	
QP/2223/ 083	**Integrated Performance Report** **<u>Quality Summary</u>** Maternity UHDB stillbirth rate & reported neonatal death rate remains above national rates. An extended perinatal mortality thematic review has been completed and the final report is awaited. Following a recent CQC inspection the report is due for publication and the trust remains in Tier 3 oversight by DDICB & NHSE. Identification of legionella in the water supply on the Hillside Unit at Ash Green. Small doses of legionella were detected in the water supply at the Hillside Unit which has led to the temporary, precautionary transfer of residents to the vacant ward at Walton Hospital to allow for further work to be carried out. Currently two services users are displaced at Walton Hospital. Safe & Well checks completed for both individuals. The Deputy Chief Nurse at CRHFT has been showcasing their work on assessment of care excellence programme both regionally and nationally. **<u>Performance Summary</u>** Planned Care and Cancer – August Performance • The number of people waiting 65 weeks or longer on an incomplete RTT pathway: The position has declined further in August 2023,	

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with 1,263 more patients waiting 65 weeks or longer than planned at an ICB level (UHDB: 2,572 actuals vs. 1,304 plan; CRH: 342 actual vs. 347 plan)

- The number of people on a community service waiting list: The community service waiting list at the end August 2023 is 25,971 an increase of 1,945 compared to when we started this financial year (24,026 as at end of March 2023).
- Cancer waits longer than 63 days: At the end of August 2023 CRH is slightly above plan at 59 with a plan of 54, UHDB have 481 against a plan of 466.
- 75% of cancers diagnosed within 28 days of referral: The CRH continue to deliver the 75% standard. UHDB are at 70% in August.
- Diagnostics: Based on the 7 tests measure CRH is at 83.3% and UHDB are at 70.9%.

(7 tests include: MRI / CT / Non-Obstetric Ultrasound / Echocardiography / Colonoscopy / Flexi Sigmoidoscopy / Gastroscopy)

Urgent and Emergency Care – September Performance

- 4 hr A&E: Both Trusts continue to achieve against their 4-hr target, with September performance standing at 69.1% and 69.4% at the CRH and UHDB, respectively.
- Urgent Community Response: The Urgent Community Response Service continues to exceed the response time standard.
- General and Acute Bed Occupancy: Bed Occupancy for September is slightly above the national 92% target for both providers. CRH is at 93.3% and UHDB at 92.5%.
- Category 2 999 response times: Performance continues to operate above target both for Derbyshire (00:42:31) and the East Midlands as a whole (00:42:33).

Mental Health, Learning Disabilities and Autism

- IAPT, perinatal, adult SMI contacts: good performance against plan with all 3 metrics, have over-achieved at the end of Q1.
- Dementia diagnosis rate: ahead of plan at the end of August.
- SMI Health checks – just fell short at the end of Q1 but on track for quarter 2.
- Out of area placements – off plan.

CC added a piece of work has been carried out to review performance in the first 6 months of the year with a focus on planned care, cancer and emergency care pathways. This work has been done in collaboration with providers to set out the intent for the next six months as well as looking at the risks that may be faced in the coming winter months.

JED referred to the cancer targets and assurance that actions are being taken to get the trajectory back on track. MA responded and confirmed that the system is in escalation with NHSE around elective performance and cancer performance. Weekly meetings are in place with UHDB and CRH with significant oversight of the action plans. Progress will be reported back to this Committee.

AO expressed his concerns around maternity and neonatal services. AO noted the deep dive on the LMNS due to be presented at the Quality and Performance committee in November. AO noted the non-

Approved

	compliance for Saving Babies Lives (SBL) V2 and felt that this was unacceptable. CW acknowledged the issue with SBLv2 and confirmed that this is an area of focus. AO referred to 65 week waits and his lack of confidence that this target will be achieved by end March 2024. The numbers for 65-week waits are improving however this is at the expense of the longer waiters. SK noted the actions in place to mitigate this such as outsourcing and mutual aid. SK also noted work taking place to ensure focus is not diverted from the other long-term waiters. Providers are still predicting these targets will be hit. CC and MA explained the level of scrutiny that is happening by providers on a daily basis to look at all waiting lists. CW then mentioned the national target for bed occupancy of 92% and the evidence that hospitals run most efficiently when bed occupancy is between 87% and 92%. Care becomes more difficult when these levels are exceeded in an acute trust setting. This also impacts on the ability to deliver care relating to elective and cancer. Mitigation is in place for this winter which is the virtual ward programme and there is increased utilisation of virtual ward beds across the system. AO summarised, noting, although there is some assurance from the report there are still areas of concern which have been discussed.AO noted the work taking place to address the concerns. **The Committee noted and approved the Integrated Performance Report.**	
Q&P/2223 /084	**Board Assurance Framework including Q2 update.** The Quality and Performance Committee are recommended to: • **APPROVE** the Board Assurance Framework Strategic Risks 1 and 2 for the final quarter 2 position for 2023/2024. • **APPROVE** the decrease in risk score for both Strategic Risks 1 and 2 from a very high 20 to a very high score of 16, from September 2023. The BAF Task and Finish Working Group last met was held on 2nd October 2023. This operational working group meets on a monthly basis to review the BAF and members of the Quality & Performance Committee are invited to attend. Following the last meeting and discussions held, the Working Group now recommend decreasing the risk score for both Strategic Risks 1 and 2. This is as a result of the Integrated Care System increasing in maturity, the work carried out and progress so far this year. Strategic Risks 1 and 2 are recommended to be decreased from a very high score of 20 to a very high score of 16. The BAF Task and Finish Working Group discussed the impact of on-going industrial strike action in relation to both Strategic risks 1 and 2; however, the Group noted that the impact of industrial action should not be taken into account as an impact on the Strategic risks.	

Approved

	The Audit and Governance Committee are responsible for an operational, corporate risk relating to Emergency Planning Resilience and Response (EPRR) which incorporates and manages the impact of industrial strike action. It was also discussed that Strategic risk 8 has been split into two separate strategic risks. The Quality and Performance Committee are asked to note, for information: ○ SR8: There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making. The ICB Lead for this risk is Dr Chris Weiner. Following discussions at the Finance, Estates and Digital Committee meeting held on 26th September, it was agreed that, as the intelligence and analytical solution risk is led by Dr Chris Weiner, this risk should be owned by the Population Health & Strategic Commissioning Committee and not the Finance, Estates and Digital Committee. The ownership of this risk has now been transferred to the PHSCC. This was presented and agreed at the PHSCC meeting held on 12th October 2023. ○ 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 risk score is a high 12. The ICB Lead for this risk is Jim Austin and remains the responsibility of the Finance, Estates and Digital Committee. As the meeting was not quorate the paper will be circulated for virtual approval. **ACTION**. **The Committee noted the BAF which will be approved virtually.**	
Q&P/2223 /085	**System Quality Assurance Group Assurance Report** The Quality and Performance Committee are recommended to **NOTE** the System Quality Group Assurance Report 3rd October 2023. Areas of concerns are Perinatal Quality and Safety Forum - in the future data for UHDBFT will be split between RDH and QHB to give a fuller picture that will feed into the LMNS and Perinatal Quality Surveillance Group (PQSG). PQSG requests escalation of the position of Trusts in being unable to meet full compliance with element 2 of SBLCBv3 until further guidance on implementing digital blood pressure monitoring is received from NHSE. It is currently on the LMNS risk register and Trusts have been advised to ensure it is reflected internally.	

Approved

	The Committee noted the System Quality Group Assurance Report and were assured by its contents.	
Q&P/2223 /086	**SQG ToR** The Quality and Performance Committee are recommended to **APPROVE** the System Quality Group's Terms of Reference. The System Quality Group's (SQG) Terms of Reference was formally adopted by the ICB Board on the 1st July 2022. They have been reviewed as part of the annual review and following guidance[1] published by the National Quality Board, which states that SQGs should not form part of the statutory accountability or performance management structure of the ICB, although they are expected to inform the ICB through its governance structure and Quality and Performance Committee. As the System Quality Group no longer forms part of the statutory accountability or performance management structure of the ICB, the Terms of Reference no longer requires ICB Board approval when changes are made to them. The Quality and Performance Committee is now required to approve the SQG Terms of Reference. JH noted that her team and undertaking a piece of work to ensure that issues raised in the terms of reference are reflected in the forward planner. JED noted the inconsistencies within the ToR. JH acknowledged the comments and will feedback to the corporate team to ensure the amendments are made. **ACTION.** AO requested an amened version of the ToR be presented at the Quality and Performance Committee meeting in November and the minutes of the SQG meeting are included in the papers for information going forward. **PAPER.**	
Q&P/2223 /087	**NOF Q2 submission** The Committee was asked by email on 5th October to **NOTE** the Provider segmentations outlined below in line with the previous agreement that the recommendations should remain as they were for the reasons outlined. • Chesterfield Royal Hospital NHS Foundation Trust - segmentation 2 • University Hospitals of Derby and Burton NHS Foundation Trust - segmentation 3 • Derbyshire Community Health Services NHS Foundation Trust – segmentation 1	

Approved

	• Derbyshire Healthcare NHS Foundation Trust Mental Health - segmentation 2 • East Midlands Ambulance Service NHS Trust Ambulance – segmentation 2 It is recommended that there are no changes to the ratings from the last quarter. This is based on the assumption that for the already noted performance issues driving the current ratings there are no significant areas of improvement or deterioration, and there are no new areas of concern regarding performance. LA queried the role of the Quality and Performance Committee in the approval of the NOF segmentations. JH offered to liase with Chrissy Tucker (add role here) to gain more clarity on the process and role of the Committee in the NOF segmentations and invite her to one of the meetings. **ACTION.** **The committee noted the NOF segmentations and will gain further clarity at the next meeting**.	
Q&P/2223 /088	**Quality & Performance Committee Annual Report 1st July 2022 to 31st March 2023** The Committee noted and approved the Quality & Performance Committee Annual Report 1st July 2022 to 31st March 2023.	
Q&P/2223 /089	**Bi-Annual Quality and Performance Committee Attendance Report** The Quality & Performance Committee are recommended to **NOTE** the Bi-Annual Attendance Report to Quality & Performance Committee**.** The purpose of this report is to for the Committee to review the attendance of Quality & Performance Committee members from April to September 2023**.** 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. 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. As the Committees enter 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 is sufficient representation by members.	

Approved

	A report will be submitted on a rolling basis and included in the papers from November. **PAPER**. **The Committee noted the attendance report.**	
Q&P/2223/090	**LeDeR Annual Report** The Quality and Performance Committee are recommended to **NOTE** the LeDeR Annual Report. The report is the fourth annual report for Derbyshire on the learning from deaths of those with learning disabilities. The report uses data collated from 1st April 2022 up until 31st March 2023. The annual report is published in June each year. It is signed off through the LeDeR Steering Group. The report, including an accessible version, is published in June each year and available on the JUCD website. The report is shared with NHSE/I regional teams. LC noted the report relates to the year up until March 2023 and highlighted the work that has taken place since then that is listed within the priorities section of the report. CW noted the good work and improvement in figures relating to constipation and congratulated the local team on this achievement. JH also noted the importance of the work across the system to reduce inequalities for this group of patients. AM asked where the top two areas of focus should be for the Derby and Derbyshire system. LC replied to say that there is a shortage of LeDeR reviewers and the need for a dedicated coordinator for Epilepsy. AM offered to have a further conversation with LC to help with the issues raised. **The Committee noted the LeDeR Annual Report and commended the team for its good work.**	
Q&P/2223/091	**Ratified Minutes of DPG 07.09.23** The minutes from the DPG meeting on 7th September 2023 were noted.	
MINUTES AND MATTERS ARISING		
Q&P/2223/092	**Minutes from the meeting held on 28th September 2023** The minutes from the meeting held on 28th September 2023 were agreed as a true and accurate record pending the amendments noted.	
Q&P/2223/093	**Action Log from the meeting held on 28th September 2023** The action log was reviewed and updated, as necessary.	
CLOSING ITEMS		

Approved

Q&P/2223/094	**Forward Planner** The forward planner was noted.	
Q&P/2223/094	**AOB** There were no matters raised under AO.	

Approved

1.	Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes?	**Y**
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?	**Y**
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?	**Y**
4.	Were papers that have already been reported on at another Committee presented to you in a summary form?	**Y**
5.	Was the content of the papers suitable and appropriate for the public domain?	**Y**
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?	**Y**
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?	**N**
8.	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting?	**JH and AO will discuss**

		Memb	Quorum	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Dean	Howells	Yes	* CNO OR MD (1)						N	N
Jo	Hunter	Yes	* CNO OR MD (1)	Y	Y	Y	Y	Y	Y	Y
Tracy	Burton	Yes	* CNO OR MD (1)	N	N	Y	N	N	N	N
Paul	Lumsdon	Yes	* CNO OR MD (1)					y		
Brigid	Stacey	Yes	* CNO OR MD (1)	Y	Y	Y				
Chris	Weiner	Yes	* CNO OR MD (1)	N	Y	Y	N	Y	Y	Y
Michelle	Arrowsmith	Yes	* ICB						N	y
Jones	Zara	Yes	*ICB	N	Y	Y	N	N	N	
Nora	Senior	Yes	*NED - CRH (2)						N	N
Kay	Fawcett	Yes	*NED - DCHS (2)	Y	Y	Y	N	Y	N	N
Lynn	Andrews	Yes	*NED - DHCFT (2)	Y	Y	Y	Y	Y	y	Y
Billie	Lam	Yes	*NED - UHDB (2)						N	N
Chris	Harrison	Yes	*NED - UHDB (2)						N	N
Jill	Dentith	Yes	*NEM - ICB (1)				Y	Y	y	Y
Adedeji	Okubadedejo	Yes	*NEM - ICB (1)	Y	Y	Y	Y	Y	y	Y
Margaret	Gildea	Yes	*NEM - ICB (1)	Y	Y					N
Richard	Wright	Yes	*NEM - ICB (1)	Y	Y					N
Andy	Mott	Yes	GP						N	Y
	Quoracy met			Y	Y	Y	N	Y	N	N

DATE AND TIME OF NEXT MEETING
Date: 30th November 2023
Time: 9am to 10:30am
Venue: Florence Nightingale Room, Cardinal Square, DE1 3QT

Approved

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON

30th NOVEMBER 2023 AT 13:00PM

MS TEAMS

Present:		
Adedeji Okubadejo	AO	Chair
Dean Howells	DH	Chief Nursing Officer - DDICB
Chris Weiner	CW	Chief Medical Officer – DDICB
Jill Dentith	JED	Non-Exec Director – DDICB
Lynn Andrews	LA	Non-Exec Director – DHCFT
Kay Fawcett	KF	Non-Exec Director - DCHS
Robyn Dewis	RD	Director of Public Health – Derby City Council
Nora Senior	NS	Non-Exec Director - CRHFT
Chris Harrison	CH	Non-Exec Director – UHDBFT
In Attendance:		
Jo Hunter	JH	Director of Quality - DDICB
Phil Sugden	PS	Assistant Director of Quality & Patient Safety Specialist - DDICB
Letitia Harris	LH	Assistant Director of Quality - DDICB
Tracy Burton	TB	Deputy Chief Nurse- DDICB
Jo Pearce (minutes)	JP	EA to Dean Howells - DDICB
Dr Andy Mott	AM	GP and Medical Director for the GP Provider Board
Samuel Kabiswa	SK	Assistant Director of Planning & Performance
Annamarie Johannesson	AJ	Complex Case Strategic Facilitator - DDICB
Claire Johnson	CJ	Project Midwife – DDICB
Dan Merrison	DM	Senior Performance & Assurance Manager, DDICB
Craig Cook	CC	Director of Acute Commissioning, Contracting and Performance – DDICB
Apologies:		
Gemma Poulter	GP	Assistant Director, Safeguarding, Performance and Quality- Derbyshire County Council
Michelle Arrowsmith	MA	Chief Strategy and Delivery Officer/Deputy CEO - DDICB

Item No.	Item	Action
Q&P/2324/096	**Welcome, Introductions and Apologies**	
Q&P/2324/097	**Confirmation Of Quoracy** The quorum shall be one ICB Non-Executive Member, to include the Chair or Vice Chair, plus at least the Chief Nursing Officer, or Chief Medical Officer from the ICB (or deputy), and two provider representatives (to include one provider Non-Executive Director, with responsibility for Quality). Nominated deputies are invited to attend in place of the regular member as required.	

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	It was noted that the meeting was quorate.	
Q&P/2324 /098	**Declarations Of Interest** AO reminded Committee members of their obligation to declare any interest they may have on any issues arising at Committee meetings which might conflict with the business of the ICB. Declarations declared by members of the ICB Quality and Performance Committee are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/?cn-reloaded=1 Declarations of interest from sub-Committees No declarations of interest were made. Declarations of interest from today's meeting No declarations of interest were made.	
QP/2324 /099	**Update On The Ongoing Concerns Relating To Maternity Services.** DH started off by saying that UHDB had their full maternity CQC inspection published yesterday. The report shows there are some significant must do 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. In advance of the publication of the report and in terms of the broader impact of the rating on service users, carers, families, and staff, ICB colleagues have been working closely with NHSE. The appointment of Sarah Noble as Director of Midwifery and the change of a new clinical director has been an important leadership change. IT is anticipated CQC will not be in a position to visit UHDB to complete a reassessment on progress until the end of summer 2024. DH noted that he is chairing the second Tier 3 assurance meeting between the ICB and NHSE and the meeting 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. DH stated that he would anticipate 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 if and when required.	

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	There are also plans to invite Kate Blanchett, chief midwife for England into UHDB early in the spring 2024 to have the opportunity to gauge progress made from a national perspective. The following questions were raised: NS asked about the current position around cultural change, how it will be managed and measured. DH offered to explain in more details how cultural change will be measured and monitored. KF asked about media messages and the impact it could have on recruitment and retention as well as mothers who have planned to birth at UHDB. DH gave thanks to the Comms teams and noted the social media coverage which was clear on how service users could raise any concerns. JD asked about well led element and asked if it related to maternity or the wider provider organization. DH confirmed that the well led domain for the overall provider has dropped to Requires Improvement from good. JD asked in terms of workforce and the strategy in place to get workforce numbers to the correct levels. DH confirmed that as of the second week of December there will be no midwifery vacancies within UHDB. LA questioned how much of the organisation was cited on in advance which could be used for other organizations. DH replied to say UHDB maternity services have been part of the National Improvement program for almost a year and gives an indication of the level of improvement that was being anticipated prior to CQC inspecting. DH also noted that the ICB will be carrying out Ockenden visits within the system. TB then went onto present the paper. The paper was taken as read and TB gave committee members the key highlighted themes listed in the report. AO raised his concerns around the culture within the maternity service at UHDB. AO referred to SBLCB which was 5 years old however UHDB had only managed to implement one-third. CW agreed that culture is an issue and questioned how the ICB can a shed a light into organisations so that cultural issues can be addressed sooner rather than later. KF made a comment on the role of the maternity advisors and the hope that they are supporting staff and gaining an understanding of the reasons why maternity services were unable to meet compliance. RD asked about having sight of antenatal and newborn screening. CJ replied to say that the screening coordinators attend the Operational Delivery Group meetings on a quarterly basis. There is reporting on	

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	antenatal newborn screening and the associated KPI's and UHBDFT were 20 /21 compliant the last quarter reported. AO summarised confirming his confidence in the role of the LMNS in terms of oversight, support and challenge and building relationships. AO suggested that in light of the seriousness of the issues, the amount of work taking place and the external interest that this has generated, Quality and Performance Committee receive a maternity update report at each meeting. Workforce issues are being addressed in detail. AO noted the impact of culture and also the complexity of maternity services. Considering all of the above AO stated there is partial assurance.	
Q&P/2324 /098	**Public Health Inequalities** RD shared the following presentation to the committee and the key highlights were noted. Following the presentation RD posed the question to the committee around how this progress should be reported and is there the opportunity to embed system reporting. The committee had discussions around 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, which would provide assurance to the ICB Board. **ACTION- JP to add to the forward planner.**	**JP**
Q&P/2324 /099	**Impact on the difficulty to place children into ED beds.** AJ shared a presentation with the committee which showed a pathway overview and the challenges being seen. Numbers in the presentation relate to young people who have been experiencing mental health difficulties which has led to a delayed discharge from the acute settings. 2022 was the first year of recording this data, at which time there was one young person at CRH awaiting a Tier 4 bed and five awaiting a Local Authority community placement. UHDB had 97 and 10, respectively. In 2023, the numbers have changed significantly, at CRH there are two young people and six across UHDB awaiting Tier 4 beds. There has been a significant increase in out of area young people. Derbyshire are net importers of looked after children from other localities and often these providers will utilise acute hospitals as a way of ending their placement. There has been a decrease in our numbers across Derbyshire, of young people going into Tier 4 beds. The last four or five years	

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	numbers have averaged between 11 and 16 young people at any one time in Tier 4 beds. Currently this year there is an average of four young people and across the North and South of the county. Most of this is due to the dedicated work by CAMHS services in the North and South in creating their wider tier 3 1/2 crisis response. A gap that has been identified within children's services is the need for a crisis house provision where children could be held whilst awaiting assessment to manage risk and to limit their movements. The gap is being escalated as a risk. JD asked questions around support offered to parents to support taking their children back home. JD asked what proportion is this cohort in relation to the wider CAMHS numbers. AJ stated that this cohort of children form a very small part of the overall CAMHS figures which are approx. five hundred. JD asked about associated costs. AJ replied that packages are often jointly funded between Health and Social care. JD asked how the system manages out of area placements in terms of funding. AJ stated that the originating ICB is charged for the funding of staffing and agency support. **The committee noted the presentation.**	
Q&P/2324 /100	**Board Assurance Framework – for discussion** The BAF was noted and there were no comments raised.	
Q&P/2324 /101	**Review of Forward Planner against the Terms of Reference** JH referred to the last time the ToR were discussed at the Quality and Performance Committee meeting and noted the questions that were raised in terms of gaining assurance that items that are included in the ToR have been addressed within the forward planner. JH proposed to the Committee that she undertakes this piece of work and bring back a formal reporting schedule to the meeting in January 2024. **ACTION – JP to add to the forward planner.**	**JP**
Q&P/2324 /102	**Integrated Performance Report** The paper was taken a read. JH noted two quality items. 1. **DHcFT CQC Inspection** This was an unannounced visit focused on ward 35 at the Radbourne unit in relation to a number of issues that had been	

Approved

	raised with the CQC around patient experience and quality. As a result, there were eleven must do and thirteen should do actions which are now being implemented. 2. **Safeguarding (Derby City)** Designated Doctor for Looked After Children issues in Derby City. There continues to be a vacant post which is being covered by the Community Paediatric team within Derbyshire Healthcare and therefore the risk is being mitigated. SK noted the following points: Significant rises in waiting list across the board. SK gave assurance that the ICB is working closely with providers to understand the numbers and put in place mitigations. Particular focus on the long waiters of the 104 weeks, it is believed that there are none in the system. UHDBFT is on tier one escalation for elective and cancer recovery. There is an improvement action plan in place. AO asked a question regarding the RTT's and asked what the expectation is for the year end. SK replied to say that the expectation is to have everyone under 65 weeks however there may be a few 78 week waits. This can only be confirmed a month in advance. CW noted the letter received on 8th November 2023 around the challenge of systems to review plans. CW commented that this could result in a change in the year end outturn. JED asked about out of area placements for mental health and learning disabilities and quality of care and financial implications. JED asked if work has been done to explore this. JH responded to say this is under quarterly review from NHSE. There are not many options for placements within the county and city and when people are placed externally every effort is made to repatriate as soon as possible. There is also a monthly review between DHCFT and the ICB. The Committee noted the Integrated Performance Report	
Q&P/2324 /103	**Ratified Minutes DPG 05.10.2023** The minutes of the DPG were noted for information.	
Q&P/2324 /104	**Minutes of the meeting on 2nd November 2023.** The minutes of the meeting on 2nd November 2023 were approved pending the following amendments: Correction to AO job title.	

Approved

Q&P/2324 /105	**Action Log** The action log was reviewed, and updates noted.	
Q&P/2324 /106	**Forward Planner** The forward planner was reviewed.	
Q&P/2324 /107	**Any Other Business** There were no matters raised under AOB.	

1.	Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes?	**Y**
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?	**Y**
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?	**Y**
4.	Were papers that have already been reported on at another Committee presented to you in a summary form?	**Y**
5.	Was the content of the papers suitable and appropriate for the public domain?	**Y**
6.	Were the papers sent to Committee members at least five working days in advance of the meeting to allow for the review of papers for assurance purposes?	**Y**

		Member	Quorum	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Tracy	Burton	Yes	* CNO OR MD (1)	N	N	Y	N	N	N	N	Y
Dean	Howells	Yes	* CNO OR MD (1)						N	N	Y
Jo	Hunter	Yes	* CNO OR MD (1)	Y	Y	Y	Y	Y	Y	Y	Y
Paul	Lumsdon	Yes	* CNO OR MD (1)					Y			
Brigid	Stacey	Yes	* CNO OR MD (1)	Y	Y	Y					
Chris	Weiner	Yes	* CNO OR MD (1)	N	Y	Y	N	Y	Y	Y	Y
Nora	Senior	Yes	*NED - CRH (2)						N	N	Y
Kay	Fawcett	Yes	*NED - DCHS (2)	Y	Y	Y	N	Y	N	N	Y
Lynn	Andrews	Yes	*NED - DHCFT (2)	Y	Y	Y	Y	Y	y	Y	Y
Chris	Harrison	Yes	*NED - UHDB (2)						N	N	Y
Billie	Lam	Yes	*NED - UHDB (2)						N	N	N
Jill	Dentith	Yes	*NEM - ICB (1)				Y	Y	y	Y	Y
Margaret	Gildea	Yes	*NEM - ICB (1)	Y	Y						
Adedeji	Okubadedejo	Yes	*NEM - ICB (1)	Y	Y	Y	Y	Y	y	Y	Y
Richard	Wright	Yes	*NEM - ICB (1)	Y	Y						
Andy	Mott	Yes	GP						N	Y	Y
Jones	Zara	Yes	Not required	N	Y	Y	N	N	N		
Michelle	Arrowsmith	Yes	Not required						N	Y	N
	Quoracy met			Y	Y	Y	N	Y	N	N	y

Approved

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?	**N**
8.	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting?	**JH and AO will discuss**
DATE AND TIME OF NEXT MEETING		
Date: 21st December 2023		
Time: 9am to 10:30am		
Venue: MST		

Approved

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON 21st DECEMBER 2023 MS TEAMS

Present:		
Adedeji Okubadejo	AO	Chair and Non-Exec Member
Dean Howells	DH	Chief Nursing Officer - DDICB
Paul Lumsdon	PL	Exec Director of Operations
Chris Weiner	CW	Chief Medical Officer – DDICB
Chris Harrison	CH	Non-Exec Director – UHDBFT
Jill Dentith	JED	Non-Exec Director – DDICB
Robyn Dewis	RD	Director of Public Health – Derby City Council
In Attendance		
Jo Pearce (minutes)	JP	EA to Dean Howells - DDICB
Tracy Burton	TB	Deputy Chief Nurse- DDICB
Jo Hunter	JH	Director of Quality - DDICB
Dr Andy Mott	AM	GP and Medical Director for the GP Provider Board
Dan Merrison	DM	Senior Performance & Assurance Manager, DDICB
Anne Pridgeon		Head of Maternity Transformation Programme
Phil Sugden	PS	Assistant Director of Quality & Patient Safety Specialist - DDICB
Dean Wallace	DW	Chief Operation Officer - DCHS
Jo Warburton	JW	System Discharge Lead - DCHS
Apologies:		
Gemma Poulter	GP	Assistant Director, Safeguarding, Performance and Quality- Derbyshire County Council
Lynn Andrews	LA	Non-Exec Director – DHCFT
Kay Fawcett	KF	Non-Exec Director - DCHS
Nora Senior	NS	Non-Exec Director - CRHFT

Approved

Ref:	Item	Action
Q&P/2324 /110	**Welcome, introductions and apologies.** AO welcomed all to the meeting, introductions were made, and apologies noted as above.	
Q&P/2324 /111	**Confirmation of Quoracy** The meeting was confirmed as **not being quorate** as it did not meet the quoracy requirements of: 2 Non-Executive Members, 1 ICB Executive or Deputy, 1 Provider Representative 1 Local Authority Representative. There was only one provider representative in attendance.	

Q&P/2324 /112	**Declarations of Interest** AO reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the ICB. Declarations declared by members of the ICB Quality and Performance Committee are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/?cn-reloaded=1 Declarations of interest from sub-committees No declarations of interest were made. Declarations of interest from today's meeting No declarations of interest were made. There were no declarations of interest noted.	

	Deep Dive on Discharge and Flow
	
	DW shared a presentation with Q&P committee members.
	
	The following questions and comments were raised:
	
	• Is there anything the ICB can do in collaboration with the acute Trusts to strengthen the processes that are already in place.
	• What help is in place to support P0 in the next 12 months.
	  • UEC is supporting this work. All parties are included in the decision-making process to make sure discharges happen as early as possible in the day. A piece of work is needed to ensure all staff are working in a strength-based way to understand people's needs during the discharge journey.
	• What can the ICB do to support managing the blockages.
	• Costs of readmissions and the impacts on the quality of care.
	  - This needs to be tracked in terms of outcomes.
	• Late discharge arrangements.
	• How is the information that is included in this presentation translated into actions at the Trusts.
	• Backdrop of Newton Europe should be considered to keep the ICB on track in terms of quality and performance.
	
	The Committee members acknowledged the work that is taking place and suggested this is escalated to ICB Board and ICB Executive Team along with the need for an action plan.
	
	AO summarised stating that the discharge and flow work should be driven through System Quality Group in terms of progress and improvements. This will be fed back into Quality and Performance Committee and a report submitted at a suitable time after Q4. DH will	

Approved

	take ownership. **ACTION – JP to add to the forward planners for SQG and Q&P.**	**JP**
Q&P/2324 /113	**CQC rating progress update – UBDB Maternity services** DH updated the Committee explaining that UHDB have facilitated an inspection from the NMC to ensure they could maintain their training status within maternity. Informal feedback from the visit has been positive. LMNS met this week and there was a detailed update on the S29 and S31 submission which has gone through the required governance structures in UHDBFT. It is clear that UHDBFT will be utilising the support available in the system prior to inviting the NMC back into the Trust to review the warning notices. CJ, lead inspector from CQC has taken part in internal sessions at UHDBFT and colleagues have expressed the benefit. Consistent messaging has come from CQC in terms of maintaining the correct level of progress. The system is trying to manage expectations around governance and data flow. Focus is being given to the must do safety concerns without scaling down the need for cultural improvements. The ICB team have been very active in the system in respect of the Ockenden visits and reviews. Some flexibility has been negotiated to ensure the system is not overwhelmed and there is the right balance. recruitment around midwifery continues to go from strength to strength which has been acknowledged. Nina Morgan and DH will continue to hold to account and provide scrutiny from a progress perspective via the tier three meeting. DH asked permission to continue to update Q&P for the foreseeable future. TB went onto note the improvement to SBL which has increased to 45% however acknowledged that there is still a huge amount of work to be done. AO asked if it would be useful to request a visit and review from the Royal College of Obstetrics and Gynae to gain that level of assurance. DH will progress this with CH. **ACTION** DH continued to say that Stephen Posey, CE of UHDB is attending the ICB Board meeting on 18th January 2024 to close to circle on the flow through all of the governance structures in relation to the CQC rating and report. AO summarised noting the improvement in SBLCB and stated that it will be useful to have included in the next update report a date when UHDB will be fully compliant in this area.	**DH / CH**

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Q&P/2324 /114	**Integrated Performance Report** The Integrated Performance Report was noted. JH highlighted three areas in terms of quality: 1. Quality and safety of maternity services 2. Wilson Street surgery was subject to a comprehensive CQC inspection in October and has now been awarded an overall rating of "Good". 3. DCHS had an unpleasant social media incident linked to the conflict in Israel and Palestine. This was a case of mistaken identity and police are looking into malicious communications. JH commended DCHS in the way this was managed. DM referred to the updated report that has been circulated the previous day noting that the section on Mental Health now includes more detail on LDA and in patient areas. DM went on to note the general highlights: • Total waiting list for electives has reduced slightly in October 2023 • 65-week waits are still an issue • Focus on long waiters (78 weeks plus) and a lot of these patients are being seen in the independent sector. • Cancer performance is slightly improved as at end October 2023. • The new constitutional standards were reported on in October 2023 which means 2 weeks waits is no longer being reported nationally and the 31 day and 62-day standards have been consolidated. 28-day faster diagnosis remains unchanged. • UCDB position has deteriorated for both Trusts. This is a similar picture across the Midlands. • CAT 2 responses for November were at 41 minutes however there is still a target to reduce to 30 minutes. • Mental Health targets for IAPT, Dementia and Perinatal access are being achieved. • Community waiting list for 12 weeks + remain high. • Attendances in urgent care have been higher than planned. Preventative services are running well. AO summarised and acknowledged the CQC rating for Wilson Street Surgery and commended Primary colleagues and the Primary care Quality team for the work they have done. AO referred to Virtual Wards and their capacity and utilisation. AO raised the question asking for clarification on what the current issues. CW provided clarity stating that the estimated capacity would be in the range of 250-260 beds, however not all of the beds have come online due to issues with recruitment. There are currently approximately 160 Virtual Ward beds across Derby and Derbyshire and a utilisation rate of	

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	approx. 50% which is improving. There is also a cultural challenge to the use of virtual ward beds. AO asked about the established capacity of the UTCs and questioned if they were being used to their maximin benefit. CW stated that the ICB have received consistent assurance around the use of the UTCs, staffing levels are good and there is a good flow of patients through the units. DM shared information on numbers and stated the UTCs see around 11k-12k patients per month. Co located UTC spaces see around 4k patients at UHDB and 1k-2k patients at CRH per month, high numbers of these patients are being seen within the 4-hour targets. AM noted the DCHS run UTS is over planned activity. The Committee noted the Integrated Performance Report. AO commented on the need for Quality and Performance committee to gain a better understanding on the UTCs and asked for a report, which details the effectiveness and efficiency of the UTCs as well as a forward look to come to the meeting in April 2024**. ACTION – JP to add to the forward planner.**	**JP**
Q&P/2324 /115	**Board Assurance Framework** The paper was taken as read. JH noted the report covers the beginning of Q3. The BAF working group met on 13th December 2023 and reviewed all risks on the risk register, considered the updates and control measures that are in place. Committee members received and noted the Board Assurance Framework.	
Q&P/2324 /116	**System Quality Group Assurance Report** The System Quality Group Assurance report was noted. There were no questions or comments raised.	
Q&P/2324 /117	**Ratified Minutes** The ratified minutes of the DPG meeting November 2023 were noted for information. There were no comments or questions raised.	

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Minutes and Matters Arising		
Q&P/2324 /118	**Minutes From the Meeting Held On 30th November 2023.** The minutes from the meetings on 30th November 2023 were approved as a true and accurate record.	
Q&P/2324 /119	**Action Log and Future Papers - From the Meeting Held On 30th November 23** The action log was reviewed and updated.	
Closing Items		
Q&P/2324 /120	**Forward Planner** It was agreed that the following papers will be added to the forward planner.	
Q&P/2324 /121	**AOB** DH referred to the forward plan and deep dives and commented that the agenda is light from a system quality improvement perspective. Following the development session on 29th February 2024 this will be quality improvement will have more focus. JH updated the committee on the process for receiving deep dives into the Quality and Performance Committee. JH proposed that the deep dives will be presented at Q&P Committee and should there be additional operational work or wider system work required then it will be referred to System Quality Group. The Committee agreed with the proposal which will commence in February 2024.	

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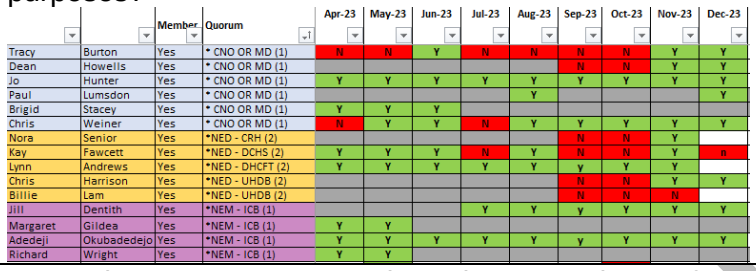
Assurance Questions		
1	Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? 	No – there was only one provider representative in attendance.
2	Were the papers presented to the Committee of an appropriate professional standard, did they incorporate 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?	Amendment to one of the papers which came late.
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?	As per the forward planner.
8	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting?	AO will discuss further with DH and JH

DATE AND TIME OF NEXT MEETING
Date: 25th January 2024
Time: 9.30am to 11.00am
Venue: MS Teams

Approved

NHS
Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board

Meeting in Public

Forward Planner 2024/25

Please Note: All reporting timeframes are currently indicative and subject to review and confirmation.

ICB Key Areas	Apr	16 May	Jun	18 Jul	Aug	19 Sep	Oct	21 Nov	Dec	16 Jan	Feb	20 Mar
Welcome / Apologies and Quoracy		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
Minutes and Matters Arising												
Minutes of the previous meeting		X		X		X		X		X		X
Action Log		X		X		X		X		X		X
Strategy and Leadership												
Chair's Report		X		X		X		X		X		X
Chief Executive Officer's Report		X		X		X		X		X		X
Annual Report and Accounts						X						

ICB Key Areas	Apr	16 May	Jun	18 Jul	Aug	19 Sep	Oct	21 Nov	Dec	16 Jan	Feb	20 Mar
Risk Management												
Risk Register		X		X		X		X		X		X
Board Assurance Framework		X		X				X				X
Strategic Planning & Commissioning												
NHS Joint Forward Plan and refresh		X		X								
NHS Long Term Workforce Plan				X								X
Operational Plan 2024/25 and 2025/26								X				X
Organisational Development and People – ICB staff survey		X										
Organisation Development and People - ICB Strategic Framework		X										
Medium Term Financial Planning (part of the planning round and submission)										X		
Financial Plan		X										X
Winter Plan								X				
Primary Care Strategy								X				X
Primary Care Access Recovery Plan		X										
Derby and Derbyshire Primary Care Model – questions from November 2023 Board bring back to Board 24/25		X										

ICB Key Areas	Apr	16 May	Jun	18 Jul	Aug	19 Sep	Oct	21 Nov	Dec	16 Jan	Feb	20 Mar
Innovation & Information • Digital Development Update • Research		X										X
Green NHS Plan and Progress												X
One Public Estate Strategy												X
System Focus												
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
Finance, Estates and Digital Committee Assurance Report		X		X		X		X		X		X

ICB Key Areas	Apr	16 May	Jun	18 Jul	Aug	19 Sep	Oct	21 Nov	Dec	16 Jan	Feb	20 Mar
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						X
Freedom to Speak Up								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		X
Closing Items												
Forward Planner		X		X		X		X		X		X
Risk Assurance Questions		X		X		X		X		X		X

ICB Key Areas	Apr	16 May	Jun	18 Jul	Aug	19 Sep	Oct	21 Nov	Dec	16 Jan	Feb	20 Mar
Any Other Business		X		X		X		X		X		X
Questions received from members of the public		X		X		X		X		X		X