NHS
Dudley Integrated Health and Care

DUDLEY INTEGRATED HEALTH AND CARE BOARD

TUESDAY 5th MAY 2020
VIRTUAL MEETING (VIA MICROSOFT TEAMS)
10:00 – 12:00

PUBLIC AGENDA

Item No	Agenda Item	Enclosure	Presented by	Time
1.	**Chairman's Welcome**	Verbal	Mr H Turner	10:00
2.	**Apologies**	Verbal	Mr H Turner	10:02
3.	**Declarations of Interest**	Enclosure 1	Mr H Turner	10:03
4. 4.1	**Stakeholder Story** Update on Respiratory Assessment Centre (Red Centre)	Verbal	Dr R Bramble	10:05
5.	**Minutes from the previous meeting held on 1st April for approval**	Enclosure 2	Mr H Turner	10:15
6.	**Action Register and Matters Arising**	Enclosure 3	Mr H Turner	10:20
7.	**Agenda for next Private Board session**	Enclosure 4	Mr H Turner	10:25
8.	**Chief Executive's Report**	Enclosure 5	Mr P Assinder	10:30
9. 9.1	**Chair's Update** NHS Improvement NExT Director Scheme	Verbal Enclosure 6	Mr H Turner Mr H Turner	10:35
10. 10.1 10.2	**Exceptional items** COVID19 Response – Financial Processes to be followed under COVID COVID 19 Response – Wider System Support	 Enclosure 7 Verbal	 Mr M Gamage Mrs S Cartwright	10:40
11. 11.1 11.2	**Corporate Governance and Compliance** Report from Audit & Risk Committee Corporate Risk Register	 Enclosure 8 Enclosure 9	 Mr D Gilburt Mr J Young	10:55
12. 12.1 12.2 12.3 12.4	**Quality & Safety** Report from Integrated Governance Committee Quality dashboard – update on development Chief Nurse report Medical Director report	 Enclosure 10 Verbal Verbal No Update	 Mrs C Brunt Mr J Young Mrs C Brunt	11:05

Item No	Agenda Item	Enclosure	Presented by	Time
13. 13.1 13.2 13.3	**Finance, Performance and Digital** Report from Integrated Governance Committee Finance & Performance dashboard – IAPT Performance Budget Setting 2020/21	 Enclosure 10 Enclosure 11 Enclosure 12	 Mr M Gamage Mr M Gamage Mr M Gamage	11:15
14. 14.1 14.2	**Workforce & OD** Report from Integrated Governance Committee Workforce dashboard	 Enclosure 10 Verbal	 Mrs B Edgar Mrs B Edgar	11:25
15. 15.1	**Transaction and ICP Development** Report from Delivery Board	 Enclosure 13	 Mrs S Cartwright	11:35
16.	**Any Other Business**	Verbal	Mr H Turner	11:45
17.	**Questions from the public**	Verbal	Mr H Turner	11:50
18.	**Board reflections**	Verbal	Mr H Turner	11:55
19.	**Date of next meeting:** 2nd June 2020, 10:00 – 12:00 Venue TBC			

Dudley Integrated Health and Care NHS
Declaration of Interest Register

Title	Name	Job Title/Relationship with Dudley Integrated Health and Care	Declared Interest	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To
Mrs	Beverley Edgar	Interim Associate Director of People	Edgar HR Consultancy, owner via Resourcebank	✓			✓	Sep 2019	Mar 2020
Mr	David Gilburt	Non-Executive Director & Audit Chair	Chair of Cheshire PCC and Chief Constable's Joint Audit Advisory Committee.	✓				2017	
			Non-Executive Director and Audit Chair of the Robert Jones & Agnes Hunt NHS FT	✓				2015	
			Member of the HFMA Governance & Audit Committee		✓			2018	
Mrs	Caroline Brunt	Interim Director of Nursing and Allied Health Professionals	Currently seconded to Interim Executive Director role from Dudley CCG		✓			Apr 2020	Dec 2020
Dr	Chris Weiner	Interim Medical Director	N/A						
Dr	George Soloman	Non-Executive Director	Partner is a Non-Executive Director of Walsall Healthcare NHS Trust				✓	Apr 2020	
Dr	Gillian Love	Associate Non-Executive Director	GP Partner Halesowen Medical Practice		✓	✓			
			Clinical Director of Halesowen PCN		✓				
			Director of Future Proof Health		✓			Jan 2020	
			Share Holder of Future Proof Health		✓			Aug 2014	
			Director of Mary Martin Enterprise Ltd						

Title	Name	Job Title/Relationship with Dudley Integrated Health and Care	Declared Interest	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To
Mr	Harry Turner	Chairman	Deputy Chair S.I.D Robert Jones Orthopaedic Hospital	✓				Jan 2017	
			Chair – John Taylor Hospice		✓			Nov 2016	
			Intercontinental Hotels – Consultant	✓				Aug 2006	
			Chair St Mary's Hospice, Birmingham		✓				
Mr	Ian Buckley	Non-Executive Director	N/A						
Mr	James Young	Interim Head of Quality & Governance	N/A						
Miss	Katie Weston	Interim Executive Assistant	Currently seconded to Executive Assistant role from Sandwell & West Birmingham CCG		✓			Jan 2020	Dec 2020
Mr	Martin Evans	Non-Executive Director	Management consultancy - Director	✓				March 2020	
			Resilience Advisors Network - Member	✓				March 2020	
Mr	Matthew Gamage	Interim Director of Finance	CIMA Member		✓			2012	
			Currently seconded to Interim Director of Finance role from Dudley CCG		✓			Apr 2020	Dec 2020
Mr	Paul Assinder	Interim Chief Executive Officer	Non-Executive Director of Walsall Healthcare NHS Trust	✓				Nov 2019	
			Director of Rodborough Consultancy Ltd (providing financial consultancy to NHS and other clients)	✓				Jun 2014	
			Honorary Lecturer, University of Wolverhampton (unpaid)		✓			2012	
			Governor of Solihull College & University Centre (unpaid)			✓			
			Financial consultancy to Black Country Healthcare NHSFT	✓				Jun 2017	May 2020

Title	Name	Job Title/Relationship with Dudley Integrated Health and Care	Declared Interest	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To
Dr	Ruth Tapparo	Associate GP Non-Executive Director	General Practitioner at Three Villages Medical Practice		✓			Aug 2008	
			Share Holder of Future Proof Health		✓			Jan 2015	
			Primary Care Network Clinical Director		✓			Jul 2019	
			Diabetes Clinical Lead for Diabetes and Ophthalmology		✓			Jun 2015	
			General Practitioner trainer for West Midlands Deanery and Final Year Medical Student trainer for Birmingham University		✓			Aug 2010	
Mrs	Stephanie Cartwright	Interim Director of Strategy, Operations & Partnerships	Currently seconded to Interim Executive Director role from Dudley CCG		✓			Apr 2002	Dec 2020
			Married to the Chief Executive Officer of Black Country and West Birmingham CCGs			✓		Mar 2020	
Ms	Valerie Ann Little	Non-Executive Director	Vice Chair of Corporation of Dudley College of Technology		✓			Sep 2019	
			Member of the Corporation of Dudley College of Technology		✓			Jan 2016	
			Member of the Board of Care & Repair England		✓			Jun 2015	
			Patient registered with a Dudley GP			✓		2008	

DUDLEY INTEGRATED HEALTH AND CARE BOARD

MINUTES OF THE PUBLIC MEETING HELD ON 1 APRIL 2020
VIA MICROSOFT TEAMS

Present:

Mr H Turner (HT) (Chair)	Chairman, Dudley IHC
Mr P Assinder (PA)	Interim Chief Executive, Dudley IHC
Mrs S Cartwright (SC)	Interim Director of Operations, Strategy and Partnerships, Dudley IHC
Mrs B Edgar (BE)	Interim Associate Director of People, Dudley IHC
Mrs C Brunt (CB)	Interim Director of Nursing & Allied Health Professionals, Dudley IHC
Mr M Gamage (MG)	Interim Director of Finance, Dudley IHC
Mr J Young (JY)	Interim Head of Quality & Governance/Board Secretary, Dudley IHC
Mr D Gilburt (DG)	Non-Executive Director, Dudley IHC

In Attendance:

Mr M Evans (ME)	Associate Non-Executive Director
Mr G Soloman (GS)	Associate Non-Executive Director
Mr I Buckley (IB)	Associate Non-Executive Director
Ms V Little (VL)	Associate Non-Executive Director
Mr N Jamshed (NJ)	Consultant, Good Governance Institute
Mr A Hughes (AJ)	Change Director, Good Governance Institute
Mr C Dingwall (CD)	Partner, Browne Jacobson

Minute Taker:

Miss K Weston (KW)	Executive Assistant, Dudley IHC

001/20. WELCOME & INTRODUCTION

The Chair welcomed everyone to the first Dudley Integrated Health and Care (DIHC) Board and introductions were made.

SC clarified that the process is underway to legally change the name of the organisation from Dudley and Walsall Mental Health Partnership NHS Foundation Trust (DWMHPT) to DIHC NHS Trust, however due to the COVID-19 crisis this process has been delayed. Therefore from a legal position the name is still currently DWMHPT although the organisation will be known and operating as DIHC.

PA formally recognised the significant achievement and highlighted that this is not only a key moment for the population of Dudley, but also for the wider NHS. PA stated that this organisation that has commenced this morning is committed to changing for the better, the care offering to the people of Dudley. DIHC has an immediate responsibility to help support partners in the current COVID-19 pandemic, and at the same time reshape the service offering to the people of Dudley.

On behalf of all the people of Dudley, PA thanked everyone who worked on this project to help contribute to today's new organisation.

002/20. DECLARATIONS OF INTEREST

The Declaration of Interest log is enclosed within the Board papers.

PA declared that he is a Non-Executive Director of Walsall Healthcare NHS Trust and is currently doing consultancy work for the newly-formed Black Country Healthcare NHS Foundation Trust (BCH).

As the four new Non-Executive Directors have not yet been formally appointed, their declarations of interest are not included within the declarations of interest log. KW to ensure that their interests are collated for the next Board Meeting.

No further interests were declared.

Action: KW to update the declarations of interest log with the four new Non-Executive Directors and PA's interests for the next Board Meeting.

003/20. CHAIRS UPDATE

HT stated that the resilience of the team has been recognised by NHSE/I on many occasions, and he hopes that the Board continue to have the ambition and resilience to deliver on the promise made to NHSE/I and the population of Dudley. HT is excited for this opportunity and looks forward to working with the Board.

004/20. ITEM TO NOTE: PRIVATE BOARD AGENDA

The agenda for part two of the Board meeting has been shared in the Board papers for information.

005/20. ROLES & RESPONSIBILITIES OF DIRECTORS

This paper summarises the roles and responsibilities of the Interim Executive Directors.

SC stated that PA has been appointed as Interim Chief Executive Officer (CEO) and will be written to accordingly by NHSI. JY as the Head of Quality and Governance will be undertaking the role of the Company Secretary throughout the interim period.

Within the list of roles and responsibilities the Freedom of Information (FoI) lead is listed under the Director of Operations, Partners and Strategy, however it has been suggested that this responsibility is to be moved to the Director of Nursing and Allied Health Professionals. This is to be discussed and agreed by the Executive Directors.

It was noted that the closing paragraph within the paper refers to the Head of Operations who is not yet formally seconded to DIHC. The Head of Operations is currently employed by The Dudley Group NHS Foundation Trust (DGFT) and throughout the current COVID-19 crisis has operational responsibilities both within the hospital and out in community, therefore a formal secondment has not yet been made. The Head of Operations is still part of the team and will be working closely with everyone in the coming weeks and months as the organisation takes an increased leadership role in primary and community services to support the COVID-19 crisis.

It was raised that the accountability for Controlled Drugs is listed under both the Medical Director and Director of Nursing and Allied Health Professionals. VL suggested that this should be the responsibility of the Medical Director. SC stated that Dr Chris Weiner has been appointed as Interim Medical Director who currently works with NHSI and cannot be released onto secondment until 1st May 2020. Therefore it was agreed that the responsibility will sit with the Director of Nursing and Allied Health Professionals until the Medical Director commences secondment on 1st May 2020.

The Board approve the Board Composition and the roles and responsibilities of the Executive Team, noting the comment made by VL around accountability of Controlled Drugs. The Board support the nomination of PA acting as interim CEO, and the Board agree that the Head of Quality and Governance will have the responsibility of Company Secretary during the transition period.

006/20. SFIs, STANDING ORDERS & SCHEME OF DELEGATION

MG presented the report Provisional Constitution which includes the Standing Orders, Standing Financial Instructions (SFI's) and Scheme of Reservation and Delegation. The report has been developed by Browne Jacobson and the Good Governance Institute (GGI) on behalf of DIHC.

The documents have been shared with DG as the Audit and Risk Committee Chair, and it is recommended that the Board receives this report for approval today and the Audit and Risk Committee will review the documents over the next three months. As the organisation develops, the individuals within the Scheme of Delegation will change.

Failure to comply with the SFI's can result in disciplinary action, therefore if anyone has difficultly interpreting the SFI's included within the document they should contact the Director of Finance for assistance.

IB questioned if the organisation is going to take over the auditors from DWMHPT or if auditors are to be appointed. MG responded that he has had confirmation from the internal auditors of DWMPHT to extend their contract for 12 months, and is awaiting a final response from the external auditors.

The Board approve the provisional constitution and request that the Audit and Risk Committee review and recommend to the board any revisions in the next three months.

Action: Audit and Risk Committee to review and recommend to the Board any revisions of the constitution documents in the next three months.

The Board formally acknowledge the input of work by Browne Jacobson and the GGI.

007/20. COMMITTEE TERMS OF REFERENCE

JY presented the proposal for the establishment of a number of Committees:

- Audit and Risk
- Remuneration
- Finance and Performance (from July 2020)
- Quality (from July 2020)
- People & OD (from July 2020)

JY stated to support the transition into a new Committee structure it is proposed that an Integrated Governance Committee be established for the period of April 2020 – June 2020, covering the functions of the Finance & Performance, Quality and People & OD Committees.

In addition, it is proposed that a Transaction Committee is established until the ICP contract is awarded to oversee the transition of services into the organisation.

JY highlighted that within the terms of reference (ToRs) documents there were some elements that still needed to be confirmed, and that the team would endeavour to get these documents reviewed and completed within the relevant committees and feedback at the next Board meeting.

The Board acknowledged the support from GGI in drafting the ToRs.

DG suggested the following amendments to be made to the Remuneration Committee ToR to ensure the committee is constituted when it meets later today:

- Paragraph 4.1 - Members of the Committee will be appointed by the Board of Directors and will be made up of at least 2 members. This is to be reviewed when colleagues are formally appointed.
- Paragraph 4.2 – The Committee membership will comprise the Chair and all five NEDs
- Paragraph 4.11 – quoracy will be a minimum of two
- Paragraph 7.1 – Committee to meet at a minimum of twice a year.
- Paragraph 7.2 – Minutes to be made available within 10 working days following the meeting

DG also suggested the following amendments to be made to the Audit and Risk Committee ToR:

- Paragraph 4.1 Members of the Committee will be appointed by the Board and the Committee will be made up of at least 3 members
- Paragraph 4.16 quoracy necessary for the transaction of business will be 2 members

The Board agreed with the above suggestions and JY will ensure the ToRs are updated.

HT stated that he commits to appoint the Non-Executive Directors to the Committees within the course of the next week.

Following the above amendments, the Board approve the proposed Committees and associated ToRs.

Action: JY to update ToRs and bring completed documents to the next Board meeting for formal sign off.

008/20. AWARD OF ICP CONTRACT

Back in September 2019 the ICP Development Team were given permission to explore DWMHPT to use as the ICP organisation. A Strategic Outline Case was approved and an addendum was created to outline how the ICP would progress through the transaction. The addendum was also approved by NHSE/I and therefore the ICP exists as an organisation today.

The next part of the process is to complete the Full Business Case (FBC) and submit the FBC for the award of the ICP contract. The ICP is officially running two services which are Primary Care Mental Health and Improving Access to Psychological Therapies (IAPT).

SC highlighted that the plan was to complete the FBC and submit to NHSE/I at the end of April, if this was approved by NHSE/I the ICP was aiming to receive the ICP Contract Award on 1st October 2020. However given the current COVID-19 crisis, it was proposed at the Delivery Board on 25th March 2020 to delay the submission of the FBC and for the ICP to support its partners during this pandemic. The Delivery Board were in agreement with this suggestion and a formal letter was submitted to NHSE/I outlining the proposal. NHSE/I welcomed this decision made by the ICP and supports its endeavours to support the local system particularly with regards to the coordination and leadership of Primary Care and Community Services.

It was noted that the FBC for the award of the ICP contract will still be submitted however there is not a confirmed date as the current priority is to support partners during this pandemic.

A proposal has been written on how the ICP can support the system during this time and the team are already heavily involved with the system calls that are taking place on a daily basis. Communications and processes are in place with the acute to ensure that any communications that are going to be sent out to Primary Care are checked by SC and the Director of Commissioning at Dudley CCG to ensure there is consistency across communications.

It was noted that SC has had a recent conversation with the Chief Executive from DGFT and the Director of Commissioning from Dudley CCG, and it was confirmed that both partners are in support of the ICP taking a lead in Primary Care. Partners are currently reviewing the proposal from the ICP and SC is awaiting feedback with regards to support around community services.

As transformation is happening on a daily basis, SC stated that the business case will capture all of this once the team recommence the FBC work.

Given the current circumstances, the team have agreed with NHSE/I colleagues to not to undertake proactive communications on the creation of the ICP. A message has been put out on the organisations Twitter page (@IHCDudley) and a newsletter has been circulated to staff. SC commented that any communication will be subtle and sensitive to the current crisis.

It was noted that the Board are assured around the FBC process, and approve the approach that the Board is taking in respect of supporting the system during COVID-19.

009/20. INTERIM GOVERNANCE AND 'BACK OFFICE' FUNCTIONS ARRANGEMENTS

A Service Level Agreement (SLA) is currently in place with BCH to provide a number of back office functions which are outlined within the report. By having this agreement with BCH, it enables our clinical services to continue to run as they were when they were being managed by DWMHPT however the accountability will sit with DIHC. The performance of the SLA will be monitored through regular review meetings.

IB questioned if there is an intention to produce a performance report, and if there will be a monthly update provided to the Board with any Governance issues. JY responded that for the majority of the services there will be a monthly review process and the SLA covers wider information and Business Intelligence reporting functions, which will support the reports that need to come through the Board and to NHSE/I.

It was noted that the Integrated Governance Committee will be scrutinising reports before being brought to Board.

The Board are assured that all relevant systems and processes are in place.

010/20. RISK REGISTER

CB formally recognised the amount of work that has gone into the risk register both through the ICP Development Team and GGI. This process has been managed to date through the Delivery Board and has been extensively worked through with partners.

The transaction and business case risks are currently on hold however the team will be mindful of the risks until such point when the production of the FBC can be recommenced.

Work is to be progressed in terms of the Board Assurance Framework (BAF) and this will be discussed in part two of the meeting. The risk register will become a standing agenda item for the Board.

References to the finances will be picked up within item 12.

The Board have received assurance that there is a process in place for the risk register and will be developed as the organisation progresses.

011/20. BOARD ANNUAL BUSINESS CYCLE

The Board Annual Business Cycle has been developed with the GGI and it was noted that this document will be reviewed and adapted over the next few months.

This document is to provide assurance to that Board that there are systems in place and the four new Non-Executive Directors will be aligned to the relevant committees. An updated business cycle will be brought to the next Board meeting to demonstrate how the items will be managed by the Board and each committee across the year.

VL requested within the reworking of the business cycle that consideration is given to an annual safeguarding report under the Quality Committee.

The Board approve the proposed schedule and approach to its further development.

Action: JY to provide updated business cycle at the next Board meeting.

012/20. OPENING FINANCE REPORT

MG stated that the opening finance report reflects a 6 month position (April 2020 – September 2020) due to the work on the ongoing business case. The report shows an income and expenditure high level plan, along with the opening and closing balance sheet.

The opening balance sheet will need to reflect the closing position of DWMPHT after the transfer of services to BCH, and MG highlighted that £3.4m funding has been made available by BCH to support transaction costs that is repayable over a three year period.

Due to the limited volume of services in the first six months the Trust is expecting to be in a deficit financial position of £0.6m at the end of September 2020. It was noted that this position is likely to worsen as a result of delays to the FBC submission and contract award.

The financial arrangements for the NHS have changed for the first four months of the year as a response to COVID-19 and are moving to block contract payments. The block payments have been calculated using provider submissions of their month nine return however as DIHC is a new organisation, MG is to confirm the funding arrangements with NHSE/I. This could potentially mitigate the Trusts deficit position.

Once the work on the FBC recommences an updated financial model will be provided to the Board with the full complement of services, and MG recommends a separate workshop to go through the financial model.

PA stated that it is important that the board note that in response to the COVID-19 crisis, the Treasury have suspended the traditional financial and performance management framework that is applicable in the public sector. Therefore the NHS for this period is no longer operating in terms of financial control totals and do not require to hit various performance targets. The NHS is currently working in a different financial environment, and the Chancellor has made it clear that the additional expenditure resulting from COVID-19 preparations will be separately funded.

IB suggested that it would be useful to have a document that gives the Board an idea of the overall cost impact of COIVD-19. MG responded that the Trust is currently in discussions around what it will be contributing to the system, and this can be brought to a future Board meeting.

Following discussions, the Board are assured on the Trusts financial position and agree with all recommendations outlined within the financial paper.

Action: MG to bring updated financial model to June's Board meeting along with an accompanying paper that outlines the overall cost impact for the Trust as a result of COVID-19.

013/20. COVID-19 UPDATE

The Black Country are currently tracking second to London in terms of infection rates, and it is important to acknowledge and reflect that this is an indicator of our population deprivation. The peak of this virus is currently being estimated around 10th, 11th and 12th April.

Pressure levels are being tracked within Primary Care between levels 1 – 4, 4 being when only 25% of Primary Care is functional and COVID Red Centres are being fully utilised to cohort activity. Currently across the Board, Primary Care is functioning at level 2 anticipating moving up to level 3 in the next few days.

The Red Centre is functioning for confirmed or highly suspected COVID patients. Practices will be able to refer patients across the borough into the Red Centre that require a physical assessment. It has been advised that a larger site needs to be attained therefore with the support of DGFT, the Guest Hospital will be released from 3rd April 2020.

CB stated that there will be a Nightingale facility at Birmingham National Exhibition Centre (NEC) which will give additional capacity around acute, particularly around management of ventilation and CPAP machines to assist with breathing difficulties.

It was noted that there has been support from our Chambers of Commerce, and local businesses have produced Personal Protection Equipment (PPE) that is being distributed locally. There is also local production of scrubs which is similar to those worn in operating theatres to try and maximise safety for staff working on the front line.

Formal communications will be sent out to the public to notify them of the progressions that have been discussed.

VL questioned what the position is regarding antigen testing of staff who may be self-isolating. CB stated there is no testing currently in Primary Care however there is intention to following the current focus on staff in acute services.

GS questioned if the probability of going to level 3 in Primary Care is in regards to the infection rates or the number of staff that are self-isolating. CB responded that it is a combination of the two although pressure levels are determined by the ability for practices to respond.

The Board are assured around the Trusts input to the COVID plans.

014/20. ANY OTHER BUSINESS

It was agreed that the invite for the Audit and Risk Committee is to be extended to JY.

NB and AH congratulated the Board. NB questioned how the Trust is going to engage with the public given that these meetings cannot be currently held in public. HT stated that a technical solution will be worked through for the next Board.

HC commented that when the ICP newsletter was circulated earlier this week there were responses from

members of the public who were really pleased and supportive of the new Trust. Public engagement will continue.

The Board formally acknowledged and thanked the NHS Transformation Unit and Strategy Unit for their work towards the ICP Organisation.

Over the coming weeks HT will be in consultation with the Executives and Non-Executives to agree membership of the Committees, and ensure that there is both an Executive and Non-Executive lead for each.

As the four Non-Executive Directors are not yet formally appointed, it was noted that they are not able to attend the second part of this meeting.

Dudley Integrated Health and Care NHS Public Board
Open Action Register

Dudley Integrated Health and Care

Ref	Date Raised	Action	Action Lead	Due Date	Update	Date Completed
002/20	01/04/2020	Update the declarations of interest log with the four new Non-Executive Directors and PA's interests for the next Board Meeting.	KW	Apr-20	Proposed for closure	10/04/2020
007/20	01/04/2020	Update ToRs and bring completed documents to the next Board meeting for formal sign off.	JY	May-20		
011/20	01/04/2020	Provide updated business cycle at the next Board meeting.	JY	May-20		
012/20	01/04/2020	Bring updated financial model to June's Board meeting along with an accompanying paper that outlines the overall cost impact for the Trust as a result of COVID-19.	MG	Jun-20		
006/20	01/04/2020	Audit and Risk Committee to review and recommend to the Board any revisions of the constitution documents in the next three months.	MG	Jul-20		

NHS
Dudley Integrated Health and Care

DUDLEY INTEGRATED HEALTH AND CARE BOARD

5th May 2020
VIRTUAL MEETING
12:30 – 13:30

PRIVATE AGENDA

Item No	Agenda Item	Enclosure	Presented by	Time
1.	**Chairman's Welcome**	Verbal	Mr H Turner	12:30
2.	**Apologies**	Verbal	Mr H Turner	12:32
3.	**Declarations of Interest**	Enclosure 1	Mr H Turner	12:33
4.	**Minutes from previous meeting held on 1st April 2020**	Enclosure 2	Mr H Turner	12:35
5.	**Action Register and Matters Arising**	Enclosure 3	Mr H Turner	12:45
6.	**Business Case Development**	Verbal	Mrs S Cartwright	12:55
7.	**Regulator Update**	Verbal	Mrs S Cartwright	13:05
8.	**Any Other Business**	Verbal	Mr H Turner	13:20
9.	**Date of next meeting:** 2nd June 2020, 12:30 – 13:30 Venue TBC			

Dudley Integrated Health and Care

DUDLEY INTEGRATED HEALTH AND CARE BOARD

Date of Meeting: 5th May 2020
Report: Chief Executive's Report

TITLE OF REPORT:	Chief Executive's Report
PURPOSE OF REPORT:	Board update on current issues
AUTHOR OF REPORT:	Paul Assinder
KEY POINTS:	1. Summarises DIHC's role in the Dudley systems Covid-19 response. 2. Updates on Board Development & appointments 3. Sets out latest NHS plans on Post Covid-19 service restoration, recovery & re-set
RECOMMENDATION:	The Board is asked to note the report
ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	No
ACTION REQUIRED:	Decision Approval Assurance X

Chief Executive's Report

1. Covid-19 System Response

On 30th January 2020, in response to a declaration of national emergency by the Government of the UK, the NHS national leadership declared a Level 4 (highest ranked) emergency status for the English NHS. That status remains in force.

Preparing for the local system response to the global Covid-19 pandemic has been the main focus of the Organisation's activities over the past month.

In developing our local response to this crisis, we have worked very closely with other system partners, principally local GP practices; Dudley Group of Hospitals; the Local Authority and the Black Country Healthcare Trust. All partners in Dudley have risen to the challenge and the Board will note that, together with London, the Black Country (with its tradition of heavy industry and higher prevalence of chronic respiratory diseases) experienced one of the heaviest and earliest waves of recognised Covid-19 cases in the Country and appearing to peak in early April.

During April, DIHC has participated fully in daily emergency Gold Command calls and tactical discussions at Dudley, Black Country and twice weekly, at NHSEI levels.

The Chancellor of the Exchequer has made special funding available to meet the additional costs of Covid-19 prevention measures and we have been working with local NHS organisations to best utilise this funding. NHS performance targets for access and waiting times have been stood down for the duration of the Level 4 emergency.

A more detailed and comprehensive analysis of DIHC's significant contribution to local system working is provided elsewhere in these papers but of note is our role in coordinating multi-agency care across the Borough through the Clinical Hub; End of Life response support; and the establishment of the Covid-19 'Red Centre' at Guest Hospital.

The Board will wish to acknowledge the significant commitment of clinical staff locally and the impressive support and ingenuity of non-clinical colleagues.

2. Increasing Access to Psychological Therapies (IAPT) and Primary Care Mental Health Services in Dudley

The Board will recall that in focusing upon our system-wide Covid-19 response, DIHC has agreed with the Black Country Healthcare NHS Trust that these services will, for the duration of the crisis, continue to be operationally managed by BCH.

However, the 62 staff in post in IAPT & Primary Care Mental Health have remained on our payroll and we have been working closely with them during this period.

In common with other similar services across the Country, activity has fallen during the last month with referrals to our services typically falling below target by 120 per week (>60%). It is considered that some of this displaced activity has been absorbed by our primary care-based MH services but we are awaiting details of activity figures for April from BCH.

Engagement with the 62 directly employed clinical staff over the past 4 weeks has been good with positive feedback received about the efforts of our Executive Team and NEDs to 'welcome them' to DIHC.

3. Full Business Case Production

In view of the level 4 emergency declared for the NHS, DIHC has agreed with NHSEI that it should temporarily suspend the intended submission of the FBC in April. Nonetheless some work has continued to refresh the most recent draft of the case and we continue to benefit from the services of Lee Hay from the NHS England Transformation Unit and others.

It is of note that the significant and rapid changes seen in Dudley, in response to the Covid-19 challenge, has illustrated the very real benefits of truly integrated working and it is our intention to reference these practical case studies in an updated FBC.

We are currently in discussions with NHSEI to establish its capacity to receive and consider the final draft of the FBC in the next few weeks.

4. Board Development

Colleagues will be aware of our continuing relationship with the Good Governance Institute in board development. The third of three planned GGI facilitated sessions will be held in early May and will consider tactical plans and the tactical board assurance framework.

In the past week I have met virtually with each of the Executive Directors to discuss their immediate objectives and with Dr Chris Weiner, who will join the Board as Medical Director in early May. A detailed Programme of (virtual) induction is being prepared for Chris.

It has been agreed that Chris will chair the local Clinical Senate.

5. NHS restoration, recovery and re-set

All NHS commissioners and providers have recently received a formal instruction from Sir Simon Stevens, NHS Chief Executive, to begin to re-instate those (mainly elective) provider services temporarily suspended or reduced, at the commencement of the emergency (see *Appendix 1*).

In recent discussions with NHS chairs and CEO's the terms '*restoration, recovery and re-set'* have been used to describe three interconnected phases of post-Covid-19 NHS recovery.

What is clear from such discussions are that the NHS is very likely to have to live with the burden of a significant Covid-related caseload for many months to come and must at the same time begin to restore services for Non-Covid related urgent and planned referrals.

Faced with such sustained pressure on traditional service models in the future, NHS leaders are keen to retain many of the innovative working practices seen over the past few weeks of Covid-19 response, including increased care out of hospital settings and commonplace remote and agile soluitions.

The next few months will be characterised by a gradual 'restoration' of reduced or ceased services and the remainder of this financial year (to March 2021) is intended to be further characterised by a period of 'recovery' of lost ground on access and waiting lists etc.

However, in train with these, it is intended that parallel work will be commenced on a national 're-set' of how the NHS will operate in each locality or 'place' in the future.

These developments are sympathetic to the vision of integrated services, with local services led by primary care, which is outlined in our business case. We are working with other providers and local commissioners to inform this re-set for the population of Dudley and endeavour to reflect this in the final version of our FBC.

Paul Assinder
27 April 2020

Appendix 1

Skipton House
80 London Road
London SE1 6LH
england.spoc@nhs.net

From the Chief Executive Sir Simon Stevens
& Chief Operating Officer Amanda Pritchard

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services
NHS 111 providers

Copy to:
NHS Regional Directors
Chairs of ICSs and STPs
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums

29 April 2020

Dear Colleague,

IMPORTANT - FOR ACTION - SECOND PHASE OF NHS RESPONSE TO COVID19

We are writing to thank you and your teams for everything you have achieved and are doing in securing the remarkable NHS response to the greatest global health emergency in our history.

On 30th January the first phase of the NHS's preparation and response to Covid19 was triggered with the declaration of a Level 4 National Incident. Then in the light of the latest SAGE advice and Government decisions, on 17th March we wrote to initiate what has been the fastest and most far reaching repurposing of NHS services, staffing and capacity in our 72-year history.

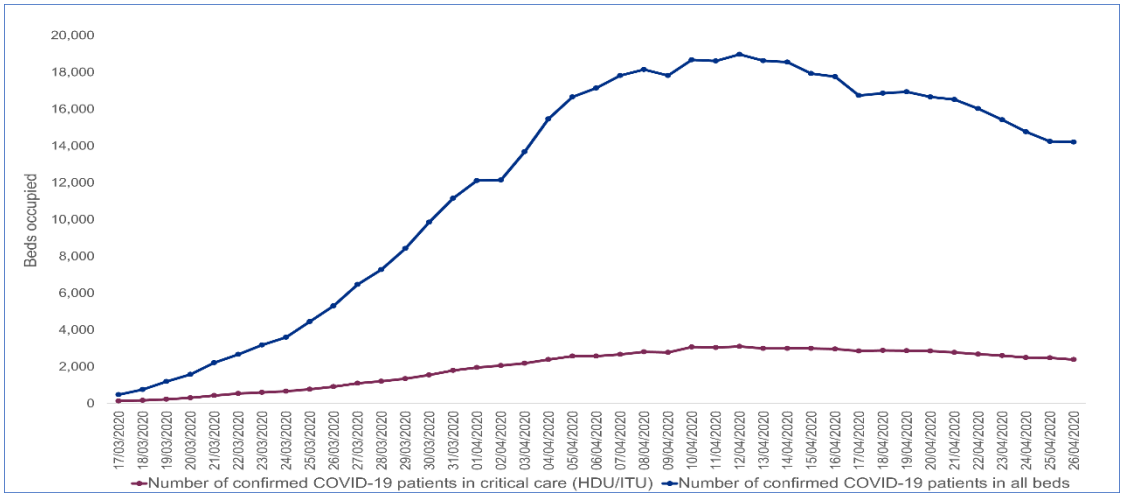
This has enabled us in the space of the past six weeks to go from looking after zero such patients to caring for 19,000 confirmed Covid19-positive inpatients per day, many of whom have needed rapidly expanded critical care support. Alongside this, the majority of patients the Health Service has continued to look after have been receiving care for other important health conditions. Despite real concern going in to the pandemic – following difficult international experience – every coronavirus patient needing hospital care, including ventilation, has been able to receive it.

This has largely been possible as a result of the unparalleled commitment and flexibility of NHS staff, combined with the public's 'social distancing' which remains in

place to cut the spread of the virus. We have also been greatly strengthened by over 10,000 returning health professionals; 27,000 student nurses, doctors and other health professionals starting their NHS careers early; 607,000 NHS volunteers; and the work of our partners in local government, social care, the military, the voluntary sector, hospices, and the private sector.

Sadly coronavirus looks set to be with the us for some time to come, so we will need continuing vigilance. We are, however, now coming through this peak of hospitalisations, as seen by the drop of nearly 5,000 in the daily number of confirmed Covid19-positive patients in hospitals across England over the past fortnight.

Patients with confirmed Covid19 in hospital beds, England



As the Prime Minister set out on Monday, we are therefore now entering the second phase in the NHS's response. We continue to be in a Level 4 National Incident with all the altered operating disciplines that requires. NHS organisations therefore need to fully retain their EPRR incident coordination functions given the uncertainty and ongoing need. The purpose of this letter is to set out the broad operating environment and approach that we will all be working within over the coming weeks.

Based on advice from SAGE, we still expect to be looking after several thousand **Covid19-positive patients**, though hopefully with continuing weekly decreases. This means:

- Ongoing and consistent application of PHE/NHS Infection Prevention and Control guidance in all NHS organisations, with appropriate cohorting of Covid/non-Covid patients (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control).

- In response to the global shortage, DHSC and the Cabinet Office together with BEIS (for UK manufacture) and DIT (for international suppliers) continue to expand the sourcing and procurement of HSE/PHE-recommended PPE for the NHS, social care and other affected sectors of the UK economy, but it is likely that current Covid-specific logistics and distribution arrangements will need to continue for the time being.

- Increased lab capacity now enables testing of all non-elective inpatients at point of admission, the introduction of pre-admission testing of all elective patients, testing prior to discharge to a care home, as well as expanded testing for staff. The corollary is the operational importance of fast turnaround times for test result reporting.

The pressure on many of **our staff** will remain unprecedented, and they will need enhanced and active support from their NHS employers to ensure their wellbeing and safety.

- Increased testing capacity means that we will now be able to extend the offer of regular testing to asymptomatic staff, guided by PHE and clinical advice. This approach is being piloted in a number of acute, community and mental health providers this week, which will inform further roll out from next week.

- As set out in our letter of 17th March, NHS organisations should continue to assess staff who may be at increased risk - including older colleagues, pregnant women, returnees, and those with underlying health conditions - and make adjustments including working remotely or in a lower risk area. Educational material, training and appropriate protection should be inclusive and accessible for our whole workforce, including our non-clinical colleagues such as cleaners and porters.

- Emerging UK and international data suggest that people from Black, Asian and Minority Ethnic (BAME) backgrounds are also being disproportionately affected by Covid19. Public Health England have been asked by DHSC to investigate this. In advance of their report and guidance, on a precautionary basis we recommend employers should risk-assess staff at potentially greater risk and make appropriate arrangements accordingly.

- Now more than ever a safety and learning culture is vital. All our staff should feel able to raise concerns safely. Local Freedom to Speak Up Guardians are able to provide guidance and support with this for any concerned member of staff. As we know, diverse and inclusive teams make better decisions, including in the Covid19 response.

- Employers are also asked to complete the process of employment offers, induction and any necessary top-up training within the next fortnight for all prospective ‘returners’ who have been notified to them.

We are going to see increased demand for Covid19 aftercare and support in **community health services, primary care, and mental health.** Community health services will need to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing health support. High priority actions for mental health providers in this next phase are set out in the Annex. General practice will need to continue to stratify and proactively contact their high-risk patients with ongoing care needs, including those in the ‘shielding’ cohort to ensure they are accessing needed care and are receiving their medications.

Given the scale of the challenges they face, we must also continue to partner with **local authorities** and Local Resilience Forums (LRFs) in providing mutual aid with our colleagues in **social care**, including care homes. This includes:

- Continuing to ensure that all patients safely and appropriately being discharged from hospital to a care home are first tested for Covid19; care homes can also check that these tests have been carried out.

- Under the direction of the LRF, local authority public health departments and CCG infection control nurses can help 'train the trainers' in care homes about PHE's recommended approach to infection prevention and control - particularly focusing on those care homes that lack the infrastructure of the bigger regional and national chains.

- To further support care homes, the NHS will bring forward from October to May 2020 the national roll out of key elements of the primary and community health service-led Enhanced Health in Care Homes service. Further detail will be set out shortly.

- Opportunities to support care homes should also be provided to younger health professional 'returnees' and public volunteers who have offered to help (subject to appropriate personal risk assessment, as described above).

As also seen in a number of other countries, **emergency activity** has sharply reduced in recent weeks. Last week emergency hospital admissions were at 63% of their level in the same week last year. This is likely due to a combination of: a) changed healthcare seeking behaviour by patients, b) reductions in the incidence of some health problems such as major trauma and road traffic accidents, c) clinical judgements about the balance of risk between care in different settings, and d) some NHS care being provided through alternative access routes (eg ambulance 'see and treat', online appointments).

There is therefore considerable uncertainty as to the timing and extent of the likely rebound in emergency demand. To the extent it happens, non-elective patients will potentially reoccupy tens of thousands of hospital beds which have not had to be used for that purpose over the past month or so.

This means we need to retain our demonstrated ability to quickly repurpose and **'surge' capacity** locally and regionally, should it be needed again. It will also be prudent, at least for the time being, to consider retaining extra capacity that has been brought on line - including access to independent hospitals and Nightingale hospitals. The national Nightingale team will work with Regions and host trusts to develop and assure regional proposals for the potential ongoing availability and function of the Nightingale Hospitals. Independent hospitals and diagnostics should be used for the remainder of the current contract which runs to the end of June. Please also start now to build a plan for each STP/ICS for the service type and activity volumes that you think could be needed beyond the end of June, which can inform discussions during May about possible contract extensions with the independent sector.

Over the next six weeks and beyond we have the opportunity to begin to release and redeploy some of the treatment capacity that could have been needed while the number of Covid19 patients was rising so sharply.

This means we are now asking all NHS local systems and organisations working with regional colleagues fully to step up **non-Covid19 urgent services** as soon as possible over the next six weeks, including those set out in the Annex. This needs to be a safe restart with full attention to infection prevention and control as the guiding principle.

In addition, you should now work across local systems and with your regional teams over the next 10 days to make judgements on whether you have further capacity for at least some **routine non-urgent elective care**. Provisional plans will need to factor-in the availability of associated medicines, PPE, blood, consumables, equipment and other needed supplies. We will continue to provide new ventilators to trusts over the coming weeks so as to sustain critical care 'surge' capacity should it again be needed in future, while progressively returning operating theatres and recovery suites to their normal use.

We should also take this opportunity to **'lock in' beneficial changes** that we've collectively brought about in recent weeks. This includes backing local initiative and flexibility; enhanced local system working; strong clinical leadership; flexible and remote working where appropriate; and rapid scaling of new technology-enabled service delivery options such as digital consultations.

In terms of wider action that will also be underway, DHSC will be designing and establishing its new 'Test, Track & Trace' service. The leadership and resourcing of local authority public health departments will be vital. Trusts and primary care networks should continue to support clinicians to enrol patients in the three major phase III clinical trials now underway across the NHS, initially testing ten potential Covid19 treatments. In addition, at least 112 Covid19 vaccines are currently in development globally. We also expect an expanded winter flu vaccination campaign alongside a school immunisation 'catch up programme'.

Looking forward, at the right time and following decision by Government, we will then need to move into the NHS's phase three 'recovery' period for the balance of the 2020/21 financial year, and we will write further at that point.

In the meantime, please accept our personal thanks and support for the extraordinary way in which you and your staff have risen to this unprecedented global health challenge.

With best wishes,

Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

ANNEX

ACTIONS RECOMMENDED FOR URGENT CLINICAL SERVICES OVER THE NEXT SIX WEEKS

Urgent and routine surgery and care

- Strengthen 111 capacity and sustain appropriate ambulance services 'hear and treat' and 'see and treat' models. Increase the availability of booked appointments and open up new secondary care dispositions (SDEC, hot specialty clinic, frailty services) that allow patients to bypass the emergency department altogether where clinically appropriate.
- Provide local support to the new national NHS communications campaign encouraging people who should be seeking emergency or urgent care to contact their GP, go online to NHS 111 or call 999 if necessary.
- Provide urgent outpatient and diagnostic appointments (including direct access diagnostics available to GPs) at pre-Covid19 levels.
- Ensure that urgent and time-critical surgery and non-surgical procedures can be provided at pre-Covid19 levels of capacity. The Royal College of Surgeons has produced helpful advice on surgical prioritisation available at: (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf)
- In the absence of face-to-face visits, primary and secondary care clinicians should stratify and proactively contact their high risk patients to educate on specific symptoms/circumstances needing urgent hospital care, and ensure appropriate ongoing care plans are delivered.
- Solid organ transplant services should continue to operate in conjunction with the clinical guidance developed and published by NHS Blood and Transplant.
- Where additional capacity is available, restart routine electives, prioritising long waiters first. Make full use of all contracted independent sector hospital and diagnostic capacity.
- All NHS acute and community hospitals should ensure all admitted patients are assessed daily for discharge, against each of the Reasons to Reside; and that every patient who does not need to be in a hospital bed is included in a complete and timely Hospital Discharge List, to enable the community Discharge Service to achieve safe and appropriate same day discharge.

Cancer

- Providers have previously been asked to maintain access to essential cancer surgery and other treatment throughout the Covid19 pandemic, in line with guidance from the Academy of Medical Royal Colleges and the NHS (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0239-Specialty-guide-Essential-Cancer-surgery-and-coronavirus-v1-70420.pdf and https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0239-Specialty-guide-Essential-Cancer-surgery-and-coronavirus-v1-70420.pdf). An exception has been where clinicians consider that for an individual patient the risk of the procedure at the current time outweighs the benefit to the patient.

- Local systems and Cancer Alliances must continue to identify ring-fenced diagnostic and surgical capacity for cancer, and providers must protect and deliver cancer surgery and cancer treatment by ensuring that cancer surgery hubs are fully operational. Full use should be made of the available contracted independent sector hospital and diagnostic capacity locally and regionally. Regional cancer SROs must now provide assurance that these arrangements are in place everywhere.
- Referrals, diagnostics (including direct access diagnostics available to GPs) and treatment must be brought back to pre-pandemic levels at the earliest opportunity to minimise potential harm, and to reduce the scale of the post-pandemic surge in demand. Urgent action should be taken by hospitals to receive new two-week wait referrals and provide two-week wait outpatient and diagnostic appointments at pre-Covid19 levels in Covid19 protected hubs/environments.
- High priority BMT and CAR-T procedures should be able to continue, where critical care capacity is available.

Cardiovascular Disease, Heart Attacks and Stroke

- Hospitals to prioritise capacity for acute cardiac surgery, cardiology services for PCI and PPCI and interventional neuroradiology for mechanical thrombectomy.
- Secondary care to prioritise capacity for urgent arrhythmia services plus management of patients with severe heart failure and severe valve disease.
- Primary care clinicians to continue to identify and refer patients acutely to cardiac and stroke services which continue to operate throughout the Covid19 response.
- Hospitals to prioritise capacity for stroke services for admission to hyperacute and acute stroke units, for stroke thrombolysis and for mechanical thrombectomy.

Maternity

- Providers to make direct and regular contact with all women receiving antenatal and postnatal care, explaining how to access maternity services for scheduled and unscheduled care, emphasising the importance of sharing any concerns so that the maternity team can advise and reassure women of the best and safest place to receive care.
- Ensure obstetric units have appropriate staffing levels including anaesthetic cover.

Primary Care

- Ensure patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns.
- Complete work on implementing digital and video consultations, so that all patients and practices can benefit.
- Given the reduction of face-to-face visits, stratify and proactively contact their high-risk patients with ongoing care needs, to ensure appropriate ongoing care and support plans are delivered through multidisciplinary teams. In

particular, proactively contact all those in the ‘shielding’ cohort of patients who are clinically extremely vulnerable to Covid19, ensure they know how to access care, are receiving their medications, and provide safe home visiting wherever clinically necessary.

- To further support care homes, the NHS will bring forward a package of support to care homes drawing on key components of the Enhanced Care in Care Homes service and delivered as a collaboration between community and general practice teams. This should include a weekly virtual ‘care home round’ of residents needing clinical support.
- Make two-week wait cancer, urgent and routine referrals to secondary care as normal, using ‘advice and guidance’ options where appropriate.
- Deliver as much routine and preventative work as can be provided safely including vaccinations immunisations, and screening.

Community Services

- Sustain the Hospital Discharge Service, working across secondary care and community providers in partnership with social care. Includes daily reviews of all patients in a hospital bed on the Hospital Discharge List; prompt and safe discharges when clinically and in line with infection control requirements with the planning of ongoing care needs arranged in people’s own homes; and making full use of available hospice care.
- Prepare to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing community health support.
- Essential community health services must continue to be provided, with other services phased back in wherever local capacity is available. Prioritise home visits where there is a child safeguarding concern.

Mental Health and Learning Disability/ Autism services

- Establish all-age open access crisis services and helplines and promote them locally working with partners such as local authorities, voluntary and community sector and 111 services.
- For existing patients known to mental health services, continue to ensure they are contacted proactively and supported. This will continue to be particularly important for those who have been recently discharged from inpatient services and those who are shielding.
- Ensure that children and young people continue to have access to mental health services, liaising with your local partners to ensure referral routes are understood, particularly where children and young people are not at school.
- Prepare for a possible longer-term increase in demand as a consequence of the pandemic, including by actively recruiting in line with the NHS Long Term Plan.
- Annual health checks for people with a learning disability should continue to be completed.
- Ensure enhanced psychological support is available for all NHS staff who need it.
- Ensure that you continue to take account of inequalities in access to mental health services, and in particular the needs of BAME communities.

- Care (Education) and Treatment Reviews should continue, using online/digital approaches.

Screening and Immunisations

- Ensure as a first priority that screening services continue to be available for the recognised highest risk groups, as identified in individual screening programmes.
- Increase the delivery of diagnostic pathways (including endoscopy) to catch up with the backlog of those already in an active screening pathway, followed by the rescheduling of any deferred appointments.
- Antenatal and Newborn Screening Services must be maintained because this is a time critical service.
- Providers and commissioners must maintain good vaccine uptake and coverage of immunisations. It is also likely that the Autumn/Winter flu immunisation programme will be substantially expanded this year, subject to DHSC decision shortly.

Reduce the risk of cross-infection and support the safe switch-on of services by scaling up the use of technology-enabled care

- In response to Covid19, general practice has moved from carrying out c.90% of consultations with patients as face-to-face appointments to managing more than 85% of consultations remotely. 95% of practices now having video consultation capability live and the remaining few percent in the process of implementation or procurement of a solution. GP Practices should continue to triage patient contacts and to use online consultation so that patients can be directed to the most appropriate member of the practice team straight away, demand can be prioritised based on clinical need and greater convenience for patients can be maintained.
- Referral streaming of new outpatient referrals is important to ensure they are being managed in the most appropriate setting, and this should be coupled with Advice and Guidance provision, so that patients can avoid an outpatient referral if their primary care service can access specialist advice (usually via phone, video too).
- All NHS secondary care providers now have access to video consultation technology to deliver some clinical care without the need for in-person contact. As far as practicable, video or telephone appointments should be offered by default for all outpatient activity without a procedure, and unless there are clinical or patient choice reasons to change to replace with in-person contact. Trusts should use remote appointments - including video consultations - as a default to triage their elective backlog. They should implement a ‘patient initiated follow up’ approach for suitable appointments - providing patients the means of self-accessing services if required.

Dudley Integrated Health and Care

DUDLEY INTEGRATED HEALTH AND CARE BOARD

Date of Meeting: 5th May 2020
Report: NHS Improvement NExT Director scheme

TITLE OF REPORT:	**NHS Improvement NExT Director scheme**
PURPOSE OF REPORT:	To inform the Board on the NHS Improvement NExT Director scheme and seek approval of the board for the Trust to participate in the scheme
AUTHOR OF REPORT:	NHS Improvement (NHSI)
KEY POINTS:	• NHSI have developed the NExT Director scheme to support the creation of a pipeline of strong and diverse candidates for future non-executive director roles in the NHS • This scheme includes individuals being offered a placement with one or more NHS healthcare providers in their area to give them the opportunity to learn first-hand about the challenges and opportunities associated with being a non-executive director (NED) in the NHS today • There will be a short planning period before any placement starts to give both the NExT Director and their host trust the opportunity to prepare • During this planning period, there are a number of activities required from the Chair of any trust who wishes to participate in this programme including: o Ensuring there is "buy-in" from the whole board and establish some basic rules of engagement o Identify an experienced NED from within the trust to act as mentor to the NExT Director o Ensure appropriate administrative and induction arrangements are in place
RECOMMENDATION:	That the Board approves the Trust participating in the NHSI NExT Director scheme together with the associated activities required in order to support any placements.
ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	None identified
ACTION REQUIRED:	Decision **Approval** ✓ Assurance

The NExT Director scheme - supporting tomorrow's non-executives

A practical guide for NHS host trusts and placements

1. Introduction

1.1. Two of NHS Improvement's (NHSI) key strategic objectives for 2020 are to *'develop, maintain and enhance effective boards'* and to expect the board of every NHS provider *'to reflect the diversity of the people it serves'*. To help meet these objectives, we have developed the NExT Director scheme to support the creation of a pipeline of strong and diverse candidates for future non-executive director roles in the NHS.

2. What is the NExT Director scheme?

2.1. The NExT Director scheme provides support to senior people from groups who are currently under-represented on trust boards with the skills and expertise necessary to take that final step into the NHS board room. Following success in London, the Midlands and East the scheme is being expanded. The focus of the scheme will be on supporting women, people from BAME communities or with disabilities into NHS board roles. People with other protected characteristics that are under-represented on boards may also be considered for inclusion in the scheme.

2.2. The NExT Director scheme will give participants a unique insight into the role and responsibilities of being an NHS non-executive director by helping them to bridge gaps in their own experience such as:

- Operating at board level
- Transition from executive to non-executive roles
- Board level exposure in organisations of huge size and complexity
- Gain knowledge of NHS structures and accountability, how the money flows, who the key partners are, where all the regulators fit and the board's role in quality and safety.

2.3. Individual NExT Directors will be offered a placement with one or more NHS healthcare providers in their area, over a six to 12 month period and will give them the opportunity to learn first-hand about the challenges and opportunities associated with being a non-executive director (NED) in the NHS today. Each placement will be shaped to meet the individual needs of participants but will include a range of support such as:

- Access to board and committee meetings and papers, including an opportunity to review and analyse meetings to learn with board members, as appropriate;

- The assignment of an experienced NED mentor for the period is critical to help shape the NExT Director's personal programme and provide regular feedback and advice;

- Access to training and networking opportunities available to substantive non-executive directors.

3. The NExT Directors

3.1. The NExT Directors were identified from a range of sources and have been through a selection process by NHSI's Non-executive Appointments Team to ensure that they have the attributes needed to be a NED one day and that they are willing and able to make the most of the opportunity provided by the scheme. They were then "matched" with participating trusts based on their geography and any service area preferences before being introduced to the trust chair, to ensure they were a good fit for that organisation.

3.2. All NExT Directors have been subject to due diligence checks and have signed the NExT Director Placement Agreement at Annex A before their placement was confirmed.

4. A strong starting point

4.1. There will be a short planning period before any placement starts to give both the NExT Director and their host trust the opportunity to prepare so that the placement gets off to a strong start. Each placement will be different but before starting NExT Directors and their trust should have a high level, shared understanding of what it will offer and the level of commitment the NExT Director will be able to make.

4.2. In this planning period, and before the placement starts, the trust chair should:

- Ensure there is "buy-in" from the whole board and establish some basic rules of engagement that wherever possible are inclusive – ie will the NExT Director have access to confidential sections of board meetings, or be invited to participate in discussions? NB – individuals will have different levels of experience and these arrangement can always be changed as the relationship between the NExT Director and trust develops over the placement;

- Identify an experienced NED from within the trust to act as mentor to the NExT Director – some host trusts identified more than one mentor but it is important everyone understands who is responsible for what;

- Ensure the NED Mentor meets their NExT Director to explain the rules of engagement and agree the first set of high level outcome based development objectives. The NExT Director should confirm the time commitment they are able to give to the placement, we estimate a minimum of two days a month, whether they have the support of their employer (where appropriate), and confirm their availability for key board / committee dates which for many trusts will be during the day;

- Ensure administrative arrangements to allow NExT Directors to have access to board and committee meetings and papers, as required and to claim travel expenses if required;

- Ask the NExT Director to sign a confidentiality agreement if he / she will have access to confidential board meetings and sub-committees or other sensitive information. Depending on the level of contributions envisaged by individual NExT Directors consider whether indemnity arrangements would be appropriate;

- Ensure that NExT Directors who will receive sensitive information know how to and are able to protect it properly. This may mean creating a secure email address, providing access to the same IT as NEDs and providing the appropriate Information Governance training;

- Develop a comprehensive local induction programme for the NExT Director. Individual trusts should determine what this will be and how this is delivered, depending on local circumstances, but it could be based on the induction provided to new substantive NEDs, and include information about the key policies and procedures that may be relevant during the NExT Director's placement; and

- Provide the NExT Director with a tour of the major sites of the trust and an opportunity to meet key members of staff. It is important that he / she is introduced to both the executive and NED team, as well as key members of the trust's wider management team.

5. NED mentors

5.1. NED mentors are experienced non-executives responsible for making sure their NExT Director is provided with the support they need during their placement and are therefore critical to its success. It is not expected that it will be too time consuming but should include:

- Regular diarised meetings with the NExT Director before and after each board meeting to discuss key issues and observations and answer any questions they may have;

- Regular and timely feedback between mentors and NExT Directors including honest reviews of development objectives. Regularly refresh these objectives and consider establishing a deliverable project - this will ensure the learning experience is targeted and productive. Experiences and exposures need to be tailored to the development needs of each individual and their journey to step into a NED role on an NHS board;

- Arranging opportunities to learn from other board members and key staff, as appropriate.

6. Maximising the placement

6.1. Any programme should be customised to the development needs of each NExT Director (see above). This paragraph provides a list of ideas that will help the trust and the NExT Director get the most from the placement:

- NExT Directors should take responsibility for their own learning and development by documenting experiences and learning outcomes, and identify areas the trust can help them develop further;
- Arrangements should be made to provide NExT Directors with a full briefing on the NHS, the trust and its stakeholders – internal and external - as part of or soon after the induction programme;
- NExT Directors should be encouraged to feel part of the team and depending on individuals experience could be invited to take part in board discussions. If this isn't possible then participating in committee debate may be more appropriate;
- Consider inviting NExT Directors to participate in any organised programme of NED ward and / or site visits, or allocate a senior member of staff who could accompany them on such visits;
- Opportunities for the NExT Director to shadow key senior staff should be offered, and meetings with representatives from staff and patient groups, HealthWatch, volunteers and hospital charities should be considered.
- Consider whether the NExT Director should observe public board meetings of other trusts in the area to gain an insight into other leadership styles and approaches to governance as well as other types of providers;
- NExT Directors will be strongly encouraged to network with and learn from other NExT Directors. NHSI will be able to support them in this (see below).

7. Support from NHSI

7.1. Workshops, networking events and webinars will take place throughout the year, the agendas for which will be largely driven by the NExT Directors and will give them exposure to subjects of wider interest both within and without the NHS. They will also provide an opportunity to reinforce connections between NExT Directors and allow them to share experience and learn from each other.

7.2. Regular tracker conversations with providers and NExT Directors will enable NHSI to track progress, quickly identify any potential issues and offer advice / guidance to ensure that the scheme provides the best possible experience and outcomes.

7.3. Access to the NExT Director LinkedIn network, reading materials and regular updates from NHSI's provider bulletin.

8. Moving towards the end of a placement

8.1. Placements with a trust can be for any period of up to twelve months, and NExT Directors can opt to rotate to a placement on a different trust if this matches their development needs. For example, an individual may wish to increase understanding of challenges faced by other service providers or exposure to different approaches to governance. If after six months it is felt that a NExT Director would benefit from such a move they and their current trust should contact NHSI to discuss options before the current arrangement comes to an end.

8.2. At the end of any placement, the trust should provide their NExT Directors with a structured appraisal, including an honest assessment of their progress and how close they are to being “board ready”. The NExT Directors should also be clear about any further development needs and be given guidance on how they might fill any gaps in their knowledge and experience going forward, particularly if the NExT Director is moving on to another placement.

8.3. At the end of the scheme, NHSI will offer NExT Directors additional support in applying for NHS NED roles in the future, including help preparing CVs and applications: independent panel assessment with a mock interview, summing up session, introductions to head-hunters, and scheme evaluation questionnaire.

Annex A

NExT DIRECTOR PLACEMENT AGREEMENT

This is important information about your placement as part of the NHS Improvement (NHSI) NExT Director Scheme. Please read it carefully and contact the NHSI Non-executive Appointments Team if you have any queries.

1. **The NExT Director Scheme** – provides you with an opportunity to gain first-hand experience of an NHS board through a placement with an NHS trust or NHS Foundation Trust. Although this will give you access to board and committee meetings, you will have no formal board role. This is not a public appointment or employment and does not entitle you to a position with the host Trust or any other Trust at the end of your placement.

2. **Principles of public life** - Public service values are at the heart of the NHS and Trust boards play a critical role in shaping and exemplifying an organisational culture that is open, accountable, compassionate, and puts patients first. Respect, compassion and care are at the centre of good leadership and governance in the NHS, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful with patients and the public. You are therefore expected to:
    - understand and commit to the personal behaviours, values, technical competence and business practices outlined in "The standards for members of NHS boards and clinical commissioning group governing bodies in England" produced by the Professional Standards Authority;
    - reflect the standards of selflessness, integrity, objectivity, accountability, openness, honesty and leadership set out in the Seven Principles of Public Life;
    - uphold the policies and procedures adopted by the host Trust;
    - treat any information that is gained during the course of your placement with the Trust in the strictest confidence.

3. **Time commitment** – To get the most from your experience, you should attend all of the board, committee and other meetings you have agreed as with your mentor that you should attend as part of your development. You should confirm the time commitment you are able to give to the placement with your Trust, a minimum of two days a month, and whether you have the support of your employer (where appropriate).

4. **Public speaking** – You should not make political speeches or engage in other political activities relating to the work of the Trust during your placement.

5. **Conflicts of interest** – At the beginning of your placement you should declare to the Trust any business interests, position of authority in a charity or voluntary body in the field

of health and social care, and any connection with bodies contracting for NHS services that may be relevant to the Trust.

6. **Visiting guidelines** - Visits to wards or other areas with access to patients must always be accompanied and planned beforehand, identifying where you are going and who you will speak to. Senior staff should be notified well in advance and always be clear about who you are and why you are there.

7. **Change in circumstances** - You should also notify the Trust and NHSI if there is any change to your situation or connections during the period of your placement. Any failure to do so could jeopardise the reputation of the Trust and / or NHSI and result in an end to your placement.

8. **Allowances** – Your Trust can reimburse you for reasonable and receipted travel and expenses incurred during your placement if necessary.

9. **Length of placement** – Your placement will last a minimum of six months. You may leave the scheme at any time by giving notice to your Trust and NHSI. Where possible, you should first speak with the chair of your host Trust.

10. **Ending your placement** - When your placement comes to an end, for whatever reason, you will immediately return any Trust property in your possession or under your control, and irretrievably delete or destroy any electronic or other information you hold that is relating to the business of the Trust and if requested, provide a signed statement that you have complied with this obligation.

I have read and understand the information above:

SIGNED…….. Date……..

PRINT NAME…….

Dudley Integrated Health and Care

DUDLEY INTEGRATED HEALTH AND CARE BOARD

Date of Meeting: 3rd May 2020
Report: Covid-19 Financial Arrangements and Processes

TITLE OF REPORT:	Covid-19 Financial Arrangements and Processes
PURPOSE OF REPORT:	To provide a summary of the financial arrangements for NHS providers during the Covid-19 crisis and to review the internal financial controls and processes to ensure they are sufficient to allow staff to respond to the crisis.
AUTHOR OF REPORT:	Matthew Gamage – Director of Finance
KEY POINTS:	• In March, NHSEI published a document with the revised arrangements for NHS contracting and payment during the Covid-19 pandemic • Revised arrangements intend to provide certainty for all organisations providing NHS-funded services • NHS commissioners and NHS Trusts/NHS Foundation Trusts are not required to sign contracts between them for 2020/21 at this time • The nationally mandated terms of the NHS Standard Contract for 2020/21 will apply for these relationships from 1 April 2020 • Payments are being made on the block basis for each month from April to July 2020 • Two block payments of £263,000 have now been received relating to April and May 2020 • A review of the current SFIs and scheme of delegation has been undertaken • Temporary amendments to the scheme of delegation have been proposed during the Covid-19 period • Temporary staff costs will be through a subcontract with Futureproof Health and will be paid in line with the rates of pay for these services agreed by CCGs across the Black Country
RECOMMENDATION:	• The Board is asked to approve the revised scheme of delegation for Covid-19 related expenditure
ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	
ACTION REQUIRED:	Decision Approval x Assurance x

1. Introduction

This reports provides details regarding the revised arrangements for NHS contracting and payments during the Covid-19 pandemic. A review of the Standing Financial Instructions and Scheme of Delegation has also been undertaken to ensure that the Trust has sufficient controls in place to be able to respond to Covid-19 requirements, particularly in relation to the operation of the Red Centre facility.

2. Revised arrangements for NHS contracting and payment during the Covid-19 pandemic

In March 2020, NHS England and NHS improvement (NHSEI) published a document which issued the revised arrangements for NHS contracting and payment during the Covid-19 pandemic. This included the contractual arrangements for 2020/21 with NHS Trusts.

The principles of the revised approach are to

• provide certainty for all organisations providing NHS-funded services under the NHS Standard Contract that they will continue to be paid for the period April to July 2020; and

• minimise the burden of formal contract documentation and contract management processes, so that staff can focus fully on the Covid-19 response.

2.1 Contracting Arrangements

The NHS Operational Planning and Contracting Guidance 2020/21 had a deadline of 27 March 2020 for contracts to be signed between the CCG and Dudley Integrated Health and Care NHS. However, the revised arrangements state that NHS commissioners and NHS Trusts/NHS Foundation Trusts are not required to sign contracts between them for 2020/21 at this time. The nationally mandated terms of the NHS Standard Contract for 2020/21 will apply for these relationships from 1 April 2020. Commissioners and Trusts must not vary from the national terms.

2.2 Payment Arrangements

Payments are being made on the block basis for each month from April to July 2020. The table below is an extract from the *CCG Cash Management and Block Payment Guidance April 2020 – July 2020.*

Payment Date	From commissioners	From NHSE/I central
1 April 2020	• Block Payment for April 2020; or • April 2020 NHS Provider invoice if already received	• On-account central Top Up Payment for April
15 April 2020	• Block Payment for May 2020; and • where applicable, adjustment to April 2020 payment made to true up to Block Payment Amount; i.e. at this date NHS Provider should have received cash to the equivalent of 2 months of Block Payment	• Central Top Up Payment for May; and • any adjustment to the April on-account payment
15 May 2020	• Block Payment for June 2020	• Central Top Up Payment for June; and • final payment for additional Covid-19 costs for 19/20
1 June 2020		• Additional Covid-19 costs for April
15 June 2020	• Block Payment for July 2020	• Central Top Up Payment for July

The block payments have been calculated based on the provider submissions for Agreement of Balances (AoB) values from the 2019/20 Month 9 (M9) collection. This means that the payments have been calculated on a basis prior to the transfer of staff and services to Black Country Health and Care NHS Foundation Trust (BCHFT) and the creation of the Dudley Integrated Health and Care NHS (DIHC).

DIHC has been working with the finance team at BCHFT to ensure that the proportion of the block payment which relates to Primary Care Mental Health and IAPT is transferred to DIHC.

Two block payments of £263,000 have now been received relating to April and May 2020. The May payment has been received earlier than usual to ensure that providers have sufficient cash funding to manage in the current climate.

The table above shows that advance payments will also be received for June and July 2020.

Covid-19 expenditure will collected as part of the monthly financial returns to NHSEI and funding will be provided for costs incurred.

Further guidance about payment and contracting beyond 31 July 2020 will be issued by NHSEI in due course.

3. Review of internal financial controls and processes during Covid-19 pandemic

A review of the current SFIs and scheme of delegation has been undertaken to ensure that we are able to sufficiently respond to the needs of the system during the pandemic. For example, the provision of the services for the Covid-19 Red Centre would not have been a consideration at the time of the drafting of these documents.

3.1 Scheme of Delegation

The Scheme of Delegation includes the financial limits for which individuals have delegated authority. These limits are in place and are adhered to by the current services within the Trust (IAPT and Primary Care). However, there is no budget or assigned manager within the scheme of delegation for Covid-19.

As outlined earlier, the costs of Covid-19 will be funded nationally and therefore does not present a financial risk to the Trust, however it is important to maintain good financial governance during this period.

The table below shows the relevant sections of the authorisation limits and the proposed delegated authority for Covid-19 related items. A budget has also been established for Covid-19 and is included in the separate budget setting paper for approval by the Board in May 2020.

DELEGATED MATTER	**AUTHORITY DELEGATED TO**	**PROPOSED DELEGATION FOR COVID-19 RELATED EXPENDITURE**
Non-Pay Revenue and Capital Expenditure/Requisitioning/Ordering/Payment of Goods and Services		
Stock/non stock requisitions up to £4,999	Budget Holder	Director of Nursing, AHPs and Quality
all requisitions from £5,000 to £9,999	Service Manager	Director of Nursing, AHPs and Quality
all requisitions from £10,000 to £14,999	Head of Service	Director of Nursing, AHPs and Quality
all requisitions from £14,999 to £19,999	Associate Director	Director of Nursing, AHPs and Quality

all requisitions from £20,000 to £49,999	Appropriate Director	Director of Nursing, AHPs and Quality
all requisitions from £50,000 to 249,999	Director of Finance	Director of Finance
all requisitions over £250,000	Reserved to Trust Board	Reserved to Trust Board
Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above)	Director of Finance	Director of Finance
Engagement of Temporary Staff and Services		
Non-Medical and Medical Staff Where aggregate commitment in any one year (or total commitment) is more than £10,000	Appropriate Director and Director of Finance	Director of Nursing, AHPs and Quality and Director of Finance

The predominant cost for Covid-19 will be temporary staffing costs through a subcontract with Futureproof health. The rates of pay for each member of staff will be in line with the rates of pay agreed by Black Country CCGs.

4. Recommendations

It is recommended that the Board agree the proposed amendments to the scheme of delegation for Covid-19 expenditure. The separate budget setting proposal also establishes a Covid-19 budget for 2020/20.

With the exception of the above change, no further revisions are required to the Scheme of Delegation or Standing Financial Instructions.

Dudley Integrated Health and Care

DUDLEY INTEGRATED HEALTH AND CARE BOARD

Date of Meeting: 5th May 2020
Report: Report from Audit & Risk Committee

TITLE OF REPORT:	**Report from Audit & Risk Committee**
PURPOSE OF REPORT:	To provide the Board with: • Assurance on the key discussions and decisions made at Audit & Risk Committee • Details of any significant risks or issues that require escalation from Audit & Risk Committee to the Board
AUTHOR OF REPORT:	Jim Young, Interim Head of Quality & Governance
KEY POINTS:	• The meeting was not quorate • No significant risks or issues identified for escalation • Agreed to recommend the extension of the current internal auditors for a period of 12 months whilst the approach for a longer-term solution was developed
RECOMMENDATION:	That the Board note this report for assurance on the key discussions and decisions made at Audit & Risk Committee and that there are no significant risks or issues to be escalated to the Board
ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	None identified
ACTION REQUIRED:	Decision Approval **Assurance ✓**

COMMITTEE ASSURANCE REPORT TO THE BOARD

Committee: **Audit and Risk Committee**

Date of meeting: 1st April 2020 (via Microsoft Teams)

Significant risks/issues for escalation	None identified
Key issues/matters discussed at the Committee	• Chair noted that the meeting was not quorate due to the Non-Executive Director (NED) appointments not having been confirmed yet; a further formal meeting would therefore be convened as soon as is practically possible following the NED appointments • Noted that the three core governance documents - Standing Orders, Standing Financial Instructions and the Scheme of Delegation – were provisionally agreed at the earlier Board meeting; also agreed approach to reviewing and updating these documents going forward •
Decisions made by the Committee	Meeting not quorate but agreed to recommend: • The extension of the current internal auditors for a period of 12 months whilst the approach for a longer-term solution was developed • In line with the Terms of Reference, quarterly meetings would be supplemented by a flexible approach to additional meetings where required; this would be of particular relevance given the current situation regarding COVID-19
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	No specific implications identified within the meeting; the corporate risk register is already being reviewed in light of the COVID response
Items/Issues for referral to other Committees	None identified

Dudley Integrated Health and Care

DUDLEY INTEGRATED HEALTH AND CARE BOARD

Date of Meeting: 5th May 2020
Report: Corporate Risk Register

TITLE OF REPORT:	**Corporate Risk Register**
PURPOSE OF REPORT:	To present the risks rated as red – having a score of 15 or higher - on the Corporate Risk Register to the Board for discussion, to provide assurance that the risks are being appropriately managed and to approve proposed changes.
AUTHOR OF REPORT:	Nicholaus Hall, Interim Project Manager / Business Analyst Jim Young, Interim Head of Quality & Governance
KEY POINTS:	• The risk register has been extensively reviewed by the risk owners – key updates recommended for approval following this review are: • Six risks are currently red rated including: o **C-103**: a new risk relating to COVID-19 o **T-012**: recommended for closure • Three risks previously red rated have been recommended for a reduction to a rating below 15: o **C-030**: Likelihood reduced from 4 to 3 o **C-070**: Likelihood & Impact reduced until medicines management is incorporated into the organisation o **C-101**: Likelihood & Impact reduced following updated controls • A further new risk (**C-102**) has been identified as a consolidation of two other risks previously listed • COVID-related risks are now clearly identifiable within the risk register and are currently being reviewed
RECOMMENDATION:	The Board is asked to note the report and: • Be assured that the risks are being appropriately managed • Approve the proposed amendments to the risk register
ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	None identified
ACTION REQUIRED:	Decision **Approval** ✓ **Assurance** ✓

Dudley Integrated Health and Care Risk Register

Dudley Integrated Health and Care

STEP 1 - IDENTIFY																STEP 2 - EVALUATE									STEP 3 - PLAN						
Date Last Reviewed	Date of next review	Ref	Risk Category/type	COVID-19	Committees (integrated Governance joined until 1 Jul 2020)						Accountable Director (Risk Sponsor)	Risk Description		Inherent / Initial Risk Score			Controls in Place i.e. arrangements that are already in place and are helping to control the risk – please provide evidence of the risk being controlled	Assurance (RAG) rating for the strength of controls	Current Score			Risk Movement from last assessment	Risk Response Tolerate / treat / transfer / terminate	Actions to address the risks: i.e. What actions are you going to take to strengthen control of the risk and achieve the target risk rating. SMART actions: S = Specific M= Measurable A= Attainable R= Relevant T= Timely	Responsibility of	Action Deadline	Target Risk Rating			Status
					Audit and risk	Renumeration	Int. gov. - Quality and Safety	Int. gov. - Finance, perf. and digital	Int. gov. - People and OD	Transaction		RISK OF:	IMPACT/CONSEQUENCES	(L)ikelihood Score	(I)mpact Score	Risk Rating (L x I)			(L)ikelihood Score	(I)mpact Score	Risk Rating							(L)ikelihood	(I)mpact Score	Risk Rating (L x I)	
06/04/2020	06/05/2020	T-012	Strategic	○	✗	✗	✗	✓	✗	✓	Matt Gamage	Significant risk of non-compliance in relation to due diligence caused by proceeding at pace with a significant transaction without having completed all the financial work and due diligence.	Organisations cannot deliver the preferred model as it is financially prohibitive or does not get regulatory consent and therefore there is reputational damage due to failure to deliver the ICP model in the way currently described to the public, patients and staff across Dudley.	4	4	16	Active engagement with all partners during options appraisal development process and detailed briefings presentation to the relevant governing bodies and boards. Ensuring informed decision making process by evaluating and considering risks and taking ownership the issues.	Weak - Yellow	4	4	16	→	Treat	The delivery team to ensure consultation with staff and keeping them informed during the options appraisal process and the final outcome	Matt Gamage	30/11/2019	1	4	4	Pending closure
14/04/2020	14/05/2020	C-103	Operational	!	✗	✗	✗	✗	✗	✓	Steph Cartwright	Lack of sufficient resources being available to support 'day 2' safe landing due to delays incurred as a result of COVID-19	Unable to complete transaction to enable the next phase of transferred services to go live. Unable to provide appropriate back office functions to support expansion.	4	4	16	Ongoing review of the phasing and key deliverables to determine capacity to deliver. Appropriate discussions at Delivery Board and Transaction Committee.	Weak - Yellow	4	4	16	New	Treat	Regular review of resources at Transaction Committee. Review plans for post-SLA back office function provision and identify a suitable approach. Review the phasing of service and associated staff transfers. Define safe landing plan.	Steph Cartwright	31/5/20220	1	4	4	Pending addition

Dudley Integrated Health and Care Risk Register

Dudley Integrated Health and Care

STEP 1 - IDENTIFY															STEP 2 - EVALUATE										STEP 3 - PLAN						
Date Last Reviewed	Date of next review	Ref	Risk Category/type	COVID-19	Committees (integrated Governance joined until 1 Jul 2020)						Accountable Director (Risk Sponsor)	Risk Description		Inherent / Initial Risk Score			Controls in Place i.e. arrangements that are already in place and are helping to control the risk – please provide evidence of the risk being controlled	Assurance (RAG) rating for the strength of controls	Current Score			Risk Movement from last assessment	Risk Response Tolerate / treat / transfer / terminate	Actions to address the risks: i.e. What actions are you going to take to strengthen control of the risk and achieve the target risk rating. SMART actions: S = Specific M= Measurable A= Attainable R= Relevant T= Timely	Responsibility of	Action Deadline	Target Risk Rating			Status
					Audit and risk	Renumeration	Int. gov. - Quality and Safety	Int. gov. - Finance, perf. and digital	Int. gov. - People and OD	Transaction		RISK OF:	IMPACT/CONSEQUENCES	(L)ikelihood Score	(I)mpact Score	Risk Rating (L x I)			(L)ikelihood Score	(I)mpact Score	Risk Rating							(L)ikelihood	(I)mpact Score	Risk Rating (L x I)	
10/04/2020	10/05/2020	C-057	Operational	○	✗	✗	✗	✓	✗	✗	Matt Gamage	Risk of reduction in annual payments due to factors beyond the control of the ICP	This will impact in maintaining a positive balance between the income growth against the growth in demand	4	4	16	To be managed via Finance Meeting arrangements.	Strong - Green	4	4	16	→	Treat	Reflect adequately in contract to reduce level of impact.	Matt Gamage	30/11/2019	3	4	12	Open
06/04/2020	06/05/2020	T-047	Strategic	○	✗	✗	✓	✗	✓	✓	Steph Cartwright	Failure to engage and communicate with patients, staff and the public on ICP mobilisation and developments for the changes to existing service and models for new services in Dudley.	Resistance to proposals and change. Benefits of ICP not delivered and publics do not utilise the new services fully as not aware of them.	5	4	20	ICP has a clear communications and engagement group. Utilise existing channels e.g. Healthcare Forum and Council of Governors, PPGs to share the developments on the ICP.	Strong - Green	4	4	16	→	Treat	Fully utilise the altogether better website and social media to keep the public engaged. Ensure public involved and co-create details of new service models and fully informed stakeholders and community via the development of the dedicated new web-site and focused communication activities.	Claire Austin	30/11/2019	1	4	4	Open

Dudley Integrated Health and Care Risk Register

NHS Dudley Integrated Health and Care

STEP 1 - IDENTIFY														STEP 2 - EVALUATE										STEP 3 - PLAN						
					Committees (integrated Governance joined until 1 Jul 2020)							Risk Description		*Inherent / Initial Risk Score*					*Current Score*								*Target Risk Rating*			
Date Last Reviewed	Date of next review	Ref	Risk Category/type	COVID-19	Audit and risk	Renumeration	Int. gov. - Quality and Safety	Int. gov. - Finance, perf. and digital	Int. gov. - People and OD	Transaction	Accountable Director (Risk Sponsor)	RISK OF:	IMPACT/CONSEQUENCES	(L)likelihood Score	(I)impact Score	Risk Rating (L x I)	Controls in Place i.e. arrangements that are already in place and are helping to control the risk – please provide evidence of the risk being controlled	Assurance (RAG) rating for the strength of controls	(L)likelihood Score	(I)impact Score	Risk Rating	Risk Movement from last assessment	Risk Response Tolerate / treat / transfer / terminate	Actions to address the risks: i.e. What actions are you going to take to strengthen control of the risk and achieve the target risk rating. SMART actions: S = Specific M= Measurable A= Attainable R= Relevant T= Timely	Responsibility of	Action Deadline	(L)likelihood	(I)impact Score	Risk Rating (L x I)	*Status*
06/04/2020	06/05/2020	T-102	Operational	!	✗	✗	✗	✗	✗	✓	Steph Cartwright	COVID-19 affecting available resources to deliver the ICP and BCH transactions	Delay to the creation of the ICP and/or BCH	2	4	8	Action being taken and plans being put in place by PHE, NHS, and other agencies and organisations.	Ineffective - Red	4	4	16	→	Treat	Implement a daily SitRep process, align with partner organisations, monitor developments, review remote working capabilities and indentify possible contigencies for key meetings and decision points. Align action with NHSEI 'COVID-19 NHS preparedness and response' letter.	Caroline Brunt	31/03/2020	2	4	8	Open
10/04/2020	10/05/2020	C-031	Operational	●	✗	✗	✗	✓	✗	✓	Matt Gamage	Risk of contract financial envelope less than the cost of providing the services.	This may result in the ICP starting its first trading year with a financial deficit and limited ability to hit the control total and restrict investment opportunities.	5	4	20	Due diligence has been undertaken on the services transferring to DIHC to ensure costs of services are robust Financial model for DIHC will need to signed off by the Board. SFIs have now been agreed by the DIHC Board. Financial monitoring to be reported to Integrated Assurance committee	Strong - Green	5	3	15	↘	Treat	Ensure the financial due diligence on fixed costs and start up costs and identify all known cost pressures. Financial model is being developed as part of business case. Need to ensure that this demonstrates financial sustainability for DIHC.	Matt Gamage	30/06/2020	2	2	4	Pending rating change

Dudley Integrated Health and Care Risk Register

Dudley Integrated Health and Care

STEP 1 - IDENTIFY															STEP 2 - EVALUATE										STEP 3 - PLAN						
Date Last Reviewed	Date of next review	Ref	Risk Category/type	COVID-19	Committees (integrated Governance joined until 1 Jul 2020)						Accountable Director (Risk Sponsor)	Risk Description		Inherent / Initial Risk Score			Controls in Place i.e. arrangements that are already in place and are helping to control the risk – please provide evidence of the risk being controlled	Assurance (RAG) rating for the strength of controls	Current Score			Risk Movement from last assessment	Risk Response Tolerate / treat / transfer / terminate	Actions to address the risks: i.e. What actions are you going to take to strengthen control of the risk and achieve the target risk rating. SMART actions: S = Specific M= Measurable A= Attainable R= Relevant T= Timely	Responsibility of	Action Deadline	Target Risk Rating			Status
					Audit and risk	Renumeration	Int. gov. - Quality and Safety	Int. gov. - Finance, perf. and digital	Int. gov. - People and OD	Transaction		RISK OF:	IMPACT/CONSEQUENCES	(L)likelihood Score	(I)mpact Score	Risk Rating (L x I)			(L)likelihood Score	(I)mpact Score	Risk Rating							(L)likelihood	(I)mpact Score	Risk Rating (L x I)	
23/04/2020	23/07/2020	C-030	Strategic	○	✗	✗	✗	✗	✓	✓	Bev Edgar	Risk of significant vacancy factors in staff groups that transfer into the ICP due to the workforce becoming unsettled around the new model of care or organisational change.	This will Impact on delivery of the clinical model and delay in improving patient access, continuity and co-ordination of care. Delays in improving population health outcomes.	5	4	20	Establish the workforce development group with representation from all affected providers. The ongoing training needs analysis to be aligned to the clinical skills pathway redesign. Currently this is on hold due to the COVID-19 response.	Weak - Yellow	3	4	12	↘	Treat	Complete workforce modelling of community services and mental health. Identify vacancies, sickness and skills gaps. Develop targeted workforce action plan and programme of staff engagement to describe the new care model in more detail. Promote joined up working through the ICT/PCN networks and host engagement workshops with frontline staff to understand what's important to them.	Bev Edgar	30/09/2020	1	4	4	Pending rating change

Dudley Integrated Health and Care Risk Register

Dudley Integrated Health and Care

STEP 1 - IDENTIFY															STEP 2 - EVALUATE										STEP 3 - PLAN						
Date Last Reviewed	Date of next review	Ref	Risk Category/type	COVID-19	Committees (integrated Governance joined until 1 Jul 2020)						Accountable Director (Risk Sponsor)	Risk Description		Inherent / Initial Risk Score			Controls in Place i.e. arrangements that are already in place and are helping to control the risk – please provide evidence of the risk being controlled	Assurance (RAG) rating for the strength of controls	Current Score			Risk Movement from last assessment	Risk Response Tolerate / treat / transfer / terminate	Actions to address the risks: i.e. What actions are you going to take to strengthen control of the risk and achieve the target risk rating. SMART actions: S = Specific M= Measurable A= Attainable R= Relevant T= Timely	Responsibility of	Action Deadline	Target Risk Rating			Status
					Audit and risk	Renumeration	Int. gov. - Quality and Safety	Int. gov. - Finance, perf. and digital	Int. gov. - People and OD	Transaction		RISK OF:	IMPACT/CONSEQUENCES	(L)ikelihood Score	(I)mpact Score	Risk Rating (L x I)			(L)ikelihood Score	(I)mpact Score	Risk Rating							(L)ikelihood	(I)mpact Score	Risk Rating (L x I)	
10/04/2020	10/07/2020	C-070	Operational	○	✗	✗	✗	✓	✗	✓	Matt Gamage	Risk of increase in drug volume and prices in excess of planned growth and inflation	This will impact recurrent cost base to increase and restrict margins for investments and service developments and Unplanned cost increases resulting in failure to achieve control total or increased CIP requirement	4	4	16	Strong medicines management practices to ensure appropriate and consistent use. Prescribing expenditure will be monitored at Integrated Assurance Committee Prescribing performance will be monitored at a PCN level Practice Based Pharmacists and medicines management team will have budget responsibility.	Strong - Green	3	4	12	↘	Treat	Strong medicines management practices to ensure appropriate use, and switch to alternatives were possible. Negotiate volume discount were possible. Horizon scanning as part of planning process. Close engagement with the Medicines Management team prior to transferring to DIHC. Ensure that existing prescribing policies and procedures are adopted by DIHC. Explore further opportunities with Medicines Management team.	Matt Gamage	30/06/2020	3	4	12	Pending rating change

Dudley Integrated Health and Care Risk Register

Dudley Integrated Health and Care

STEP 1 - IDENTIFY															STEP 2 - EVALUATE										STEP 3 - PLAN						
Date Last Reviewed	Date of next review	Ref	Risk Category/type	COVID-19	Committees (integrated Governance joined until 1 Jul 2020)						Accountable Director (Risk Sponsor)	Risk Description		Inherent / Initial Risk Score			Controls in Place i.e. arrangements that are already in place and are helping to control the risk – please provide evidence of the risk being controlled	Assurance (RAG) rating for the strength of controls	Current Score			Risk Movement from last assessment	Risk Response Tolerate / treat / transfer / terminate	Actions to address the risks: i.e. What actions are you going to take to strengthen control of the risk and achieve the target risk rating. SMART actions: S = Specific M= Measurable A= Attainable R= Relevant T= Timely	Responsibility of	Action Deadline	Target Risk Rating			Status
					Audit and risk	Renumeration	Int. gov. - Quality and Safety	Int. gov. - Finance, perf. and digital	Int. gov. - People and OD	Transaction		RISK OF:	IMPACT/CONSEQUENCES	(L)likelihood Score	(I)mpact Score	Risk Rating (L x I)			(L)likelihood Score	(I)mpact Score	Risk Rating							(L)likelihood	(I)mpact Score	Risk Rating (L x I)	
28/04/2020	12/05/2020	C-101	Operational	!	✗	✗	✓	✗	✓	✗	Steph Cartwright	Risk of COVID-19 affecting staff	Impact on delivery on services and/or management of ICP	4	5	20	DIHC senior management team involved in BCH daily COVID-19 meetings, which includes a review of workforce arrangements. Remote home working implemented wherever possible; DIHC exec team hold weekly Teams meetings with all IAPT and PCMH staff for both informal chat and formal communication. PPE provision for Red Centre staff above minimum specification for higher risk patients such as children. Weekly meetings held with Red Centre staff and management. Daily operations calls with Senior Management Team.	Strong - Green	3	4	12	↘	Treat	Review and update the Business Continuity Plan. Review workload of Red Centre and identify any improvements to clinical practice required.	Caroline Brunt	28/05/2020	3	4	12	Pending rating change
14/04/2020	14/05/2020	C-102	Strategic		✗	✗	✗	✗	✗	✓	Steph Cartwright	Risk of lack of system alignment	This has the potential to lead to organisational, board and/or procurement challenges and could impact on trust amongst partners.	3	4	12	Active engagement with partners during Business Case development. Regular Delivery Board meetings involving representation from all key partners.	Strong - Green	3	4	12	New	Treat	Continued engagement and stakeholder involvement in final business case submission.	Steph Cartwright	30/06/2020	1	4	4	Pending addition

Dudley Integrated Health and Care

DUDLEY INTEGRATED HEALTH AND CARE BOARD

Date of Meeting: 5th May 2020
Report: Report from Integrated Governance Committee

TITLE OF REPORT:	**Report from Integrated Governance Committee**
PURPOSE OF REPORT:	To provide the Board with: • Assurance on the key discussions and decisions made at Integrated Governance Committee • Details of any significant risks or issues that require escalation from Integrated Governance Committee to the Board
AUTHOR OF REPORT:	Jim Young, Interim Head of Quality & Governance
KEY POINTS:	• No significant risks or issues identified for escalation • The three month timeframe that this Committee was due to be in place for has been removed and will be reviewed as appropriate • Assurance was provided on a number of COVID-related areas including supporting system-wide working
RECOMMENDATION:	That the Board note this report for assurance on the key discussions and decisions made at Integrated Governance Committee and that there are no significant risks or issues to be escalated to the Board.
ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	None identified
ACTION REQUIRED:	Decision Approval **Assurance** ✓

COMMITTEE ASSURANCE REPORT TO THE BOARD

Committee: **Integrated Governance Committee**

Date of meeting: 7th April 2020 (via Microsoft Teams)

Significant risks/issues for escalation	None identified
Key issues/matters discussed at the Committee	• The new Non-Executive Directors were welcomed • It was acknowledged that the organisation is supporting and facilitating integrated system working during the COVID crisis, both through the establishment of the Red Centre and engagement with Primary Care and other Providers • An update was provided on the Red Centre, including its operational policy • An approach to developing the organisation policies was discussed and agreed • An update was provided on the practicalities regarding setting up financial systems for the new organisation, and how this incorporated the financial arrangements for the COVID-19 response • Assurance was provided regarding how staff were being supported with regards to the COVID-19 response and national changes to terms and conditions
Decisions made by the Committee	• The three month timeframe that this Committee was due to be in place for has been removed; the current arrangements will be reviewed in September 2020 • Following some minor amendments, the Terms of Reference (ToR) for the Committee were approved • The Committee delegated approval of changes to the Red Centre Operational Policy to the CEO & Chief Nurse
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	No specific implications identified within the meeting; the corporate risk register is already being reviewed in light of the COVID response
Items/Issues for referral to other Committees	None identified

Dudley Integrated Health and Care

DUDLEY INTEGRATED HEALTH AND CARE BOARD

Date of Meeting: 5th May 2020
Report: Quality dashboard – update on development

TITLE OF REPORT:	**Quality dashboard – update on development (verbal)**
PURPOSE OF REPORT:	To provide the Board with Assurance that: • Progress is being made on the development of a meaningful Quality Dashboard • During this time of development, a number of key quality measures are already being monitored and to date do not indicate any areas of concern
AUTHOR OF REPORT:	Jim Young, Interim Head of Quality & Governance
KEY POINTS:	• Work is underway to develop a meaningful quality dashboard for providing assurance and highlighting areas requiring further discussion • The quality dashboard will usually report through to the Board via the Integrated Governance Committee • Work to date with Black Country Healthcare NHS Foundation Trust (BCH) has established a robust reporting route for incidents, service user feedback (both formal complaints and informal concerns) and Central Alerting System (CAS) alerts; this is provided through the SLA currently in place with BCH for the provision of various support and back-office functions • A review of provisional data provided for these areas have confirmed that there are no major concerns identified and that these are being managed appropriately • The development of the quality dashboard is aligned with the ongoing work to develop a meaningful performance dashboard; Dudley CCG have also been engaged in defining and using a shared set of data for assurance and monitoring purposes • The full dataset for April 2020 for the areas described above will be reported to the May Integrated Governance Committee; progress on further developments of the dashboard will also be provided to this Board through the same route
RECOMMENDATION:	That the Board note this report for assurance that: • Progress is being made on the development of a meaningful Quality Dashboard • During this time of development, a number of key quality measures are already being monitored and to date do not indicate any areas of concern
ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	None identified

ACTION REQUIRED:	Decision Approval **Assurance ✓**

Dudley Integrated Health and Care

DUDLEY INTEGRATED HEALTH AND CARE BOARD

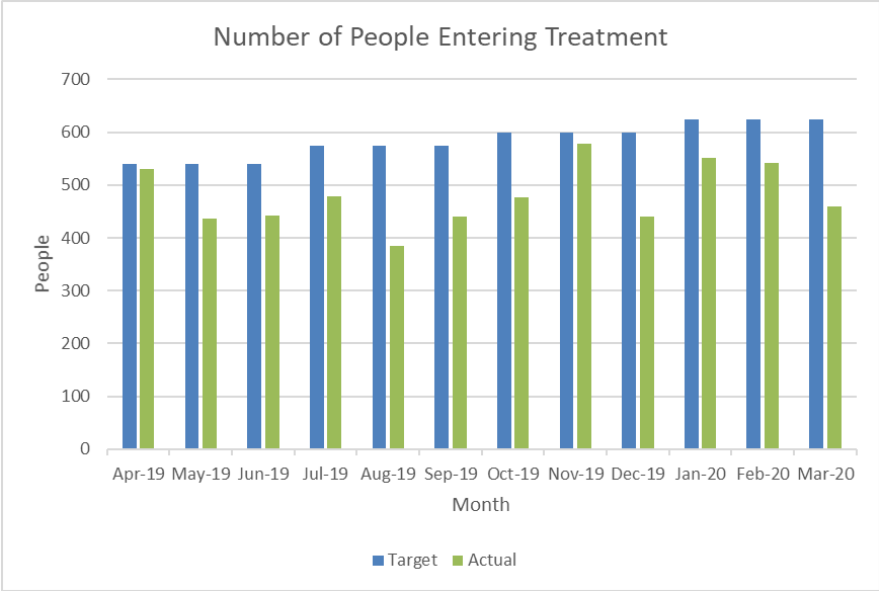
Date of Meeting: 3rd May 2020
Report: IAPT Performance

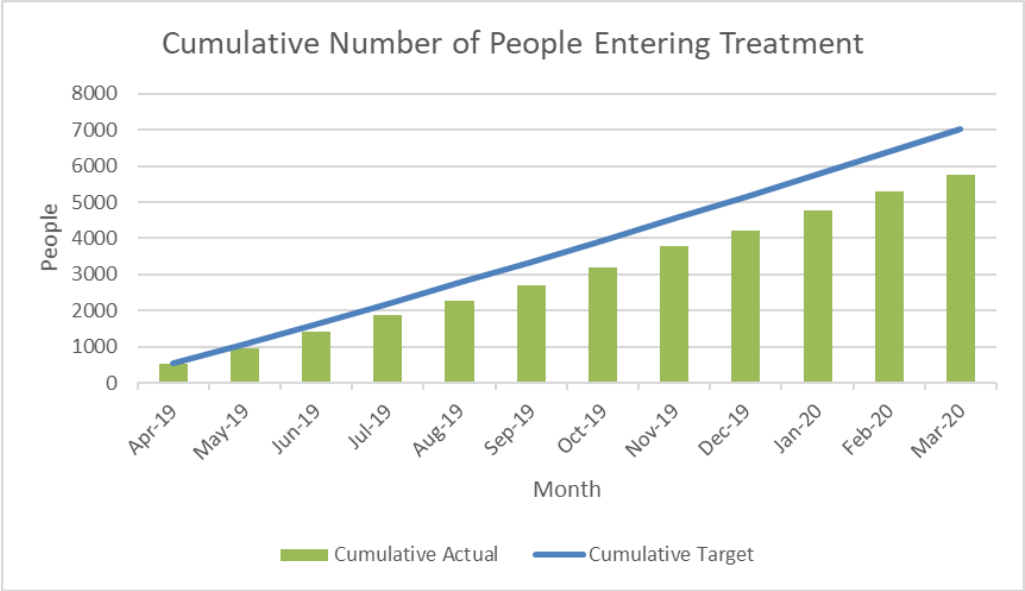
TITLE OF REPORT:	IAPT Performance
PURPOSE OF REPORT:	To update the Board on the IAPT performance for 2019/20 and the first few weeks of 2020/21.
AUTHOR OF REPORT:	Matthew Gamage – Director of Finance
KEY POINTS:	• The access target for 2019/20 was not achieved • Activity has dropped significantly during the COVID-19 pandemic • Number of referrals into the service have fallen since the middle of March • 31% of people entering treatment are seen by high intensity workers • The recovery target was nearly achieved in 2019/20. Actual performance was 49% compared to a target of 50% • Performance against the recovery target deteriorated in the second half of the financial year
RECOMMENDATION:	• Need to improve communications to encourage self-referrals, referrals from GP practices and community staff • Continue working with the primary care mental health and IAPT services to further develop the pathways for these areas • Detailed analysis to be undertaken and presented to Integrated Assurance Committee • Best practice examples from other areas should be reviewed and considered • Develop interim solutions during the COVID-19 pandemic to encourage uptake of the service, such as increased video consultations
ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	
ACTION REQUIRED:	Decision Approval x Assurance x

IAPT Performance Report

Dudley Integrated Health and Care

Access





The chart on the top left shows the number of people who entered treatment for IAPT compared to the target in 2019/20.

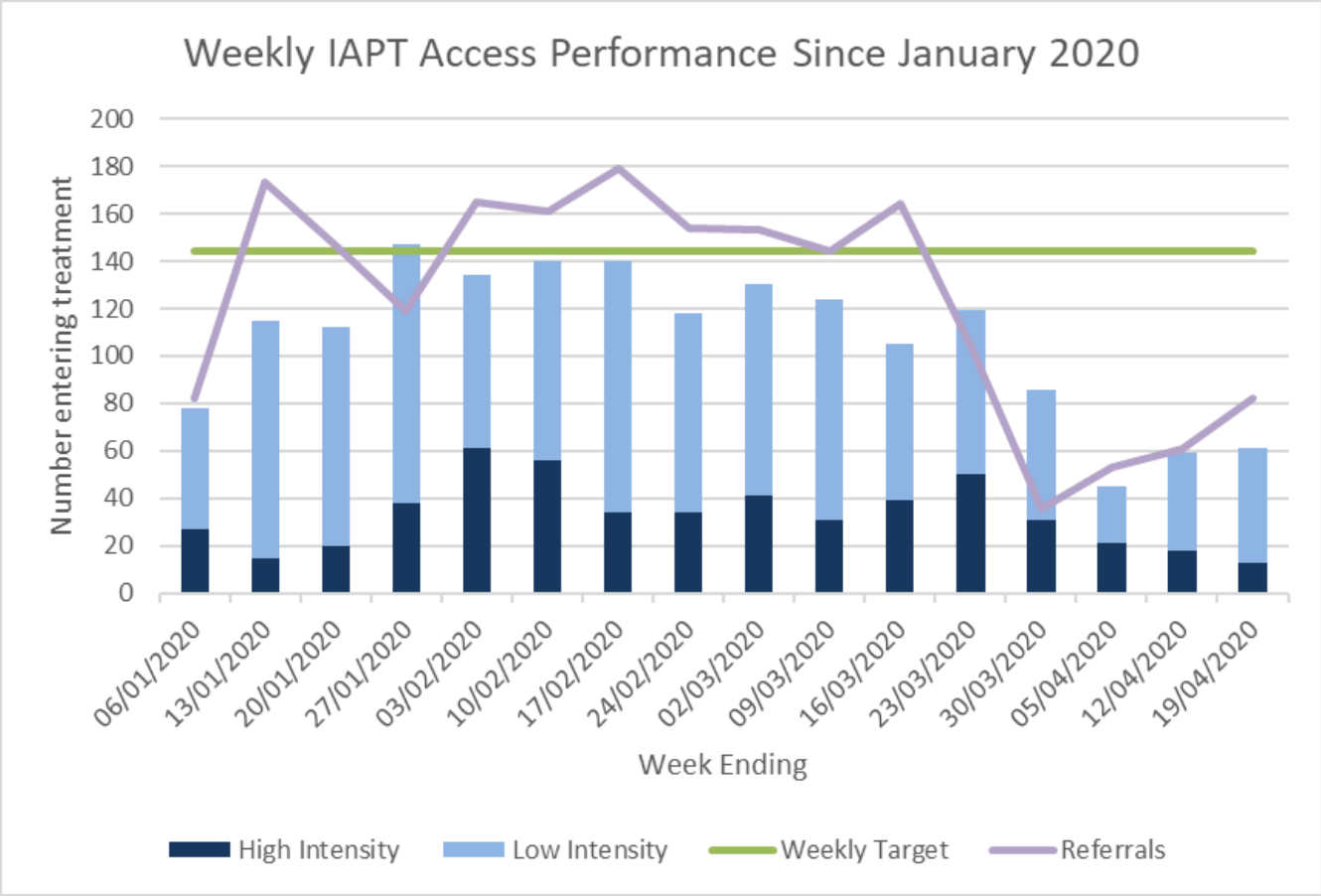
It shows that the target was not achieved in any of the individual months. The target was nearly achieved in April 2019, however most of the months fell significantly short of the monthly target with an average achievement of 82%.

The chart on the top right shows the actual performance against the cumulative target for 2019/20. The plan was to achieve a total of 7,014 people entering treatment. The actual number of people entering treatment was 5,759.

IAPT Performance Report

Dudley Integrated Health and Care

Access



The chart on the left shows the number of people entering treatment for IAPT compared to the weekly target. The chart splits the people seen by High Intensity workers and Low Intensity workers. The weekly target of 144 people entering treatment has only been achieved once in the last 16 weeks.

Activity has dropped significantly during the COVID-19 pandemic with an average of 55 entering treatment per week over the last three weeks.

The number of referrals in to the service have also fell significantly since the week ending the 16th March 2020. However, there has been a gradual increase over the last 3 weeks.

On average 69% of people entering treatment are seen by low intensity workers and 31% are seen by high intensity workers. The week ending 13th January 2020 saw the highest proportion of people being seen by low intensity workers (87%).

IAPT Performance Report

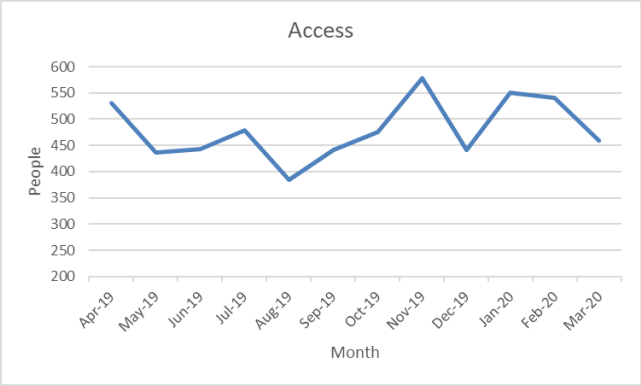
Dudley Integrated Health and Care

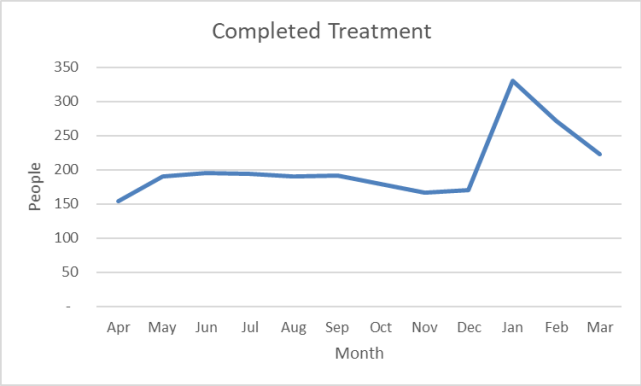
Recovery

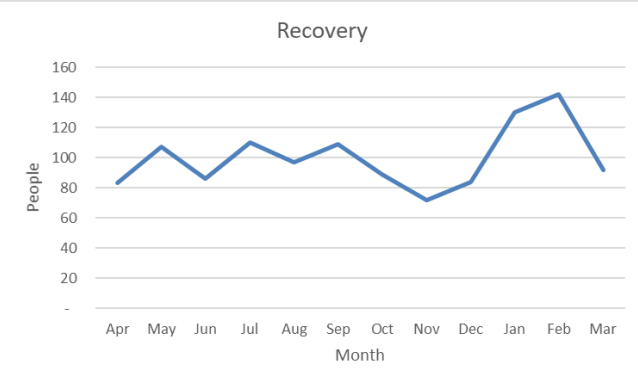
The national target is that 50% of people who complete treatment should move on to recovery. The table on the right shows that 2,458 people completed treatment during 2019/20 and that 1,201 people moved on to recovery. This equates to 49% which falls slightly short of the national target. The monthly target was achieved 5 times in the first half of the year, however performance against the target deteriorated in the last 6 months of the financial year.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Recovery	83	107	86	110	97	109	89	72	84	130	142	92	1,201
Completed Treatment	154	191	195	194	190	192	179	167	171	330	272	223	2,458
Percentage Achieved	54%	56%	44%	57%	51%	57%	50%	43%	49%	39%	52%	41%	49%

Summary Charts







IAPT Performance Report

NHS
Dudley Integrated Health and Care

Recommendations

The following actions are recommended in order to improve performance against target;

- Need to improve communications to encourage self referrals, referrals from GP practices and community staff
- The Director of Operations to continue working with the primary care mental health and IAPT services to further develop the pathways for these areas
- Further analysis to be undertaken and presented to Integrated Assurance Committee
- Best practice examples from other areas should be reviewed and considered
- Develop interim solutions during the COVID-19 pandemic to encourage uptake of the service, such as increased video consultations

Dudley Integrated Health and Care

DUDLEY INTEGRATED HEALTH AND CARE BOARD

Date of Meeting: 3rd May 2020
Report: Budget Setting 2020/21

TITLE OF REPORT:	Budget Setting 2020/21
PURPOSE OF REPORT:	Establishment of budgets for 2020/21 for approval by the Board
AUTHOR OF REPORT:	Matthew Gamage – Director of Finance
KEY POINTS:	• The budgets do not include any assumptions regarding the award of the new Integrated Care Provider contract • Budgets will be updated to reflect agreed financial model following approval of the full business case and agreement of the contract • The Board is asked to approve the budgets for 2020/21 • £3.4m contract income expected relating to the provision of primary care mental health and IAPT services • The annual budget assumes that corporate SLA is in place for the full 12 month period at a cost of £840,000 • Transaction costs of £681,000 are expected during the first part of the financial year • COVID-19 costs and associated national funding of £410,000 included for the period April to July 2020 • £1.2m deficit expected for 2020/21 due to the limited volume of services within the Trust
RECOMMENDATION:	• The proposed budgets for 2020/21 are approved • Transaction costs are closely monitored to ensure effective use of resources • Director of Finance to explore alternative funding sources • Finance report to be presented to Integrated Assurance committee on a monthly basis • IAPT and Primary Care Mental Health non pay expenditure to be reviewed as part of the pathway development work • Integrated Assurance committee to be updated on any further revisions to the national payment arrangements • Renegotiation of contract value with CCG for the period August 2020 to March 2021 • Review management SLA before extending beyond 6 months
ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	
ACTION REQUIRED:	Decision Approval x Assurance x

1. Introduction

A paper was presented at the April Board meeting which showed the financial plan for the first 6 months of the year based on the financial modelling assumptions contained in the Strategic Outline Case (SOC) for the creation of Dudley Integrated Health and Care.

This report builds on the paper previously presented to Board. It sets the budgets for the whole of 2020/21, which includes up to date planning assumptions such as the block contract payment arrangements for the period April 2020 to July 2020 and the top up payments relating to COVID-19 expenditure.

The budgets do not include any assumptions regarding the award of the new Integrated Care Provider contract. The budgets will be updated to reflect the final financial model and contract value once they have been agreed with partners and approved through the Integrated Assurance Process. The business case and associated financial model will be presented separately to Board for approval.

2. Income and Expenditure Plan

The table below shows the income and expenditure summary for 2020/21 financial year. Appendix 1 provides a breakdown of the budgets in more detail.

Budget Area	Budget Holder	Total WTE	Total £
Income			
Dudley CCG Contract	Matthew Gamage		3,349,180
Sandwell & West B'ham CCG Contract	Matthew Gamage		26,670
Sth East Staffs & Seisdon CCG Contract	Matthew Gamage		2,470
COVID-19 Funding	Matthew Gamage		410,000
Transaction Funding	Matthew Gamage		681,000
Top Up Payment (based on mth 9)	Matthew Gamage		171,460
Additional Top Up Payment	Matthew Gamage		515,736
Total Income			**5,156,516**
Expenditure			
Primary Care Mental Health	Heidi Cole	26.03	1,235,592
IAPT	Marcus Leonard	31.51	1,670,231
IAPT Physical Health	Marcus Leonard	5.60	239,684
Corporate Services SLA	Paul Assinder		840,000
Executive Team	Paul Assinder	5.24	798,182
Chairs and Non Execs	Paul Assinder	1.36	163,562
Executive Support	Paul Assinder	2.00	70,784
Finance	Matthew Gamage		222,000
Transaction Costs	Matthew Gamage		681,000
COVID-19	Caroline Brunt		410,000
Total Expenditure		**71.7378**	**6,331,035**
Surplus/(Deficit)			**(1,174,519)**

2.1 Primary Care and IAPT Services

The Trust is planning to receive £3.4m contract income from patient care activities relating to the provision of primary care mental health and IAPT services. Operating expenditure relating to these services is expected to be £3.1m.

Pay budgets have been set, based on staff in post (as of Nov-19 Electronic Staff Records report). All salary budgets are set at 20/21 agenda for change, pay-scales. Vacant posts have been funded, at the minimum of the salary scale.

Employer's national insurance and superannuation contribution, have included at the following rate;

- Employers NI - 13.80%
- Superannuation contribution – 14.38%

Recurrent non-pay budgets, have been carried forward from 19/20.

The budget holder for IAPT services is employed by Black Country Healthcare NHS Foundation Trust and is providing management support through the corporate service level agreement (SLA)

2.2 Corporate Services Service Level Agreement

The SLA with Black Country Healthcare NHS Foundation Trust for the provision of back office functions has been agreed for the period April – September 2020. This will provide stability for the services during the first 6 months of the financial year prior to the remaining services transferring into the Trust, subject to regulatory approval. The annual budget assumes that the SLA is in place for the full 12 month period at a cost of £840,000.

2.3 Board Costs

The total board costs are expected to be £961,744. This includes the costs of both the executive board members, the chair and the non-executives board members. Appendix 1 provides a detailed breakdown of both the executive team costs and the non-executive costs.

2.4 Finance

Finance costs include Internal and External Audit fees based on values from previous years. The budget also includes the 3.5% charge for the funding made available by Black Country Healthcare NHS Foundation Trust to cover the increased PDC charges being incurred.

2.5 Transaction Costs

Transaction costs of £681,000 are expected during the first part of the financial year in order to conclude the production of the business case. A large proportion of the cost is the remaining legal due diligence work to be completed. This is expected to be £414,000 and is in line with the costs included in the project plan agreed with the legal firm.

Funding for the transaction will be provided by the CCG and through external IT funding. Transaction costs and associated funding will be reviewed with the CCG during May 2020.

2.4 COVID-19 Costs

The budget includes the costs of providing the Red Centre until the end of July 2020. The costs largely relate to the subcontract with Futureproof Health to provide the temporary staffing arrangements. This will be reviewed over the next few weeks, however for the purposes of establishing the budget it has been assumed that this service will be fully provided until the end of July at an estimated cost of £410,000.

All costs associated with providing the Red Centre will be reclaimed through national COVID funding arrangements.

2.5 Top-up Payments

In line with the revised national contract payment arrangements for the period April to July 2020, expected income of £171,460 has been included in the budget based on the values submitted by the Trust for these services as part of the month 9 agreement of balances exercise in 2019/20.

Additional top up payments of £515,736 have been included to cover the total costs of the Trust during the period April to July 2020.

3 Income and Expenditure Profile 2020/21

Appendix 2 shows the expected profile of income and expenditure during 2020/21.

The Trust is expecting to deliver a breakeven position in the period April to July as a result of the top up payments being received as part of the revised national payment arrangements.

The income budget reduces to £289,855 per month from August until March 2021. This is based on the expected contract value with the CCGs for 2020/21. Expenditure is expected to be £436,670 per month from August resulting in a monthly deficit of £146,815.

Appendix 2 shows that the Trust will make a £1,174,519 deficit by the end of 2020/21 without the award of the ICP contract due to the limited volume of services within the Trust.

4 Recommendations

The Board is being asked to approve the following recommendations;

- The proposed budgets for 2020/21 are approved
- Transaction costs are closely monitored to ensure the Trust makes effective use of the available funding
- Director of Finance to explore alternative funding sources for the period August to March 2021
- Finance report to be presented to Integrated Assurance committee on a monthly basis
- IAPT and Primary Care Mental Health non pay expenditure to be reviewed as part of the pathway development work
- Integrated Assurance committee to be updated on any further revisions to the national payment arrangements
- Renegotiation of contract value with CCG for the period August 2020 to March 2021
- Budgets to be updated following agreement of the full business case for the ICP contract

Budget Area	Subjective	20/21 WTE	20/21 Budget £
Dudley IAPT Team	**Pay**	**31.51**	**1,582,840**
	Admin & Clerical-Band 2	0.60	13,690
	Admin & Clerical-Band 3	1.00	25,919
	Admin & Clerical-Band 4	1.00	26,880
	Modern Apprentice	1.00	8,693
	Psychologist-Band 5	7.31	231,330
	Psychologist-Band 6	5.80	273,289
	Psychologist-Band 7	13.80	720,986
	Senior Manager-Band 8A	1.00	57,464
	Increased capacity		224,589
	Non Pay		**87,391**
	Computer Hardware		9,000
	Computer Software Licence Fee		22,000
	Hire Meeting Room-Other DHSC		8,391
	Hire of Accommodation-Meetings		27,000
	Mobile Phone Calls		8,000
	Staff Travel		6,000
	Training Costs		7,000
Dudley IAPT Team Total		**31.51**	**1,670,231**
Dudley PH IAPT	**Pay**	**4.60**	**226,566**
	Psychologist-Band 6	2.10	93,256
	Psychologist-Band 7	2.50	133,310
	Non Pay		**13,118**
	Hire Meeting Room-Other DHSC		13,118
Dudley PH IAPT Total		**4.60**	**239,684**
Dudley Primary Care MH Team	**Pay**	**26.03**	**1,173,692**
	Admin & Clerical-Band 2	0.50	3,340
	Admin & Clerical-Band 3	1.00	23,675
	Admin & Clerical-Band 4	1.00	29,777
	Counsellor-Band 5	1.00	30,738
	Counsellor-Band 6	4.41	195,839
	Counsellor-Band 7	0.69	38,173
	Manager-Band 8A	1.00	65,039
	Nurse-Band 6	12.43	561,691
	Nurse-Band 7	1.00	55,862
	Nurse-Band 8A	1.00	65,039
	Psychologist-Band 7	2.00	104,520
	Non Pay		**61,900**
	Course Fees		10,000
	Hire Meeting Room-Other DHSC		16,000
	Hospitality Supplies		400
	Mobile Phone Rental		7,000
	Office Equipment		1,000
	Photocopier-Operating Lease		3,750
	Printing & Stationery-NHSSC		2,250
	Staff Travel		18,750
	Training-Supervision Fees		2,750
Dudley Primary Care MH Team Total		**26.03**	**1,235,592**
Executive Team	**Pay**	**5.24**	**773,182**
	Executive Team	5.24	773,182

	Non Pay		**865,000**
	Travel		5,000
	Legal Fees		10,000
	Corporate SLA		840,000
	Other Non Pay		10,000
Executive Team Total		**5.24**	**1,638,182**
Chair and Non Execs	**Pay**	**1.36**	**160,562**
	Chair and Non Executives	1.36	160,562
	Non Pay		**3,000**
	Other Non Pay		3,000
Chair and Non Execs Total		**1.36**	**163,562**
Executive Support	**Pay**	**2.00**	**70,284**
	Admin & Clerical-Band 5	1.00	35,142
	Admin & Clerical-Band 5	1.00	35,142
	Non Pay		**500**
	Other Non Pay		500
Executive Support Total		**2.00**	**70,784**
Finance	**Non Pay**		**222,000**
	External Funding costs		110,000
	Internal Audit		50,000
	External Audit		62,000
Finance Total		**0.00**	**222,000**
COVID-19	**Pay**	**0.00**	**410,000**
	Agency (Futureproof)		410,000
COVID-19 Total		**0.00**	**410,000**
Transaction Costs	**Pay**		**177,000**
	Project Management Office (Agency)		177,000
	Non Pay		**504,000**
	Legal Fees		414,000
	Financial system set up costs		60,000
	Board Recruitment costs		30,000
Transaction Costs Total		**0.00**	**681,000**
Income	**Income**		**(5,156,516)**
	DUD CCG		(3,349,180)
	SWB CCG		(26,670)
	SE STFFS SEIS CCG		(2,470)
	Top up Funding		(171,460)
	Additional Top up Funding		(515,736)
	Transaction Funding		(681,000)
	COVID Funding		(410,000)
Income Total		**0.00**	**(5,156,516)**
Grand Total		**70.74**	**1,174,519**

Income and Expenditure Profile 2020/21 **Appendix 2**

	April £	May £	June £	July £	August £	September £	October £	November £	December £	January £	February £	March £	Total £
Income													
Dudley CCG	262,586	262,586	262,586	262,586	287,355	287,355	287,355	287,355	287,355	287,355	287,355	287,355	3,349,180
Sandwell & West B'ham CCG	2,091	2,091	2,091	2,091	2,288	2,288	2,288	2,288	2,288	2,288	2,288	2,288	26,670
Sth East Staff & Seisdon CCG	194	194	194	194	212	212	212	212	212	212	212	212	2,470
COVID-19 Funding	50,000	120,000	120,000	120,000									410,000
Transaction Funding	227,000	227,000	227,000										681,000
Top Up Payment (based on mth 9)	42,865	42,865	42,865	42,865									171,460
Additional Top Up Payment	128,934	128,934	128,934	128,934									515,736
Total Income	713,670	783,670	783,670	556,670	289,855	289,855	289,855	289,855	289,855	289,855	289,855	289,855	5,156,516
Expenditure													
Primary Care	102,966	102,966	102,966	102,966	102,966	102,966	102,966	102,966	102,966	102,966	102,966	102,966	1,235,592
IAPT	139,186	139,186	139,186	139,186	139,186	139,186	139,186	139,186	139,186	139,186	139,186	139,186	1,670,231
IAPT Physical Health	19,974	19,974	19,974	19,974	19,974	19,974	19,974	19,974	19,974	19,974	19,974	19,974	239,684
Corporate Services SLA	70,000	70,000	70,000	70,000	70,000	70,000	70,000	70,000	70,000	70,000	70,000	70,000	840,000
Executive Team	66,515	66,515	66,515	66,515	66,515	66,515	66,515	66,515	66,515	66,515	66,515	66,515	798,182
Chairs and Non Execs	13,630	13,630	13,630	13,630	13,630	13,630	13,630	13,630	13,630	13,630	13,630	13,630	163,562
Executive Support	5,899	5,899	5,899	5,899	5,899	5,899	5,899	5,899	5,899	5,899	5,899	5,899	70,784
Finance	18,500	18,500	18,500	18,500	18,500	18,500	18,500	18,500	18,500	18,500	18,500	18,500	222,000
Transaction Costs	227,000	227,000	227,000										681,000
COVID-19	50,000	120,000	120,000	120,000									410,000
Total Expenditure	713,670	783,670	783,670	556,670	436,670	436,670	436,670	436,670	436,670	436,670	436,670	436,670	6,331,035
Surplus/ Deficit (-)	**0**	**0**	**0**	**0**	**-146,815**	**-146,815**	**-146,815**	**-146,815**	**-146,815**	**-146,815**	**-146,815**	**-146,815**	**-1,174,519**

Dudley Integrated Health and Care

DUDLEY INTEGRATED HEALTH AND CARE BOARD

Date of Meeting: 5th May 2020
Report: Report from Delivery Board

TITLE OF REPORT:	Report from Delivery Board
PURPOSE OF REPORT:	To provide an update to the Board on the Delivery Board that took place on Wednesday 22nd April 2020
AUTHOR OF REPORT:	Mrs Stephanie Cartwright
KEY POINTS:	• The ICP Chair gave an update on recent development and the current position on the development of the ICP • The upcoming appointment of the ICP Interim Medical Director on 4th May 2020 was discussed • An update was provided on the current position with regards to the development of the full business case and partner support was discussed and agreed • The system risk register was noted • An update was provided on the current position of the financial modelling • The Delivery Board were updated on the support the ICP leadership team are providing to the local system on the impact of COVID-19 • The terms of reference of Delivery Board were discussed
RECOMMENDATION:	To note the contents of this report.
ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	None that are not declared on the Delivery Board Register of Interests
ACTION REQUIRED:	Decision Approval Assurance ✓

REPORT FROM DELIVERY BOARD HELD ON WEDNESDAY 22ND APRIL 2020

Introduction

Delivery Board took place on Wednesday 22nd April 2020. The Board meeting place virtually using Microsoft Teams due to the current COVID-19 crisis.

Summary of Delivery Board

Chairs Update

Mr Harry Turner provided an update on the support that the ICP leadership team had been providing during the COVID crisis, including the provision of the COVID "red" centres initially at the site previously occupied by High Oak surgery in Pensnett and now at the Guest hospital in Dudley. Mr Turner also updated the Board on the appointment of the remaining members of the ICP Board, including Mr Paul Assinder as Interim Chief Executive and the Non-Executive Directors. Mr Turner explained that as previously agreed at the Delivery Board on 25th March 2020 the submission of the Business Case has been delayed at the ICP team's request but explained that work on benefits and evidence base had been continuing within the team. Mr Turner referenced a recent conversation with regional NHSI colleagues where encouragement had been given on the development of the ICP.

Appointment of Medical Director

Mrs Stephanie Cartwright informed the Board that Mr Chris Weiner would be joining the ICP leadership team as Interim Medical Director on 4th May 2020. Chris will be on secondment from his current role as Associate Regional Medical Director of NHSI until the end of December 2020. Mrs Cartwright explained that due to conflicts of interest Mr Weiner would be joining the team in full time capacity and discussed with partners whether there was an opportunity for Mr Weiner to support work in any other areas of the system. Mr Tom Jackson felt that Mr Weiner's experience would work well with DGFT and agreed to discuss with colleagues.

Full Business Case Update

Mrs Cartwright discussed the situation with regards to the production of the business case following the decision at the last Delivery Board to delay the submission. Mrs Cartwright explained that the business case is being kept "live" within the team, who are continuing work particularly with regards to transformation work that has taken place over recent weeks (eg. Clinical hub expansion and emerging new primary care operating model). Mrs Cartwright asked partners when they felt it may be an appropriate time to begin working on the business case again as partners and both partners suggested the ICP leadership team direct this work and inform partners when further input is required.

System Risk Register

Mr Axcell commented a number of the risks appeared to be omitted from the register and Mrs Cartwright explained that the previous risk register had now been split into three registers; system, transactional and operational. Both the operational and transactional risk registers are managed by the ICP Board.

Financial Modelling

Mr Gamage provided an update with regards to the progress made up until the submission of the business case was delayed and explained that a refreshed approach would need to be applied to the financial modelling to ensure all the benefits are captured correctly. The timelines for submission and decision points would need to be updated within the project plan. It was agreed that this would be through the Transaction Committee planned in early May. The financial due diligence exercise has been undertaken and the draft report has been received. This is currently being reviewed and the outputs will be shared at a future meeting.

Response to COVID-19

Mrs Caroline Brunt updated the Delivery on the work that the ICP team had undertaken to support the local system with the current COVID-19 crisis. This include the provision of the primary care "red" centres, which are bespoke centres to see primary care patients who have COVID symptoms to allow the GP practices to be "green" and see all other patients, the establishment of a home visiting service for COVID symptoms through the clinical hub, and the expansion of services within the clinical hub (end of life care, support to long term conditions patients etc). Mr Mark Axcell suggested it would be helpful for partners to receive an updated version of the COVID support proposal developed by the ICP leadership team. This will be actioned by Mrs Cartwright.

Terms of Reference

It was agreed that the terms of reference for Delivery Board would be reviewed and shared for comment before the next meeting.

Recommendation

That the report from Delivery Board is noted.