NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC AGENDA

Thursday, 16th January 2025 at 9:15am to 11:15am

Joseph Wright Room, Council House, Derby

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

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

Time	Reference	Item	Presenter	Delivery
09:15	**Introductory Items**			
	ICBP/2425/099	Welcome, introductions and apologies:	Dr Kathy McLean	Verbal
	ICBP/2425/100	Confirmation of quoracy	Dr Kathy McLean	Verbal
	ICBP/2425/101	Declarations of Interest • Register of Interests • Summary register for recording interests during the meeting • Glossary	Dr Kathy McLean	Paper
09:20	**Minutes and Matters Arising**			
	ICBP/2425/102	Minutes from the meeting held on 21st November 2024	Dr Kathy McLean	Paper
	ICBP/2425/103	Action Log – November 2024	Dr Kathy McLean	Paper
09:25	**Leadership**			
	ICBP/2425/104	Citizen's Story – "Can community-based projects begin to reduce health inequalities?"	Dr Andy Mott Dr Allie Hill Sara Bains	Paper
	ICBP/2425/105	Chair's Report – December 2024	Dr Kathy McLean	Paper
	ICBP/2425/106	Chief Executive Officer's Report – December 2024	Dr Chris Clayton	Paper
09:40	**Strategy, Commissioning and Partnerships**			
	ICBP/2425/107	One Workforce System Strategy, Approach and Ethos	Lee Radford	Paper

Time	Reference	Item	Presenter	Delivery
	ICBP/2425/108	Empowering General Practice Programme Update	Michelle Arrowsmith Dr Andy Mott	Paper
	ICBP/2425/109	Digital Strategy – Progress and Priorities for 2025/26	Dr Chris Weiner, Andrew Fearn	Paper
10:15	**Delivery and Performance**			
	ICBP/2425/110	2025/26 Operating Plan – Improvement objectives	Michelle Arrowsmith	Paper
	ICBP/2425/111	Integrated Performance Report (including level of assurance from the relevant Committee) • Quality • Performance • Finance • Workforce	 Deji Okubadejo, Prof Dean Howells Margaret Gildea, Michelle Arrowsmith Jill Dentith Claire Finn Margaret Gildea, Lee Radford	Papers
10:35	**People and Culture**			
	ICBP/2425/112	Remuneration Committee Assurance Report – December 2024	Margaret Gildea	Paper
10:40	**Governance and Risk**			
	ICBP/2425 113	ICB Risk Register – December 2024	Helen Dillistone	Paper
	ICBP/2425/114	Audit and Governance Committee Assurance Report – December 2024	Sue Sunderland	Paper
	ICBP/2425/115	Finance Estates and Digital Committee Assurance Report – November and December 2024	Jill Dentith	Paper
	ICBP/2425/116	Population Health Commissioning Committee Assurance Report – November 2024	Margaret Gildea	Paper
	ICBP/2425/117	Public Partnership Committee Assurance Report – November 2024	Sue Sunderland	Paper
	ICBP/2425/118	Quality and Performance Committee Assurance Report – November 2024	Deji Okubadejo	Paper

Time	Reference	Item	Presenter	Delivery
11:00	**Items for information**			
The following items are for information and will not be individually presented				
	ICBP/2425/119	Mental Health, Learning Disability and Autism specialised services host ICB commissioner and contract model	Helen Dillistone	Paper
11:10	**Closing Items**			
	ICBP/2425/120	Forward Planner	Dr Kathy McLean	Paper
	ICBP/2425/121	Any Other Business	Dr Kathy McLean	Verbal
	ICBP/2425/122	Questions received from members of the public	Dr Kathy McLean	Verbal
Date and time of next meeting in public: **Date:** Thursday, 20th March 2025 **Time:** 9:15am to 11:15am **Venue:** Joseph Wright Room, Council House, Derby				Verbal

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

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Allen*	Tracy	Participant to the Board for Place	Primary & Community Care Delivery Board Chair of Digital and Data Delivery Board Integrated Place Executive	CEO of Derbyshire Community Health Services NHS Foundation Trust	✓				01/07/22	15/09/24	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Partner is a Director (not Board Member) for NHS Derby and Derbyshire ICB				✓	01/07/22	15/09/24	
				Sister-in-law is Business Development Director of Race Cottam Associates (who bid for, and undertake projects for the Derbyshire system estates teams)				✓	01/07/22	15/09/24	
Arrowsmith	Michelle	Chief Strategy and Delivery Officer/ Deputy Chief Executive Officer	Finance, Estates & Digital Committee Population Health & Strategic Commissioning Committee Quality & Performance Committee ICS Executive Team Meeting	Director of husband's company - Woodford Woodworking Tooling Ltd				✓	01/11/14	Ongoing	No action required as not relevant to any ICB business
Austin	Jim	Participant to the Board for Place	Primary & Community Care Delivery Board Chair of Digital and Data Delivery Board Integrated Place Executive	CEO of Derbyshire Community Health Services NHS Foundation Trust	✓				16/09/24	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Employed jointly between NHS Derby and Derbyshire Integrated Care Board and Derbyshire Community Health Services NHS Foundation Trust	✓				01/11/22	01/08/24	
				Spouse is a locum GP and the Local Place Alliance lead for High Peak (8 hours per week)				✓	01/11/22	Ongoing	
Bhatia	Avi	Participant to the Board for the Clinical & Professional Leadership Group	Chair - Clinical and Professional Leadership Group, Derbyshire ICS Population Health & Strategic Commissioning Committee	GP partner at Moir Medical Centre	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				GP partner at Erewash Health Partnership	✓				01/07/22	Ongoing	
				Part landlord / owner of premises at College Street Medical Practice, Long Eaton, Nottingham	✓				01/07/22	Ongoing	
				Work as Training Programme Director for Health Education England		✓			01/04/24	29/10/24	
				Spouse works for Nottingham University Hospitals				✓	01/07/22	Ongoing	
				Work as Training Programme Director and as an Associate Postgraduate Dean for the East Midlands GP Deanery, NHSE		✓			29/10/24	Ongoing	
Clayton	Chris	Chief Executive Officer	ICS Executive Team Meeting	Spouse is a partner in PWC				✓	01/07/22	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Dentith	Jill	Non-Executive Member - Finance, Estates & Digital	Audit & Governance Committee Finance, Estates & Digital Committee People & Culture Committee Quality & Performance Committee	Self-employed through own management consultancy business trading as Jill Dentith Consulting	✓				2012	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Director of Jon Carr Structural Design Ltd	✓				06/04/21	Ongoing	
Dillistone	Helen	Chief of Staff	Audit & Governance Committee Public Partnership Committee Greener Delivery Board	Nil							No action required
Finn	Claire	Interim Chief Finance Officer	Finance, Estates & Digital Committee Population Health & Strategic Commissioning Committee Integrated Place Executive ICS Executive Team Meeting Midlands 111 Board	Trustee of Newfield Charitable Trust			✓		01/10/23	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Garnett*	Linda	Interim Chief People Officer	People & Culture Committee Population Health & Strategic Commissioning Committee Finance, Estates & Digital Committee ICS Executive Team Meeting Clinical & Professional Leadership Group	My husband is an independent consultant and is currently working in the ICS via a commission with Amber valley CVS				✓	01/07/22	31/07/24	None required currently
Gildea	Margaret	Non-Executive Member / Senior Independent Director	Audit & Governance Committee People and Culture Committee Population Health & Strategic Commissioning Committee Remuneration Committee Derby City Health & Wellbeing Board	Director of Organisation Change Solutions a leadership, management and OD consultancy. I do not work for any organisation in the NHS, but do provide coaching and OD support for First Steps ED, an eating disorder charity	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Chair of Melbourne Assembly Rooms (a voluntary not for profit organisation that runs the former SDDC controlled leisure centre)			✓		01/07/22	Ongoing	
Griffiths*	Keith	Chief Finance Officer	Finance, Estates & Digital Committee Population Health & Strategic Commissioning Committee Integrated Place Executive ICS Executive Team Meeting Midlands 111 Board	Nil							No action required

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Houlston	Ellie	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)	System Quality Group Integrated Care Partnership Health and Wellbeing Board - Derbyshire County Council Women's Health Hub Steering Group ICS Executive Team Meeting	Director of Public Health, Derbyshire County Council	✓				01/09/22	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair.
				Director and Trustee of SOAR Community			✓		01/09/22	Ongoing	Sheffield based - unlikely to bid in work in Derbyshire
Howells	Dean	Chief Nurse Officer	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee Local Maternity and Neonatal System Board Clinical and Professional Leadership Group Information Governance Assurance Forum ICS Executive Team Meeting Midlands 111 Board	Honorary Professor, University of Wolverhampton	✓				13/09/23	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair.
McLean	Kathy	ICB Chair	Remuneration Committee	Non Executive Director Barking Havering and Redbridge NHS Trust		✓			20/06/23	30/06/2024	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Kathy McLean Limited - a private limited company offering health related advice	✓				05/08/19	Ongoing	
				Non Executive Director at Barts Health NHS Trust	✓				01/12/19	30/06/2024	
				Occasional adviser for CQC well led inspections	✓				24/06/22	Ongoing	
				Chair of Nottingham and Nottinghamshire Integrated Care Board		✓			01/02/21	Ongoing	
				Chair of Nottingham and Nottinghamshire Integrated Care Partnership		✓			01/02/21	Ongoing	
				Joint Chair of Joint Negotiating Committee Staff and Associate Specialists on behalf of NHS Employers		✓			24/06/22	Ongoing	
				Member of NHS Employers Policy Board		✓			Ongoing	Ongoing	
				Interim Chair The Public Service Consultants	✓				Ongoing	Ongoing	
				Chair of ICS Network, NHS Confederation		✓			01/04/24	Ongoing	
				Chair of East Midlands Specialised & Joint Committees		✓			01/04/24	Ongoing	
				Advisor to Oxehealth		✓			17/02/22	Ongoing	
Mott	Andrew	GP Amber Valley (Primary Medical Services Partner Member)	System Quality Group Joint Area Prescribing Committee Derbyshire Prescribing Group Clinical and Professional Leadership Group End of Life Programme Board Children's Urgent Care Group Community Same Day Urgent Care Delivery Group Amber Valley Place Alliance Group Virtual Wards Delivery Group GP Leadership Group Women's Health Hub Steering Group	GP Partner of Jessop Medical Practice	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Practice is shareholder in Amber Valley Health Ltd (provides services to our PCN)	✓				01/07/22	Ongoing	
				Medical Director, Derbyshire GP Provider Board	✓				01/07/22	Ongoing	
				I am the managing Partner at Jessop Medical Practice, involved in all aspects of provision of primary medical services to our registered population.		✓			01/07/22	Ongoing	
				Wife is Consultant Paediatrician at UHDBFT				✓	01/07/22	Ongoing	
Okubadejo	Adedeji	Clinical Lead Member	Population Health & Strategic Commissioning Committee Quality & Performance Committee Remuneration Committee	Director, Carwis Consulting Ltd. Provision of clinical anaesthetic and pain management services as well as management consulting services to patients and organisations in the independent healthcare sector	✓				01/04/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Provision of private clinical anaesthesia services	✓				01/04/23	Ongoing	
				Director and Chairman, OBIC UK. Working to improve educational attainment of children from black and minority ethnic communities in the UK			✓		01/04/23	Ongoing	

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Posey	Stephen	Chief Executive Officer, UHDBFT (NHS Trust & FT Partner Member)	Provider Collaborative Leadership Board (Chair)	Chief Executive Officer of UHDBFT	✓				01/08/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Board Trustee of the Intensive Care Society		✓			10/12/19	30/09/24	
				Executive Well-Led Reviewer for the Care Quality Commission		✓			01/06/18	30/09/24	
				Chief Executive Member of the National Organ Utilisation Group		✓			02/07/21	30/09/24	
				Partner is Chief Executive Officer of the Royal College of Obstetricians and Gynaecologists				✓	01/08/23	Ongoing	
				Partner is a Non-Executive Director for the Kent, Surrey & Sussex (KSS) AHSN				✓	01/08/23	Ongoing	
				Partner is a Non-Executive Director for Manx Care				✓	17/05/23	Ongoing	
Powell	Mark	Chief Executive Officer, DHcFT (NHS Trust & FT Partner Member)	People & Culture Committee	CEO of Derbyshire Healthcare NHS Foundation Trust	✓				01/04/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Treasurer of Derby Athletic Club			✓		01/03/22	Ongoing	
Radford	Lee	Chief People Officer	People & Culture Committee Population Health & Strategic Commissioning Committee Finance, Estates & Digital Committee ICS Executive Team Meeting	Nil							No action required
Sadiq*	Perveez	Service Director - Adult Social Care, Derby City Council	N/A	Nil							No action required
Simpson	Paul	Local Authority Partner Member	N/A	Chief Executive Officer, Derby City Council	✓				Ongoing	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair.
Smith	Nigel	Non-Executive Member	TBC	NED at Nottinghamshire Healthcare NHS FT	✓				02/02/22	Ongoing	Declare interets when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Trustee at Derbyshire Districts Citizens Advice Bureau		✓			01/02/19	Ongoing	
Sunderland	Sue	Non-Executive Member - Audit & Governance	Audit and Governance Committee Finance, Estates & Digital Committee Public Partnership Committee IFR Panels CFI Panels	Audit Chair NED, Nottinghamshire Healthcare Trust	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Independent Audit Chair of Joint Audit, Risk & Assurance Committee for Derbyshire Office of the Police & Crime Commissioner and Chief Constable	✓				01/07/22	Ongoing	
				Husband is an independent person sitting on Derby City Council's Audit Committee				✓	01/07/22	Ongoing	
Weiner	Chris	Chief Medical Officer	Population Health & Strategic Commissioning Committee Quality & Performance Committee System Quality Group EMAS 999 Clinical Quality Review Group Local Maternity & Neonatal System Board Clinical and Professional Leadership Group ICS Executive Team Meeting Digital & Data Board	Nil							No action required
Wright*	Richard	Non-Executive Member	Population Health & Strategic Commissioning Committee Public Partnerships Committee IFR Panel	Nil							No action required

Derby and Derbyshire
Integrated Care Board

SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

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

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

Abbreviations & Glossary of Terms

A&E	Accident and Emergency
AfC	Agenda for Change
AGM	Annual General Meeting
AHP	Allied Health Professional
AQP	Any Qualified Provider
Arden & GEM CSU	Arden & Greater East Midlands Commissioning Support Unit
ARP	Ambulance Response Programme
ASD	Autistic Spectrum Disorder
BAF	Board Assurance Framework
BAME	Black Asian and Minority Ethnic
BCCTH	Better Care Closer to Home
BCF	Better Care Fund
BMI	Body Mass Index
bn	Billion
BPPC	Better Payment Practice Code
BSL	British Sign Language
CAMHS	Child and Adolescent Mental Health Services
CATS	Clinical Assessment and Treatment Service
CBT	Cognitive Behaviour Therapy
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile
CEO (s)	Chief Executive Officer (s)
CfV	Commissioning for Value
CHC	Continuing Health Care
CHP	Community Health Partnership
CMHT	Community Mental Health Team
CMP	Capacity Management Plan
CNO	Chief Nursing Officer
COO	Chief Operating Officer (s)
COP	Court of Protection
COPD	Chronic Obstructive Pulmonary Disorder
CPD	Continuing Professional Development
CPN	Contract Performance Notice
CPRG	Clinical & Professional Reference Group
CQC	Care Quality Commission
CQN	Contract Query Notice
CQUIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CSE	Child Sexual Exploitation
CSF	Commissioner Sustainability Funding
CSU	Commissioning Support Unit
CTR	Care and Treatment Reviews
CVD	Chronic Vascular Disorder
CYP	Children and Young People
D2AM	Discharge to Assess and Manage
DAAT	Drug and Alcohol Action Teams
DCC	Derbyshire County Council or Derby City Council
DCHSFT	Derbyshire Community Health Services NHS Foundation Trust
DCO	Designated Clinical Officer
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHSC	Department of Health and Social Care
DHU	Derbyshire Health United
DNA	Did not attend
DoF(s)	Director(s) of Finance
DoH	Department of Health
DOI	Declaration of Interests
DoLS	Deprivation of Liberty Safeguards
DPH	Director of Public Health
DRRT	Dementia Rapid Response Team
DSN	Diabetic Specialist Nurse
DTOC	Delayed Transfers of Care
ED	Emergency Department
EDS2	Equality Delivery System 2
EDS3	Equality Delivery System 3

EIA	Equality Impact Assessment
EIHR	Equality, Inclusion and Human Rights
EIP	Early Intervention in Psychosis
EMASFT	East Midlands Ambulance Service NHS Foundation Trust
EMAS Red 1	The number of Red 1 Incidents (conditions that may be immediately life threatening and the most time critical) which resulted in an emergency response arriving at the scene of the incident within 8 minutes of the call being presented to the control room telephone switch.
EMAS Red 2	The number of Red 2 Incidents (conditions which may be life threatening but less time critical than Red 1) which resulted in an emergency response arriving at the scene of the incident within 8 minutes from the earliest of; the chief complaint information being obtained; a vehicle being assigned; or 60 seconds after the call is presented to the control room telephone switch.
EMAS A19	The number of Category A incidents (conditions which may be immediately life threatening) which resulted in a fully equipped ambulance vehicle able to transport the patient in a clinically safe manner, arriving at the scene within 19 minutes of the request being made.
EMLA	East Midlands Leadership Academy
EoL	End of Life
ENT	Ear Nose and Throat
EPRR	Emergency Preparedness Resilience and Response
FCP	First Contact Practitioner
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FIRST	Falls Immediate Response Support Team
FRP	Financial Recovery Plan
GDPR	General Data Protection Regulation
GP	General Practitioner
GPFV	General Practice Forward View
GPSI	GP with Specialist Interest
HCAI	Healthcare Associated Infection
HDU	High Dependency Unit
HEE	Health Education England
HI	Health Inequalities
HLE	Healthy Life Expectancy
HNA	Health Needs Assessment
HSJ	Health Service Journal
HWB	Health & Wellbeing Board
H1	First half of the financial year
H2	Second half of the financial year
IAF	Improvement and Assessment Framework
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICM	Institute of Credit Management
ICO	Information Commissioner's Office
ICP	Integrated Care Partnership
ICS	Integrated Care System
ICU	Intensive Care Unit
IG	Information Governance
IGAF	Information Governance Assurance Forum
IGT	Information Governance Toolkit
IP&C	Infection Prevention & Control
IT	Information Technology
IWL	Improving Working Lives
JAPC	Joint Area Prescribing Committee
JSAF	Joint Safeguarding Assurance Framework

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

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

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

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

Derby and Derbyshire Integrated Care Board

MINUTES OF NHS DERBY AND DERBYSHIRE ICB BOARD MEETING IN PUBLIC

Held on Thursday, 21st November 2024

Joseph Wright Room, Council House, Derby DE1 2FS

Unconfirmed Minutes

Present:		
Dr Kathy McLean	KM	ICB Chair (Meeting Chair)
Jim Austin	JA	Chief Executive Officer, DCHSFT (Participant Member to the Board for Place)
Dr Chris Clayton	CC	ICB Chief Executive Officer
Craig Cook	CCo	ICB Director of Strategy and Planning (on behalf of Michelle Arrowsmith)
Jill Dentith	JED	ICB Non-Executive Member
Helen Dillistone	HD	ICB Chief of Staff
Claire Finn	CF	Interim Chief Finance Officer
Margaret Gildea	MG	ICB Non-Executive Member / Senior Non-Executive Member
Ellie Houlston	EH	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)
Prof Dean Howells	DH	ICB Chief Nurse
Jennifer Leah	JL	ICB Deputy Chief Finance Officer (on behalf of Keith Griffiths)
Dr Andrew Mott	AM	GP Amber Valley (Partner Member for Primary Care Services) / Medical Director of GP Provider Board
Dr Deji Okubadejo	DO	ICB Clinical Lead Member
Stephen Posey	SPo	Chief Executive, UHDBFT / Chair of the Provider Collaborative Leadership Board (NHS Trust and FT Partner Member)
Mark Powell	MP	Chief Executive DHcFT (NHS Trust and FT Partner Member)
Lee Radford	LR	ICB Chief People Officer
Paul Simpson	PS	Chief Executive, Derby City Council (Local Authority Partner Member)
Sue Sunderland	SS	ICB Non-Executive Member
Dr Chris Weiner	CW	ICB Chief Medical Officer
In Attendance:		
Kathryn Durrant	KD	ICB Executive Board Secretary
Tamsin Hooton	TH	Programme Director, Provider Collaborative
Christina Jones	CJ	ICB Head of Communications
Suzanne Pickering	SP	ICB Head of Governance
Uzman Niazi	UN	360 Assurance
Sean Thornton	ST	ICB Director of Communications and Engagement
10 members of the public		
Apologies:		
Michelle Arrowsmith	MA	ICB Chief Strategy and Delivery Officer / Deputy CEO
Dr Avi Bhatia	AB	Participant to the Board for the Clinical & Professional Leadership Group
Keith Griffiths	KG	ICB Chief Finance Officer

Item No.		Item	Action
ICBP/2425/073		**Welcome, introductions and apologies:** Dr Kathy McLean (KM) welcomed all Board Members and attendees to the Board Meeting in Public. Introductions were made as below:	

		• KM welcomed the observing members of public; • KM formally acknowledged and welcomed Paul Simpson, Chief Executive of Derby City Council and Local Authority Partner Member, to his first Board meeting; • KM acknowledged the ICB's Chief Finance Officer (CFO) Keith Griffiths' last meeting, and thanked him in absence for his hard work and the huge contribution that he has made to the work of the system; • KM introduced and welcomed Claire Finn, the ICB's Interim Chief Finance Officer, to her first Board meeting; and • KM welcomed Tamsin Hooton, Programme Director of the Provider Collaborative, to the Board to present item 082. Apologies for absence were received as noted above. It was noted that the meeting was being observed by external auditors from 360 Assurance. KM advised the Board and observers that ten questions to the Board were received from members of the public across a variety of topics, and that these questions would be addressed under the usual agenda item at the end of the meeting.	
ICBP/2425/074		**Confirmation of quoracy** It was confirmed that the meeting was quorate.	
ICBP/2425/075		**Declarations of Interest** The Chair reminded Committee Members of their obligation to declare any interests they may have on issues arising at Committee meetings which might conflict with the business of the ICB. Declarations made by members of the Board are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the ICB Board Secretary or the ICB website, using the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/integrated-care-board-meetings/ It was noted that Mark Powell, due to his role as Chief Executive at Derbyshire Healthcare NHS Foundation Trust, had an interest in item 084, however this interest did not denote a conflict.	
ICBP/2425/076		**Minutes of the meeting held on 19th September 2024** **The Board APPROVED the minutes of the above meeting as a true and accurate record of the discussions held.**	
ICBP/2425/077		**Action Log – September 2024** **The Board NOTED the action log, which will be updated accordingly.**	
ICBP/2425/078		**Chair's Report** KM highlighted the following: • the meeting's planned Citizen's Story with a Perinatal Support Service was unable to take place and was deferred until	

		January's Board Meeting. KM added that her recent visit to the service was very positive and inspirational. It was agreed that citizens' stories are very powerful and help the Board to understand the impact of such healthcare schemes on communities; • it is a very interesting period in the development of health services, with the Secretary of State signalling healthcare's shift into community and digital. These messages align with the system's own strategies and ambitions and it will be key for the system to engage with the 10 Year Plan arising from Lord Darzi's review; • it is clear from the national perspective in terms of devolution of health services that focus will be on local neighbourhood teams, place alliances and Primary Care Networks (PCNs); • KM's predecessor as ICB Chair, Richard Wright, has now left the ICB and taken retirement. The Board thanked Richard for his work; and • Richard Wright's replacement Non-Executive Board Member is being recruited and will be announced soon. **The Board NOTED the Chair's report.**	
ICBP/2425/079		**Chief Executive's Report** Dr Chris Clayton (CC) highlighted the following: • Keith Griffiths was formally thanked for his service to the ICB and also his long career across the NHS. Keith has strongly supported the ICB and the NHS family in Derbyshire through his stewardship of financial resources and his ability to take serious judgements. CC offered thanks to Interim CFO Claire Finn for attending this meeting and noted that Claire will take up the new role from end of November 2024; • receipt of a petition relating to Talking Therapies was formally acknowledged; • the system is currently awaiting guidance from NHS England (NHSE) with regards to the recently announced increase in the health budget; • the NHS Staff survey is currently live and colleagues are encouraged to complete it; • reduction of waste is a continuing national theme with a new strategy aiming to crack down on single use medical devices; • there is a national focus on obesity and in the 12-24 months ahead the Board will need to consider obesity as a general risk factor; • it is currently key vaccination season; CC confirmed that he has received his seasonal vaccines and encouraged all to receive theirs; and • CC referred to public health and local authorities, recent consultations with regards to care homes and the new CT scanner at Ilkeston. **The Board NOTED the Chief Executive's report.**	
ICBP/2324/080		**Joint Forward Plan update** An overview of the five year plan was presented; the system are currently in the second year of the nationally mandated plan, which	

		is to support transition from a focus on immediate treatment of health issues to prevention. An incremental shift over time will be required and the system's plan will need to be aligned to the government's long-term plan for health, which will be made public in Spring 2025. The system is increasing focus on prevention in areas such as cardiovascular, Team Up, dementia diagnosis, weight management and reducing admissions in frail cohorts. Work is being done to ensure connectivity and alignment of the joint forward plan to the Integrated Care Partnership (ICP), the Integrated Care System (ICS) and the Health and Wellbeing Board (HWB). The Board discussed the update, with the following comments: • for future iterations of the plan, it must be made clear how immediate pressures are addressed and how this is balanced against the need to make these fundamental changes in a way that is sustainable in the long-term. In the next few years the Board will likely need to make decisions on key initiatives to find and maintain this balance; • the strategic importance of shared care records and digital innovations across all practitioners was stressed. There is currently no plan to share the acute Trusts' Electronic Patient Record system Nervecentre with other practitioners using TPP SystmOne, such as GPs and mental health clinicians, as clinical information from both of these systems goes into the shared care records; • Derbyshire have been recognised at the national level for the good practice taking place in psychiatric liaison teams to improve rates of dementia diagnosis in community and acute settings. It was agreed that success stories such as this should be shared to staff, investors and the population; and • the joint forward plan risk strategy needs to reflect the BAF, integrated care strategy and the 10 Year Plan, and engagement on this issue with key partners outside the NHS, such as local authorities and voluntary sector, was emphasised. Moving forwards it will be useful to establish a measure of the ambition, with the target, strategy, progress towards the target, challenges and areas of inequality clearly identified, plotted against relevant population information and monitored for the Board's scrutiny. **Action: Monitor and establish measure against system ambition and link to board assurance framework** **The Board NOTED the Joint Forward Plan Update for assurance purposes.**	**MA**
ICBP/2425/081		**Seasonal Plan** An overview of the seasonal plan for the Board's approval was provided. The system's Winter Plan is in continual development and is based on previous plans, incorporating numerous checkpoints. The initial review has yielded good-high levels of assurance of the breadth and depth of the plan, however it is important to recognise that the system has been under pressure for months and the winter will increase the pressure, particularly on urgent care, and the	

		season will be challenging. Currently weekly oversight meetings are taking place however plans are in place for daily oversight. The Board discussed the plan, with the following comments: • the plan does not cover the financial implication and pressure on beds, which have been kept open through the year due to demand. The importance of keeping finance in mind was stressed; • the acute Trusts are well engaged with work underway and a focus on patient safety. Waiting times are still too high however Derbyshire is showing resilience under pressure due to the plans put in place in the last few weeks and work across all partner organisations has been very positive, with more patients getting treatment from the right providers for better outcomes; • primary care has been very engaged with the plan throughout development, with potential for escalation and some available capacity. There is always some uncertainty present in general practice however there are also opportunities to be explored; • it was noted that the RAG rating showed a considerable amount of amber, denoting some unmitigated risk. The system has received assurance from NHSE with regards to delivery of the plan, and the Board were assured that appropriate mitigations of risks are in place despite the very pressured and challenging environment; • acute bed capacity is a pressing issue and will be picked up during the stocktake item. Virtual wards can provide additional capacity, particularly during times of additional pressure, however the system has not had the expected level of engagement with virtual wards. The virtual ward programme is a national initiative for shifting activity for acute illness from acute environments to communities and patients' homes. The change will take time and the system have reached the maximum level of step-down use of beds. The Place team are working on the step-up model of care now and the current approach will be reviewed in the new year to see where a stronger step-up model can be implemented by the end of the winter season; • it was confirmed that a full Communications plan is in place to encourage the general public to keep themselves healthy, including taking up seasonal vaccinations where possible; and • the importance of the NHS working in partnership with local authorities was stressed, including taking advantage of the help that the local authorities can give. This help could include getting targeted messages out to particular groups within the local population as required and facilitating partnerships with the local voluntary sector. The local authorities expressed confidence that their budgets for 2025/26 will be balanced and commented on the importance of assurance of the plan from NHSE.	

		The ICB Board APPROVED the Derby and Derbyshire 2024/25 Seasonal Plan.	
ICBP/2425/082		**Strategic Update from the Provider Collaborative** The paper was taken as read and some additional context was provided. The collaborative comprises providers working together to support the joint forward plan, to ensure the limited resources are used as effectively as possible and to deliver impactful improvements that cannot be managed individually, working towards delivering a £127m cost improvement plan during 2024/25. The team is small but effective and works alongside programme and project SROs across all organisations. So far progress has been made despite constrained resources, significant pressures and requirements to deliver improvements in quality and safety alongside organisational efficiencies and productivity. There is a theme reflected in the joint forward plan of two competing priorities; immediate pressures and the importance of left shift and future planning. Material progress must be made towards both priorities and there are some good examples of where this is happening in current programmes across the collaborative. Currently a priority is the need to develop and deliver against comprehensive benefit realisation plans, although currently the ability to articulate the planned impact is lacking. The Board discussed the report, with the following comments: • it was recognised that the development and maturing of the provider collaborative is very positive and welcome, and has been the result of a considerable amount of hard work; • it will be useful to streamline the governance that is currently set up for the provider collaborative, to allow them to support and interlink with the ICB where appropriate in its role as strategic commissioner. Currently wider governance is being reviewed by the ICB with a view to adding value, eliminating repetition and duplication of work and providing a clear framework of expectations for providers; • with regards to fragile services and stroke rehabilitation services, there is concern across the system that this is going to be expanded into acute and hyperacute pathways. In terms of oversight and assurance, work is taking place to stratify services and to agree where they will best be resolved. Acute stroke services are being led by the East Midlands Acute Provider Collaborative and this is where solutions will need to lie in terms of workforce; • there are potential opportunities for the collaborative to work inclusively with local authorities to save public money, for example through the One Public Estate initiative or through procurement opportunities. Digital services also represent an opportunity for the NHS and local authorities to work together on issues such as prevention; • there is also a positive workforce element to collaboration with local authorities, as this ensures that organisations are not in competition to recruit the same people, potentially driving up costs. Joined up working will help ensure that	

		colleagues are in the most appropriate role and organisation for their skills; and • it was stressed that a small number of outcomes and ambitions that are achievable amid the current challenges is preferable to a large number of ambitions that are less likely to be attainable. **The ICB Board NOTED the update on the Strategic Update from the Provider Collaborative for assurance.**	
ICBP/2425/083		**Progress against Plan (H1 strategic review)** CC thanked colleagues across the system for their hard work in preparing the 2024/24 half year review, which is a very important piece of planning discipline. A shorter review will be prepared at the end of Quarter 3 to ensure the plans remain in place and are progressing. The review summarises key points and achievements in the first half of the year, including the following points of note: • more patients than planned have been seen in same day emergency care pathways and community mental health pathways; • more GP appointments than planned have taken place; and • the challenge is overall pressures across the plan, especially in terms of winter pressures. There are risks in terms of finite bed capacity which are being worked through now and will flow into next year. The system is currently above plan in terms of open acute beds, leading to two actions: • in the present, everything possible is being done to relieve pressure on hospitals, as this leads to pressure on ambulances, decreases flow through hospitals and affects the 4-hour target; and • over the rest of the year, work will be done to decompress the hospitals in acute and planned care. Beds will need to be closed over time, in a safe and effective way; alternatives must be found to acute bed usage and this is being worked on. The balance between urgent care and planned care is being worked through and must be delivered within the system's £50m deficit position. A focus is on planned care and seeing as many patients as possible who have been on waiting lists. Some areas such as cancer care are showing very positive improvements and these improvements must be maintained. There was discussion around increased pressure on the system leading to increased rates of staff sickness due to overwork, and if this issue can be addressed alongside bed occupancy and decompression within the available resources. It was noted that bed capacity has always been an issue in the NHS and it might be helpful for the Board to focus on health inequalities as concentration of prevention work on these areas may help to reduce pressure on urgent care.	

		The ICB Board NOTED the progress against plan (H1 Review) for assurance.	
ICBP/2425/084		**Review of Intensive & Assertive Community Treatment within Community Mental Health Teams** KM noted that this work is being carried out by all ICBs in reaction to the tragic events in Nottinghamshire and the reports that subsequently emerged. The paper outlines the national approach from NHSE to all ICBs and mental health providers towards assertive outreach and community models. The Board has seen the refreshed mental health and learning disabilities strategy and action plan. In terms of process, a very in-depth partnership approach has been completed and overseen by the Delivery Board. A thorough response has been submitted to NHSE; a limited assurance position was confirmed based on the 14 areas of assessment. The action plan, which fully complies with the requirements for the next year, is brought before the Board for approval, however the plan will need to be revised when the anticipated refreshed operational planning guidance is made available. The Quality and Performance Committee and Delivery Board will be monitoring progress against the plan; NHSE are part of the Delivery Board. The system is in a realistic and credible position, with some work to be done and commitment to do so. The Board discussed the action plan, with the following comments: • with regards to the limited assurance position, the Board were assured that this can be progressed to a position of more significant assurance within the year; • it was noted that several actions were categorised as 'ongoing', whereas a more detailed breakdown of progress with interim deadlines and expected completion dates would help identify if actions are on track. It was clarified that certain actions require agreement from NHSE at the Delivery Board, which will take place on 17th December 2024; • The Quality and Performance Committee will be able to receive the overarching performance report; the Board will require a mechanism to monitor performance and progression against the action plan; • patient safety risks sit with the mental health Trust, and so there is a level of oversight and scrutiny of the plan there; and • over the coming months the Board will need to make choices about how some of these issues are addressed with the resources available; this is an important part of community mental health teams' development. The events in Nottingham represent an important opportunity for learning for the system, and a development session in December will allow the Board to look at these issues in detail. Although Derbyshire is not formally involved in the six pilot areas for	

		neighbourhood mental health approach work, there are lessons that the system can learn from this scheme. **The Board:** • **NOTED the outcomes of the ICB Maturity Index Self-Assessment Tool for Community Mental Health Service Review submitted to NHSE on the 30th of September 2024;** • **APPROVED the intensive and assertive community treatment action plan, developed as part of the review of CMHTs; and** • **NOTED that the action plan will have regular oversight within Executive Management Team Meetings of both the ICB and DHcFT and will report into the Mental Health and Learning Disabilities and Autism Delivery Board.**	
ICBP/2425/085		**Integrated Performance Report (including level of assurance from the relevant Committee)** The integrated performance report was taken as read. • Quality Key points of note were: ○ themes of the report are maternity and an improvement of indices at University Hospitals Derby and Burton NHS Foundation Trust (UHDB). There are some concerns at Chesterfield Royal Hospital Foundation Trust (CRHFT) where there has not been as much progress; ○ the first iteration of a predictive dashboard tool has been received; the tool predicts difficulties in primary care and is proving useful; and ○ a harm review and risk assessment has been carried out. There are a number of risks relating to winter, and six significant harm review structures. ICB colleagues and NHSE will be completing quality front line visits in January 2025 to seek feedback from staff and service users on the front line. The Chair of the Quality and Performance Committee gave adequate assurance from the committee. • Performance Key points of note were: ○ although performance is generally behind trajectory, the positive messages from the H1 stocktake were reinforced; there is a considerable amount of work aligning with regards to finance and workforce; ○ other concerns include the potential of industrial action, the conflict between immediate and long-term needs, and the need to address inequality. The ICB has a crucial role in this as the anchor organisation and can assist in resolving issues without duplication of effort; and ○ overall there has been good learning this year and this will be carried forward in to plans for next year. The Chair of the Quality and Performance Committee gave adequate assurance from the committee.	

		• Finance Key points of note were: ○ several points from the report were noted for the Board's assurance, including triangulation of workforce, finance and efficiency and delivering the updated breakeven position. The importance of Committee oversight of the H2 position and mitigations was emphasised; and ○ there was a discussion around the increase in NHS budget and the ramifications of this, including with respect to working with local authorities. It was agreed that the current financial scenario is very challenging and that NHS and LA organisations must work closely together to maximise what can be achieved within the available resources without duplicating work. It was noted that it would be helpful for the NHS and LA organisations to have increased understanding of each other's financial processes. The Chair of the System Finance, Estates and Digital Committee gave adequate assurance from the committee. • Workforce Performance Key points of note included: ○ the benefits of the H1 stocktake in understanding the current workforce position; ○ costs associated with industrial action; and ○ pay awards. The Chair of the People & Culture Committee gave adequate assurance from the committee. **The ICB Board NOTED the Performance Report and Committee Assurance Reports.**	
ICBP/2425/086		**Remuneration Committee Assurance Report – 8th October 2024** This report was taken as read, and the Board were assured that the restructure and redundancy process has almost been completed. **The ICB Board NOTED the Remuneration Committee Assurance Report**.	
ICBP/2425/087		**Board Assurance Framework – Quarter 2 2024/25** An overview was presented of the updated BAF for quarter 2 of 2024/25, and the development seminar in October 2024, in which the Board considered the levels of risk and tolerance. Two changes to strategic risks 1 and 5 have been made. More work will need to be done to ensure the risks are accurate to the Joint Forward plan and the 10 Year Plan, however this framework is recommended to be used for the remainder of the financial year. A revised BAF will be implemented in 2025/26 in line with the 10 Year Plan and other guidance to be issued. The Board endorsed the updated BAF and made the following comments: • the reduction to Risk 5 around workforce vacancies across the system, including in social care, has been understood in	

		People and Culture Committee. The risk references culture and can incorporate issues such as encouraging people into the healthcare sector, and what it feels like to work for the NHS; • the Board will hold a seminar session in February 2025 to look at workforce, including aspects such as local education colleges, career pathways and neurodivergent pathways. The importance of workplace culture in attracting the right candidates to the workforce was stressed; and • risks can be reduced ahead of the new BAF in April 2025, taking positive assurances and looking at scores going forwards. **The ICB Board:** • **RECEIVED the final Quarter 2 24/25 BAF strategic risks 1 to 10;** • **NOTED the revised risk description for Strategic Risk 5;** • **NOTED the increase in risk score in respect of Strategic Risk 1;** • **NOTED the decrease in risk score in respect of Strategic Risk 5.**	
ICBP/2425/088		**ICB Risk Register – October 2024** There were no comments on this item. **The Board RECEIVED and NOTED:** • **Appendix 1, the risk register report;** • **Appendix 2, which details the full ICB Corporate Risk Register;** • **Appendix 3, which summarises the movement of all risks in October 2024.** **The Board APPROVED CLOSURE of:** • **Risk 07 relating to the secure storage of staff files;** • **Risk 24 relating to the requirement to commission and have in place a Designated Doctor for looked after children.**	
ICBP/2425/089		**Audit and Governance Committee Assurance Report – 10th October 2024** The report was taken as read. There were no questions or comments on this report. **The Board RECEIVED and NOTED the report for assurance purposes.**	
ICBP/2425/090		**Finance Estates and Digital Committee Assurance Report – 24th September and 22nd October 2024** The report was taken as read. There were no questions or comments on this report. **The Board RECEIVED and NOTED the report for assurance purposes.**	

ICBP/2425/091		**Population Health Commissioning Committee Assurance Report – 24th October 2024** The report was taken as read. There were no questions or comments on this report. **The Board RECEIVED and NOTED the report for assurance purposes.**	
ICBP/2425/092		**Public Partnership Committee Assurance Report – 24th September 2024** The report was taken as read. There were no questions or comments on this report. **The Board RECEIVED and NOTED the report for assurance purposes.**	
ICBP/2425/093		**Quality and Performance Committee Assurance Report – 31st October 2024** The report was taken as read. There were no questions or comments on this report. **The Board RECEIVED and NOTED the report for assurance purposes.**	
ICBP/2425/094		**For information - Primary Care Access Improvement Plan** **The ICB Board NOTED that the ICB has continued to make good progress against the Primary Care Access Recovery plan in year 2 and has robust plans to deliver to target by the end date of 31st March 2025.**	
ICBP/2425/095		**For information - Delegation of additional specified Specialised Acute Services and Mental Health, Learning Disability and Autism specialised services and associated workforce** **The ICB Board NOTED the contents of this report.**	
ICBP/2425/096		**Forward Planner** The forward planner was taken as read. **The Board NOTED the forward planner for information.**	
ICBP/2425/097		**Any Other Business** No other business was raised.	

ICBP/2425/098		**Questions received from members of the public** Ten questions were received from members of the public, none of which directly related to the agenda. All questions were acknowledged and it was confirmed that the questions would be responded to in writing in due course, via the ICB's usual process. With regards to the questions received regarding Talking Therapies, the Board recognised the great public interest and importance of this issue. Given the live status of the procurement there is a requirement to work within the bounds of the process in terms of answers that can be provided. However it was confirmed that the ICB are maintaining and increasing spend on Mental Health investment in the 2024/25 operational plan and that Talking Therapies link into the plans for 2024/25 and 2025/26. The full list of public questions and answers is below. • **Enquiry 1** 1) Matters relating to workforce satisfaction and retention have been discussed in today's meeting. Are the ICB aware of the work that the Arts Team at University Hospitals of Derby and Burton NHS Foundation Trust are pioneering in relation to workforce wellbeing? 2) Have the board considered the place of Creative Health within their various priorities and responsibilities? **Answer: Whilst the ICB is not directly aware of the Art Team's work at UHDB, it would be great to understand the opportunities that creative health has to offer which could support wider system integration work and colleague wellbeing.** • **Enquiry 2** The sale of the Babington Hospital site will allow a 50% drawn down of capital for the development of NHS services within the local area. What specific plans does the ICB have to use this money? **Answer: Thank you for your enquiry regarding the sale of Babington Hospital. It is important to note that the ICB is not party to the sale of the hospital; this is being undertaken by colleagues in NHS Property Services. The latest information the ICB holds is that the hospital remains for sale.** **Current capital rules indicate that all disposal receipts are utilised for re-investment by the NHS. In terms of local control, the current policy is that the ICB can apply for 50% of the net disposal receipt to invest a building in their area in which NHS Property Services have a legal interest. The ICB and local partners have not yet outlined specific plans to use any share of capital receipts from the sale of Babington Hospital, but in principle there is a schedule of capital works which are prioritised against available capital income and the local NHS**	

		system would consider these opportunities should capital receipts become available. • Enquiry 3 The ICB is currently reviewing the provision of urgent treatment centres across the region and plan to run an engagement/consultation process as part of this. When is this to take place, in what form and with whom? When will this be completed and conclusions published? **Answer: Our current plan is to engage with stakeholders and the wider public about the future provision of "same day emergency care", which includes the future role of Urgent Treatment Centre provision, in the first half of 2025. This will be an initial engagement piece to understand what people need and want to inform the ICB's service redesign work.** • **Enquiry 4** In light of the NHS Constitution that pledges to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered, what attempts have been made to consult the service users and people of Derbyshire on the tendering of NHS Talking Therapies to a private provider? **Answer: There was a widespread engagement exercise carried in 2018 involving patients, local people and partners including providers to look at what could make IAPT / Talking Therapies more accessible and to consider areas for development. One of the key priorities that local people expressed was consistency of offer, and this was taken into account when designing the new contractual model from 2025 onwards. A Lead Provider model was felt to have a number of advantages including centralising the offer and making Talking Therapies consistent via a single point of access / pathway development etc.** **As Talking Therapies is a manualised service based on clearly prescribed national clinical guidelines, the core service was not deemed to be changing in any material sense and therefore it was agreed that consultation was not proportionate or required. When a contract opportunity is put out to tender, the commissioner has no influence over who will wish to bid for the opportunity.** • **Enquiry 5** 1, The government has made more money available for our NHS; how do you intend to use it? 2, The government have introduced higher national insurance for certain groups, with exceptions. How will this affect the work of the ICB?	

		3, Derbyshire County Council are considering closing Aida Belfield Care Home in Belper. How would this affect Joined Up Care in the area? **Answers:** **1. The ICB are awaiting guidance from DHSC / NHSE regarding what funding will be made available to systems. At this time, as no national guidance has been made available regarding value, purpose or timelines, we have no specific plans.** **2. The cost associated with pay increases are nationally funded for the NHS to ensure there is no financial barrier to care provision.** **3. Derbyshire County Council will be undertaking a further period of consultation on the Ada Belfield facility. The outcome from its recent Cabinet Meeting is that the further consultation will not be proposing closure, and the ICB and wider NHS will be working closely with the County Council in the coming months and years to ensure we are developing the best model of community care to meet the needs of our population.** • **Enquiry 6** Given the recent scrutiny from the media, MPs and Unions, have the ICB considered re-visiting the tender process for Talking Therapies? **Answer: The ICB have considered the feedback and queries received by MPs and Unions. Responses have been provided and some discussions have been had already to discuss some of the concerns raised. The ICB's view is that the tender process will proceed as planned.** • **Enquiry 7** The chairs report refers to unlocking prevention in integrated care systems. NHS TT services are central to this agenda in preventing ill health and realising economic gains. The NHS TT manual states that system partners have a responsibility to ensure there is sufficient funding allocated to commissioning to provide sufficient sessions for effective treatment. From the expected England spend of £936.4M on Talking Therapies and an expectation that there will be 700,617 completed treatments, this makes for a spend of £1,336 per treatment. Why is the ICB offering only £593 per treatment in 2025/26? **Answer: The ICB reviewed what was needed in terms of outcomes and outputs for this service very carefully and in response to feedback from providers and wider partners. The ICB also considered affordability for the service in line with wider budget considerations. The procurement process is in the process of being concluded – this assesses providers' ability to**	

		deliver against quality and cost factors to determine suitability and ensure a viable delivery model is in place to meet local needs. • **Enquiry 8** How can you provide assurance of continued improvement in mental health care when the funding you are providing for NHS services is insufficient for safe and effective care, particularly for the categories of patients mentioned in the NHS Talking Therapy Manual. That is to say, complex cases, patients with long term conditions, PTSD or social anxiety? **Answer: The ICB recognises the benefits of investing in MH services and is committed to delivering against the nationally-mandated Mental Health Investment Standard, which it has achieved every year since its introduction. In relation to the Talking Therapy service, the ICB set out a reasonable funding settlement to deliver the core access and quality standards for all types of patient need.** • **Enquiry 9** Item 78 Chairs report refers to unlocking prevention in integrated care systems. NHS TT services are central to this agenda in preventing ill health and realising economic gains. The NHS Autumn statement says "Based on evidence the NHS Talking Therapies model can help grow the economy and Government has invested to continue expansion over the next 5 years". Given this, why does the ICB plan to treat fewer people over the next few years and where do they expect these people to go for treatment? **Answer: The ICB's commissioning intentions, as stated within the tender, represent a stronger focus on quality and fidelity to the Talking Therapies model going forwards. These procurement requirements also reflect a shift in national expectation regarding Talking Therapies access – which is more strongly focused on people completing quality treatment as opposed to numbers accessing treatment. The commissioning intentions also made specific reference to the need to move to a more streamlined model in which collaboration and integration with local pathways is key. The preferred provider(s), in conjunction with the ICB and system partners, will be instrumental in developing these pathways to ensure people are treated in the best place to meet their needs in line with evidence-based practice.** • **Enquiry 10** Item 78 Chairs report refers to unlocking prevention in integrated care systems. NHS Talking Therapy services are central to this agenda in preventing ill health and realising economic gains. The NHS Autumn statement says "Based on evidence the NHS Talking Therapies model can help grow the economy and Government has	

		invested to continue expansion over the next 5 years". Given this, why has the ICB allowed the investment to erode in Derbyshire to the point where we have the lowest spend per completed treatment? **Answer: The ICB reviewed what was needed in terms of outcomes and outputs for this service very carefully and in response to feedback from providers and wider partners. The ICB also considered affordability for the service in line with wider budget considerations. The procurement process is in the process of being concluded – this assesses providers' ability to deliver against quality and cost factors to determine suitability and ensure a viable delivery model is in place to meet local needs.**	

	Date and Time of Next Meeting
	Date: Thursday, 16th January 2025 **Time**: 9:15am to 11:15am **Venue:** The Joseph Wright Room, Council House, Derby

ITEM 103

ICB BOARD MEETING IN PUBLIC

ACTION LOG – NOVEMBER 2024

Item No.	Item Title	Lead	Action Required	Action Implemented	Due Date
ICBP/2324/050 20.7.2023	NHS Long Term Workforce Plan	Lee Radford	It was agreed that the Plan would return to a future Board for further discussion.	Workforce plan refresh is in progress by the People and Culture Committee.	**April 2025**
ICBP/2425/080 19.11.2024	Joint Forward Plan	Michelle Arrowsmith	Monitor and establish measure against system ambition and ensure there is a link to board assurance framework	This action is in process.	**April 2025**

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th September 2025

Item: 104

Report Title	Citizen's Story – Can community-based projects begin to reduce health inequalities?							
Author	Dr Allie Hill, GP / Derbyshire Trailblazer Fellow, West Park Surgery Sara Bains, Wellness and Inequalities Lead for PCN							
Sponsor (Executive Director)	Dr Andy Mott, GP Amber Valley (Partner Member for Primary Care Services) / Medical Director of GP Provider Board							
Presenter	Dr Andy Mott, Dr Allie Hill, Sara Bains							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1: Can community-based projects begin to reduce health inequalities?							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Not applicable							

Recommendations
The ICB Board are recommended to **NOTE** the information presented.
Purpose
To share frontline examples of work within the Integrated Care System, impacting on the health and wellbeing of people in Derby and Derbyshire, led by people working in services and the experiences of patients and/or volunteers involved.
Background
Local GPs in Erewash, working with the community and the university, are aiming to reduce health inequalities to proactively take Healthy Heart Checks into community and workplace venues. Using data, they identified communities with socioeconomic challenges, people in Mental Health Support Groups and working-age men. After writing to businesses in the Long Eaton area, Travis Perkins builders invited them to carry out Healthy Heart checks for staff working at their plant. Trained pharmacy and nursing students from the universities spent a day there carrying out the health checks alongside local GP Alexandra Hill. During the checks, they tested for hypertension, raised cholesterol, diabetes and atrial fibrillation. Public health colleagues also attended and talked to the cohort about lifestyle, health promotion and disease prevention.

The team would like to roll out other checks with Travis Perkins in other areas of Derbyshire if possible.

Report Summary

Please see appendix 1.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain an affordable and sustainable workforce supply pipeline and to retain staff through a positive staff experience.	☐	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Please indicate above which strategic risk(s) the paper supports and also make reference here to any risks within the ICB's risk register, which can be found here.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

Details/Findings *What is the full cost of this project/commitment/business case? How is this funded? And is the funding recurrent/non-recurrent? Is there a financial benefit expected elsewhere in the System? Is there a clear exit strategy from this project if funding is expected to cease?*	**Has this been signed off by a finance team member?** *Please indicate, by name and job title, the finance lead that has contributed to this paper.*

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

Give details of any instances where staff have been conflicted, or where conflicts have been raised at meetings where the report has been discussed

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

APPENDIX 1

NHS
Derby and Derbyshire

Can community-based projects begin to reduce health inequalities?

Dr Allie Hill, West Park Surgery, Derbyshire Trailblazer Fellow
Sara Bains, Wellness and Inequalities Lead for PCN

Our project

Local GPs in Erewash, working with the community and the university, are aiming to reduce health inequalities to proactively take Healthy Heart Checks into community and workplace venues.

Using data, they identified communities with socioeconomic challenges, people in Mental Health Support Groups and working-age men.

Our project

After writing to businesses in the Long Eaton area, Travis Perkins builders invited them to carry out Healthy Heart checks for staff working at their plant. Trained pharmacy and nursing students from the universities spent a day there carrying out the health checks alongside local GP Allie Hill.

During the checks, they tested for hypertension, raised cholesterol, diabetes and atrial fibrillation. Public health colleagues also attended and talked to the cohort about lifestyle, health promotion and disease prevention.

The team would like to roll out other checks with Travis Perkins in other areas of Derbyshire if possible.

Source: OHID Fingertips

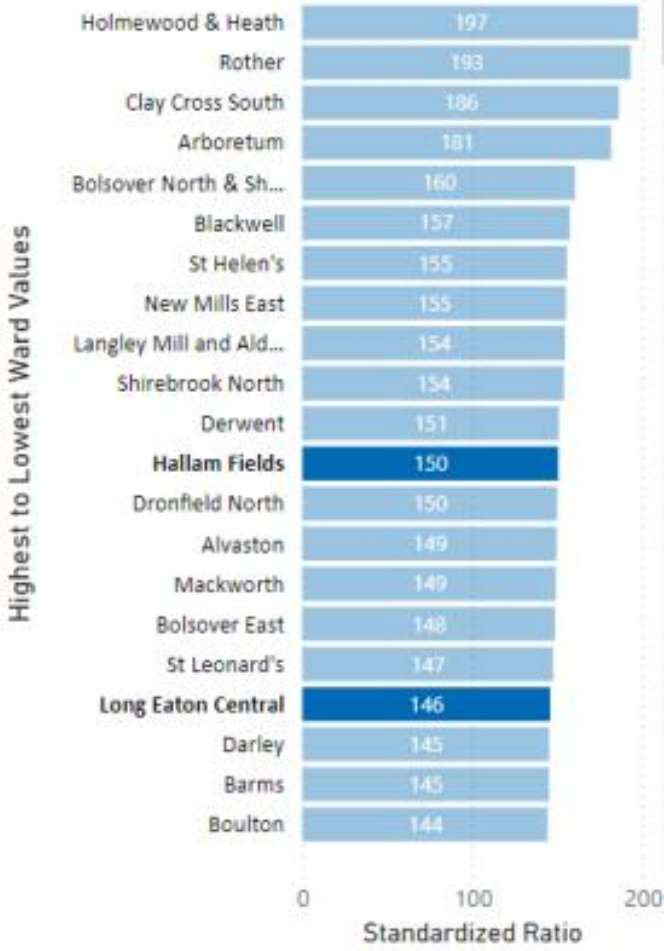
Cardiovascular Disease - Derby & Derbyshire Ward Variation

Deaths from coronary heart disease, all ages, standardised mortality ratio	Deaths from stroke, all ages, standardised mortality ratio	Emergency hospital admissions for coronary heart disease, standardised admission ratio	Emergency hospital admissions for myocardial infarction (heart attack), standardised admission ratio	Emergency hospital admissions for stroke, standardised admission ratio

Deaths from coronary heart disease, all ages, standardised mortality ratio - Derby & Derbyshire 2016/17 - 20/21

Between 2016/17 and 2020/21 in Derby and Derbyshire, people living in the most deprived areas were more likely to die prematurely or be hospitalised due to CVD, than those in the least deprived areas

Derby & Derbyshire IMD map



Cardiovascular Disease - Derby & Derbyshire Ward Variation

Deaths from coronary heart disease, all ages, standardised mortality ratio	Deaths from stroke, all ages, standardised mortality ratio	Emergency hospital admissions for coronary heart disease, standardised admission ratio	Emergency hospital admissions for myocardial infarction (heart attack), standardised admission ratio	Emergency hospital admissions for stroke, standardised admission ratio

Deaths from stroke, all ages, standardised mortality ratio - Derby & Derbyshire 2016/17 - 20/21

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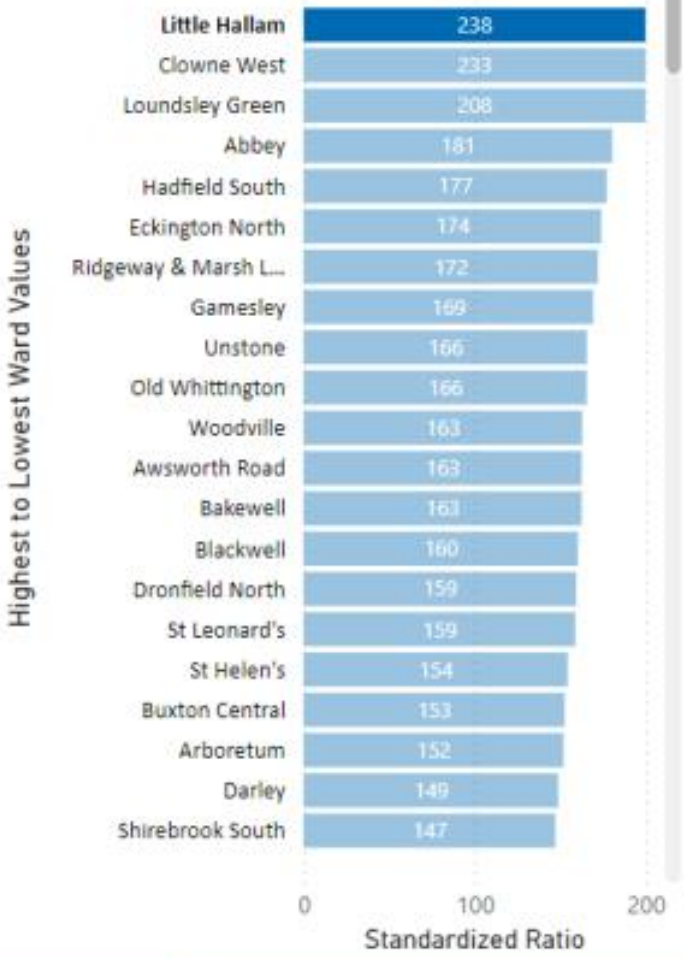
Derby & Derbyshire IMD map



Bob

- 54 M
- Builder
- Smokes 1 packet of cigarettes per day
- 2+ large sugars in his coffee
- Fast food for lunch
- Proud that he is “fit and well”
- Coughs like he has the plague
- *Knocked back significantly by winter respiratory viral illness*

Why is cardiovascular disease important

- Important role of cardiovascular health in health inequalities
- Important role of disease prevention, health promotion, early identification and treatment in reducing gaps

"Heart and circulatory disease, also known as cardiovascular disease (CVD), causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. **This is the single biggest area where the NHS can save lives over the next 10 years**."

Why is cardiovascular disease important

- CVD contributes to one-fifth of the life expectancy gap = reduction in life expectancy of nearly 2 years for males and 1.4 years for females
- 90% of cardiovascular disease caused by potentially modifiable risk factors
- 80% of premature deaths from CVD could be preventable

Question: are we reaching the right people with our NHS health checks?

- **4421** total number of people **invited for health check between age of 40y and 66y** (at the time)
- **2635** people had had health checks during that age range
- **1873 patients had been invited for a health check but not taken up the offer**

Gender	Number of people invited for health checks who did NOT take up the offer	Percentage (%)
Male	977	**52.2**
Female	896	47.8
Total	1873	100.0

Why might men be less likely to take up an offer of a free NHS health check?

- **50 men contacted** and sent a survey about why they may have not taken up the invitation
- **8 replies**
- Responses:

- 5 people “I didn't see the text message”
- 1 person “I didn’t have time to respond within the timeframe”
- 1 person “I would like to have one but was not able to make any of the appointments offered”
- 1 person “Doctors are too busy and it is hard enough to get an appointment so until I need one I won’t take up their time”

So, we wrote to 22 businesses in Long Eaton and only received 1 reply.

Healthcare students from University of Nottingham & Derby doing health checks

GP on site doing acute & mental health advice

Live Life Better Derbyshire doing health promotion & lifestyle advice

Erewash tNA doing cholesterol & AF checks


vis Perkins
Your local Timber & Builders Merchant
Welcome to
BENCHMARX
The Kitchen and Joinery Specialists
Customer Parking
Entrance
The Hub
DERBYSHIRE

Feedback

- ***Very Good*** *- "Quick Friendly and informative".*
- ***Very Good*** *– "Instant results. Extra tests booked. Very helpful and reassuring. Thank you!"*
- ***Very Good*** *– " All staff very friendly and helpful. Put at ease during checks. Informative"*
- ***Very Good*** *– "Very informative day, great participation."*
- ***Very Good*** *– "Good service – lovely people".*

Very Good *– left no additional comments.*

Good *- "Better service than from my own local doctors!! Friendly staff. Helpful advice."*

Outcome

Outcome	Number of patients
Abnormality	**15**
No abnormality	6
Total	21

21 health checks completed (people from anywhere)

71% of checks identified an abnormality

Outcome	Number of patients
Abnormality	6
No abnormality	5
Total	11

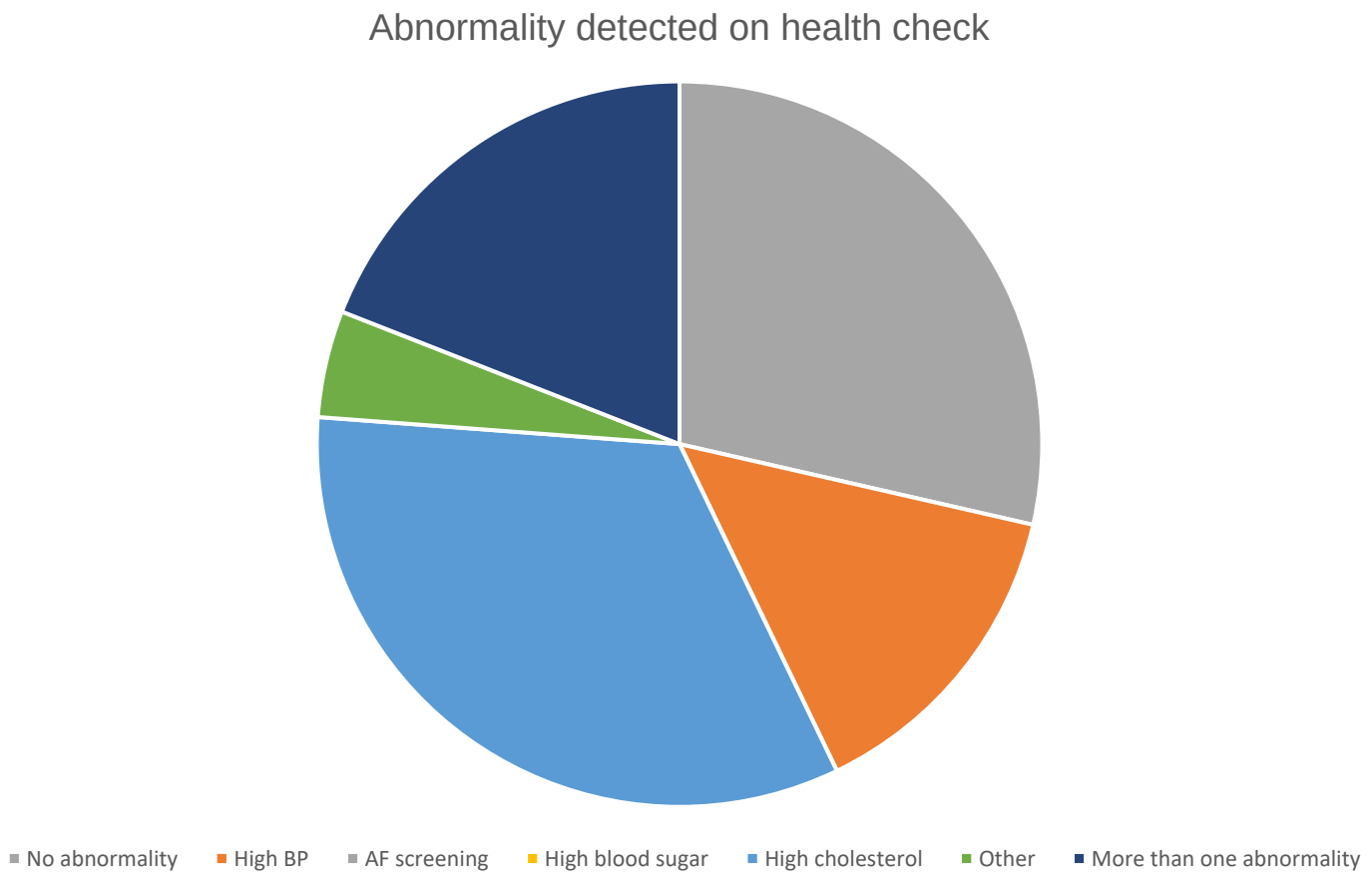
11 health checks completed (people from Erewash)

55% of checks identified an abnormality

Abnormality	Number of patients
BP	7
AF	1
High blood sugar	0
Cholesterol	10

Results of health checks completed (from anywhere)

Outcome


Abnormality detected on health check
No abnormality
High BP
AF screening
High blood sugar
High cholesterol
Other
More than one abnormality

What next?

- Erewash patients followed up as usual
- Ongoing work with Travis Perkins and Healthy Workplaces Derbyshire if possible to get the health checks into more TP sites
- More community health checks

Key learning

- People are keen and happy to engage with health checks – particularly if we make it easy for them to attend!

- High proportion of health checks done in community settings find abnormalities

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th January 2025

Item: 105

Report Title	Chair's Report – December 2024							
Author	Sean Thornton, Director Communications and Engagement							
Sponsor (Executive Director)	Dr Kathy McLean, ICB Chair							
Presenter	Dr Kathy McLean, ICB Chair							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	None							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Not applicable							

Recommendations
The ICB Board are recommended to **NOTE** the ICB Chair's Report.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
We are very grateful to colleagues who continued to provide care for our citizens during the Christmas and New Year period. Our performance reports will indicate in due course the activity across services during this traditionally very busy period, but more important than those figures will have been the efforts, commitment and resilience that NHS and partner staff display throughout the year to keep our family and friends safe and in receipt of high-quality care. This is especially the case during the Christmas and New Year periods where many of us can take some time to recharge our batteries. Thank you to everyone who has been working over the holiday period. We have continued to see the impact of the 'quad-demic' on local services, with influenza, Covid-19, RSV and norovirus impacting on both the health of patients arriving at hospital and also on our staff, where sickness absence has risen. It has been agreed to extend the vaccination programmes for flu, Covid-19 and RSV to the end of January, and potentially longer depending on how the viruses continue to have an impact. We continue to urge staff and citizens to get vaccinated where they are eligible.

We have now entered the final quarter of the 2024/25 financial year, and we will be both finalising the delivery of our operational plan for this year, as well as looking ahead to our planning for 2025/26. The Chief Executive's report sets out more information on the factors at play in the coming months as we seek to work through these plans.

Local Updates

Board Focus on Mental Health

The Board held a development session in December with a detailed focus on mental health. The session covered the potential future models for community care, the current position relating to mental health prevalence and inequality in Derby and Derbyshire and the existing model of mental health provision across our ICB. It was an enlightening session and very important that we take time to consider our priorities in the area of mental health alongside and in collaboration with those discussions on physical health, given the regular overlaps in the experience of our citizens which impact across their whole self and their care. We will take the discussion into our Joint Forward Plan prioritisation conversations during the spring.

Visit To Jericho House

I have been enjoying visits to local services in recent months and will continue this during 2025. In December I visited Jericho House, a charity which helps men in Derby and Derbyshire with drug and alcohol addiction recovery, and I was able to tour their nine-bed residential house. The charity looks after around nine men at any one time and 75 per cent remain abstinent long term, as well as supporting around 50 family members a month either by phone, email, social media and face to face at family support meetings. Jericho House is funded by residents' enhanced housing benefits through Derby City Council and donations. The unit has been operating for over 20 years and estimates it has saved the NHS more than £10 million since its inception. Individuals can self-refer or be referred through their GP or social services, although there is typically a waiting list of one to four months.

Jericho House shows the huge benefits that a lived experience model can have for people with addiction. It was clear from my visit what a huge impact both the facility and its leaders have on the men who attend. The charity not only helps in the short term to get men back on their feet but are also an ongoing support network and community for those who sometimes have nowhere else to turn for support even once recovered. We've long known that prevention is better than cure and Lord Darzi has set out his aim for the NHS to move from a reactive to a preventative health and care system. Whilst we know there is high demand for services such as this it's only by working together as a system, including the voluntary sector, that we will manage to offer more preventative services and relieve pressure on the NHS and other partners. I'm very grateful to everyone who took time to explain this impressive work.

NHS 10-Year Plan Public Engagement

The leadership, staff and public engagement in developing the Government's 10-Year Plan continues. The ICB submitted its response to the direction around the 'three shifts' from 'treatment to prevention', 'analogue to digital' and 'hospital to community' at the start on 2nd December 2024, and we will see a range of public engagement activity during January and February 2025 as we seek to collect the views of local people. Of note are three sessions which are now open for bookings, to hear from local leaders on the three approaches, and to seek to set a new pace for the way in which we continue to collect and respond to local feedback. These sessions take place on as follows, and places can be secured through the Derbyshire Involvement website:

- Wednesday 22nd January – Derby Conference Centre – 1-3pm
- Thursday 30th January – St Thomas Centre, Brampton, Chesterfield, 1-3pm
- Wednesday 5th February – Online event via MS Teams– 6-8pm

East Midlands Combined Council Authority
We continue to have dialogue with colleagues at the East Midlands Combined Council Authority. Our connection to the Mayoral agenda in support of the wider determinants of health means we need to connect closely to this agenda. It has been a period of accelerated set-up for this new body since the elections in May 2024, and the Authority's Board has begun making investment decisions using their delegated funding. In December, these included proposals for move oversight of public transport functions from local authorities to the Combined Council Authority, with a phased approach starting in 2025. Also approved in December was £9.5million in funding to go to local projects that will help support economic growth for the region.

ICB Board Matters
Nigel Smith has been appointed as a Non-Executive Member of the ICB Board and took up his appointment on 1st January 2025. Nigel is a qualified accountant who worked for the Post Office and Royal Mail for over 30 years in a variety of Finance, HR and Health & Safety roles. He has been involved with the NHS in a variety of Non-Executive Director (NED) roles for the last 12 years, across community and mental health services, is currently also a NED at Nottinghamshire Healthcare NHS Foundation Trust. Nigel is originally from Wolverhampton and lived in Nottinghamshire before moving to Matlock. We welcome Nigel to the Board.

National Updates

English Devolution White Paper
On 16th December 2024 The Secretary of State for Housing, Communities and Local Government, Rt Hon Angela Rayner MP published the White Paper on English Devolution. This sets out the Government's intended approach to accelerate and standardise the processes by which it passes powers, funding and programmes from Westminster to local areas. Its central aim is to support a boost to the economy and to promote growth, reflecting that decisions are better made close to communities and away from Whitehall. It seeks to strengthen the power of Regional Mayors to serve their residents. Central to this devolution is the creation in law of the concept of a 'strategic authority', covering areas with populations of 1.5 million people or above. There will be three levels of strategic authority, holding varying degrees of power depending on their maturity and whether they have a mayor.

While much of the White Paper describes the way in which existing powers will be strengthened and supported, there are clear connections made to the work of the NHS and wider Integrated Care Systems, with proposals to reform and join up public services. The White Paper outlines the Government's view of the work in South Yorkshire, where Oliver Coppard, the Mayor of South Yorkshire, is both the Police and Crime Commissioner for the region and the Chair of the Integrated Care Partnership. This White Paper sets out an intention to do more to align public services within Mayoral and combined authorities, including a proposal to introduce a new bespoke duty for Strategic Authorities in relation to health improvement and health inequalities, and an expectation that Mayors are appointed to Integrated Care Partnerships and are considered for the role of Chair or Co-Chair and that Mayors should also be engaged in appointing Chairs of Integrated Care Boards.

The White Paper also announces that there will be a programme of local government reorganisation for two-tier areas, will a move to unitary authorities. This will evidently have some implications for our colleagues working at Derbyshire County Council, and the current configuration of district and borough councils.

Identification of Key Risks					
SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Financial impact on the ICB or wider Integrated Care System		
Yes ☐	No☐	N/A☒
Details/Findings Not applicable to this report.		**Has this been signed off by a finance team member?** Not applicable to this report.

Have any conflicts of interest been identified throughout the decision making process?
Not applicable to this report.
Project Dependencies
Completion of Impact Assessments

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

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

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

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?			

Not applicable to this report.					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable to this report.					
Identification of Key Risks					
Not applicable to this report.					
Have any conflicts of interest been identified throughout the decision making process?					
Not applicable to this report.					
Project Dependencies					
Completion of Impact Assessments					
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**	
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**	
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**	

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

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

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Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?					
Not applicable to this report					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Not applicable to this report.					

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th January 2025

Item: 106

Report Title	Chief Executive Officer's Report – December 2024							
Author	Dr Chris Clayton, Chief Executive Officer							
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer							
Presenter	Dr Chris Clayton, Chief Executive Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	None							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Not applicable							

Recommendations
The ICB Board are recommended to **NOTE** the ICB Chief Executive Officer's Report.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
It is important to place on record my thanks to colleagues who have been working tirelessly to support our system's operational performance through December, including my thanks to those colleagues who continued to care for patients and maintain operational stability during the Christmas and New Year holiday period. The pressure we have seen in the urgent & emergency care and mental health systems has not relented, and we have strived to support the continued quality and safety of services provided during the last month. As we enter the final quarter of the current financial and planning year (Q4), I felt it important to set out the landscape of business for the next three months. We continue to restate our system priorities and the focus we must retain in key areas of today's business: • Sustaining a responsive urgent and emergency care system across both physical and mental health services • Reduction in elective care waiting lists • Maintenance of cancer performance • Financial sustainability and achievement of our agreed deficit position for 2024/25

As Q4 progresses, the NHS system will need to produce our own local operating plan for 2025/26, which takes into consideration the anticipated national planning guidance, due in January, and the emergence of the NHS 10-Year Plan which we expect to be published in the spring. We also anticipate the publication of an updated Operating Model for NHS bodies in the next few months and the emergence of policy relating to the Government's White Paper on English Devolution, which our Chair reflects on in more detail in her Board Report.

We do also continue to progress on a range of other important fronts over the next few months. Our broad transformation programme continues in many areas, and we will make decisions on our direction for fertility policy, learning disability short breaks and our review of community urgent and emergency care pathways, which have been and will continue to be supported by significant programmes of public engagement. The health and care system will also be commencing the procurement process for a partner to work alongside the NHS and local authorities on our community transformation programme, to maximise opportunities we have to streamline our community service offer and provide further stability on our approach to managing discharge.

Our colleagues at Derbyshire County Council continue their review of various aspects of their residential and respite care provision and their position as an existing provider in those markets. The NHS is working closely with the council to understand these positions, including making submissions of our own as part of the consultation processes. This is connected to the community transformation programme referenced about, as well as our formal review of the Better Care Fund process. The Council and Derbyshire Community Health Services NHS Foundation Trust are also co-consulting on a proposed Section 75 agreement to pool budgets and staff in support of maximising opportunities for joined up community care.

Derbyshire County Council elections are held once every four years for councillors to be elected for each of the divisions in the county. The next council election is due to take place on 1 May 2025, which may affect certain NHS permitted activities such as making significant spending decisions due to pre-election rules, and we anticipate this will take effect from around 20th March. This will need factoring into our planning schedule.

Derby City Council's next elections will not take place until May 2027. The current administration has published proposals for a balanced budget for the next financial year, in the face of a very challenging financial position. The proposed budget includes an investment of £31 million into essential services, savings of £10.2 million, and a significant contribution back into the Council's reserves. Again, the ICB will review these proposals and provide feedback to the Council, with responses due by 19th January 2025.

Within the ICB, we will be launching two new initiatives during January and February as part of our aim to strengthen our position as a compassionate and inclusive employer. Our Staff Recognition Scheme will announce its first winners in February as part of a monthly process, and our new Leadership Forum will hold its first meeting in February. Underpinned by our values, these are two steps as part of a broad organisational development programme, along with a review of our business processes which underpin the commissioning cycle of needs assessment, procurement and quality monitoring.

A key task for the ICB Board will be to make the connections between and across these various dimensions of policy and service development, and to set them in the context of delivering today's business while we continue to have a growing proportion of our focus on the future.

As usual, I continue to attend a range of local, regional and national meetings on behalf of the ICB Board and the wider Joined Up Care Derbyshire system. Our local performance conversations, along with regional and national assurance meetings have continued to be prominent since the last ICB Board meeting.

Chris Clayton
Chief Executive Officer

National developments

Thousands of cancers caught early through NHS lung checks
More than 5,000 people in England have been diagnosed with lung cancer earlier thanks to an innovative NHS initiative, which uses mobile scanning trucks to visit local communities.

NHS rolls out 'stop-smoking' pill to help tens of thousands quit
Thousands of lives could be saved thanks to the roll-out of an improved anti-smoking pill on the NHS in England called Varenicline. It has been shown to work as well as vapes to help people stop smoking and be a more effective aid than nicotine-replacement gum or patches.

NHS 'ping and book' screening to help save thousands of women's lives
The NHS is set to revolutionise access to cancer screening for women with a new "ping and book" service, alerting the phones of women to remind them they are due or overdue an appointment, with new functionality being developed to enable millions to book screening through the NHS App next year.

Hospital admissions for strokes rise by 28% since 2004 – as NHS urges the public to 'Act FAST'
The number of people being admitted to hospital following a stroke has risen by 28% in the last 20 years, new NHS analysis has found.

More than one million people get RSV jab in first ever NHS rollout
More than one million people have been vaccinated against Respiratory Syncytial Virus (RSV), after the NHS launched a rollout of the jab for the first time in its history this autumn.

More than 300 jabs a minute as part of NHS efforts to avoid winter 'tripledemic'
NHS teams are delivering more than 300 vaccinations a minute for COVID, flu and RSV in a huge effort to help avoid a 'tripledemic' this winter.

Hospitals managing record flu levels going into Winter
NHS fears of a potential 'quad-demic' are rising with a 350% increase in flu cases and an 86% rise in norovirus cases in hospital compared to same week last year – alongside concerns about rising COVID-19 and respiratory syncytial virus (RSV)c levels in hospitals.

World leading NHS trial to boost health and support people in work
The effectiveness of health measures in getting people back into work or keeping them in work will be trialled by the NHS in the coming months. Backed by £45 million from the autumn Budget and supported by the government, the world leading trial will see the NHS create 'Health and Growth Accelerators' in South Yorkshire, North East and North Cumbria, and West Yorkshire.

NHS artificial intelligence (AI) giving patients better care and support
The NHS is using AI to predict patients who are at risk of becoming frequent users of emergency services so staff can get them more appropriate care at an earlier stage.
The intervention will ensure that thousands of people get the support they need earlier, while also reducing demand on pressured A&Es.

Hundreds of thousands of older people to get urgent care at home this winter
Hundreds of thousands of older and frail patients will receive urgent treatment from home this winter, as part of NHS plans to manage additional pressure this winter.
Rapid teams based in local neighbourhoods will attend less clinically urgent calls within two hours and treat patients for a range of conditions and issues at home.

Winter pressure builds as no sign of 'festive flu' letting up
Flu cases in hospital have already surpassed last year's peak as festive infections "flood" hospitals early this winter.

NHS chief focuses on innovation and staff commitment in Christmas message
The head of the NHS in England has praised staff for "working tirelessly" and "constantly innovating" to modernise care for patients in her Christmas message to health workers.

GP reforms to cut red tape and bring back family doctor
The measures are backed by the biggest boost to GP funding in years, an extra £889 million on top of the existing budget for general practice.

£100 million public-private health research boost
Patients across the UK will have greater access to cutting-edge treatments and clinical trials as the government announces £100 million of public-private investment to set up 20 research hubs.

Local developments

A Christmas message from our Chair Dr Kathy McLean
Dr Kathy McLean reflects on her year in 2024 after 8 months at Derby and Derbyshire ICB.

Making a difference for people in Chesterfield
Dr Alice Fenton, Clinical Lead for Chesterfield Place Alliance, discusses work in Chesterfield to improve population health working with communities.

NHS Derby and Derbyshire appoints new Non-Executive Member
Nigel Smith has been appointed as a new Non-Executive Member of NHS Derby and Derbyshire Integrated Care Board.

ICB Chair Dr Kathy McLean visits Jericho House charity which helps men tackle addiction
The charity Jericho House, which helps men in Derby and Derbyshire with drug and alcohol addiction recovery, welcomed ICB chair Kathy McLean this week for a tour of their nine-bed residential house.

"Data-led decision making is the driving force behind our commissioning"
ICB senior analyst Neil Taylor discusses the use of data for improving care at the ICB.

Perinatal support team and volunteers welcome ICB Chair Kathy McLean for visit
Dr Kathy McLean, Chair of Derby and Derbyshire Integrated Care Board, has been back to the floor, visiting volunteers and staff at not-for-profit organisation Connected Perinatal, who support new parents.

Women asked how health services should be improved
Women across Derby and Derbyshire are being asked to give their views and help contribute towards improved health services.

Have your say on the future of fertility services in Derby and Derbyshire
People across Derby and Derbyshire are being invited to have their say over the way fertility treatments are provided in the East Midlands.

Safety and outcomes improve when patients access their own health records.
Dr Richard Fitton, retired Derbyshire GP and contributor to the World Health Organization's Patient Safety Charter, discusses patient access to records.

Digital innovation helps patients access hospital level support at home thanks to virtual ward care – at University Hospitals of Derby and Burton

National recognition for pioneering staff at UHDB who have demonstrated excellence in nursing and midwifery – at University Hospitals of Derby and Burton

Council proposes a balanced budget amidst challenging financial landscape
Derby City Council has published proposals for a balanced budget for the next financial year, making some tough decisions in the face of a very challenging financial position.

Education and health partnership apologises for delays for children and young people with special needs and disabilities in Derbyshire
The partnership responsible for planning, delivering and commissioning services for children and young people with special educational needs and disabilities (SEND) in Derbyshire has apologised that they are waiting too long for education and health assessments, missing school, having to wait for specialist health support and for poor communication with their parents.

Views sought on future shape of care services
Derbyshire residents are being invited to have their say on how our care services could be run in the future.

Council Deputy Leader sets record straight on budget position
Derbyshire County Council Deputy Leader Councillor Simon Spencer has set the record straight on its current budget position and says hard work is continuing to ensure the books continue to balance.

Publications that may be of interest:
Joined up care Derbyshire newsletter – December edition

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Not applicable to this report.

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒

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

Have any conflicts of interest been identified throughout the decision making process?				
Not applicable to this report.				
Project Dependencies				
Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

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

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?					
Not applicable to this report.					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable to this report.					

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th January 2025

Item: 107

Report Title	One Workforce System Strategy, Approach and Ethos							
Author	Lee Radford, Chief People Officer							
Sponsor (Executive Director)	Lee Radford, Chief People Officer							
Presenter	Lee Radford, Chief People Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Not applicable							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	People and Culture Committee Development Session – 11/12/24							

Recommendations
The ICB Board are asked to **NOTE** the updates on the development of the One Workforce System Strategy, approach and ethos contained within this paper.
Purpose
This report contains an update regarding the development of the One Workforce system strategy, approach and ethos.
Background
In early 2024, the Derby and Derbyshire Integrated Care Partnership (ICP) approved the development of a System One Workforce Approach Development Framework and vision to identify opportunities for greater collaboration and co-ordination of workforce approaches across the different sectors in Derbyshire. *"Our vision is that anyone working in health and care within Derby and Derbyshire feels part of a 'one workforce' which is focused on enabling our population to have the best start in life, to stay well and age well and die well.* *Our workforce will feel valued, supported and encouraged to be the best they can be and to achieve the goals that matter to them wherever they work in the system."* The principles of developing this One Workforce strategy, approach and ethos are to: • **Retain and support the wellbeing** of all our people. • **Develop a sense of belonging and embedding equality, diversity and inclusion** throughout to ensure we reach and develop a diverse workforce.

- **Develop a culture which is compassionate and inclusive** and supports our people to thrive and that will retain our existing workforce as well as attracting future talent into Derbyshire.
- **Develop our people to** fully utilise and invest in the skills and talents of the current workforce to enable them to do more throughout their careers, as well as identifying future skills needed.
- **Expand at scale, roles and skills that can be deployed across all sectors** and different settings.
- **Create new routes into local careers** across different workforce sectors and professions across Derbyshire.
- **Develop shared solutions to shared problems.**

This work also forms an important part of the ICB's anchor institution commitment and to support social mobility by addressing workforce supply challenges across the system through widening participation programmes and supporting solutions for social and economic development. We are starting from a strong position as the following programmes of work have been implemented already:

- **Step into work** is an established flexible pre-employment training programme that provides broad access to employment across the sector including NHS trusts, local authority and PVI providers of social care. This programme has a distinct identity and role as a programme to support and to enable inclusion and diversity through active recruitment and referral partnerships.
- **Scaling up system wide recruitment campaigns** including engagement with schools, local HEI's/colleges to grow our own local workforce supply, collaborative recruitment and hosting of system-wide careers recruitment events.
- **BME respite sitting service** - new cohort 2024 – provides a progression route into step into work or employment.
- **Care covenant programme –** is a system employability offer to young people leaving care which includes coaching and guaranteed job interviews.
- A JUCD **health and social care workforce charter** has been developed as a commitment to improving the wellbeing in the workplace in order to recruit and retain new staff.
- **Working with Derbyshire BME forum and refugee communities** to deliver a range of widening participation careers initiatives to improve careers advice and opportunities.

Report Summary

In July 2024, a new Chief People Officer joined the ICB and has engaged with health, social care, VCFSE, local authority, Higher and Further Education partners to build strong support for the developing of a One Workforce strategy, approach and ethos.

There has been significant support and enthusiasm across all sectors to be part of this journey in making Derby and Derbyshire a great place to live and work.

In February 2025, a multi-sectoral and multi-professional steering group will be established to lead this programme of work which will focus on:

- To undertake an extensive system wide engagement process across all health, care, local authority and VCFSE sectors to understand the **current state** of the workforce, areas of under representation, social mobility cold spots, culture, areas of best practice, challenges and risks.
- To understand ‘left shift’ priorities and sector specific strategic drivers to identify commonality to enable mutual understanding and what this means for a future workforce.
- To identify system collaboration opportunities and learning from all sectors to develop shared approaches where appropriate to attract, develop and retain a workforce and talent supply as part of a One Workforce approach.
- To identify and deploy widening participation programmes of work to recruit our local population and to create career pathways across all sectors that will enable social mobility.

- To create new innovative routes and approaches into employment from college to work and remove barriers to applying to join the System workforce as part of our Anchor ambition.
- To identify ways to create a consistent and inclusive and compassionate culture to attract and retain our people across Derby and Derbyshire supported by a system EDI approach to feel part of the system workforce.
- To identify opportunities to develop and deploy people digital solutions that will enhance workforce productivity and capacity.
- To engage with system partners to test recommendations and findings and co-design our desired **future** state.
- To be able to describe to our Education Partners what the needs of our current and future workforce education and training needs are to deliver services to our communities.
- To develop a system One Workforce Strategy, approach and ethos and present to ICB and ICP Boards.

Our One Workforce strategy, approach and ethos also strongly aligns to the newly elected Mayor of the East Midlands Combined Authority's vision on developing skills and employment for local communities.

In Spring 2025, the Government will also launch its revised ten year long term plan for the NHS which will have workforce implications to support different models of care that will also need to be considered in developing our One Workforce strategy, approach and ethos.

The table below outlines the timelines for developing the System One Workforce strategy, approach and ethos.

Feb 25	Establishment of a One Workforce Steering group.
Mar – Jun 25	Engagement and diagnostic phase to understand the current system workforce, area of under representation, social mobility cold spots, culture, areas of best practice, challenges and risks.
Jul-Aug 25	Analysing results of diagnostic phase, play back findings to the system, to identify opportunities for collaboration and to test recommendations.
Sept - Oct 25	Develop draft strategy, test approaches and future desired state with system partners.
Nov 25	Present the One Workforce Strategy, approach and ethos to ICB People and Culture Committee and ICB/ICP Boards for approval.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain an affordable and sustainable workforce supply pipeline and to retain staff through a positive staff experience.	☒	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Financial impact on the ICB or wider Integrated Care System		
[To be completed by Finance Team ONLY]		
Yes ☐	No☐	N/A☒
Details/Findings Not applicable.		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision-making process?
None identified.

Project Dependencies

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

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

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☒	No☐	N/A☐	**Summary:** engagement with key stakeholders will form part of the diagnostic process to inform workforce priorities identified in the One Workforce Approach**.**

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not currently but this will be reviewed following the completion of the recommended workforce priorities in the final strategy and approach.

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

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th January 2025

Item: 108

Report Title	Empowering General Practice Programme Update							
Author	Joint GPPB and ICB EGPP team							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Presenter	Michelle Arrowsmith, Chief Strategy and Delivery Officer Dr Andrew Mott, Medical Director Derby & Derbyshire GP Provider Board							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☒
Appendices	Appendix 1: Summary of Primary Care Model Appendix 2: PCN and Place engagement details Appendix 3: Case study examples Appendix 4: Expressions of interest for Accelerator sites for the Empowering General Practice Programme Appendix 5: Further details on pilot projects for phase 1 Appendix 6: EGPP proposed governance structure							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	The following meetings/groups have discussed this subject: • ICB Primary Care Sub Group • ICB Population Health and Strategic Commissioning Committee • ICB Integrated Place Executive • Primary and Community Care Delivery Board • Place Alliance Managers • LMC • GP Practices • PCN Clinical Directors and PCN Managers • General Practice Leadership Group • Provider Collaborative Leadership Board							

Recommendations
The ICB Board is asked to **NOTE** the progress made on the Empowering General Practice Programme (EGPP) Update (formerly the GP Strategy) since being agreed by the ICB Board in November 2023 and the last update to the Board in May 2024. The Board is also asked to **SUPPORT**: • the need to expedite the work on population stratification, which is central to this strategy; • the PCN/LPA accelerator programme and the ICB and IPE commitment to supporting the PCN/LPAs involved; and • the commitment to ensuring that this plan continues to align with local and national plans to further develop integrated neighbourhood and place working.

Background

This paper provides an update on the implementation of the Empowering General Practice Programme (previously described as the General Practice Strategy or Model), approved by the ICB Board in November 2023 with a subsequent update in May 2024. The paper incudes a brief reminder of the programme, an update on implementation, key challenges, discussion points and next steps.

Report Summary

The General Practice Model sets out a vision for a sustainable, thriving General Practice. It was developed partly in response to the Fuller Report, affirmed by Lord Darzi's report on 'The State of the National Health Service in England'. The report highlights pressure in primary care, the need to move care closer to home and the importance of improving productivity and flow. The GP model provides a framework to do this, as well as a strategic response to some of the pressures and concerns that are driving the current GP collective action. The programme has been renamed to better describe the work, and ensure it is better understood at practice and PCN level.

A full summary of the Primary Care Model can be found in Appendix 1.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
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SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	
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Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☒	N/A☐
Details/Findings There is currently no funding identified for this work. A small amount of non-recurrent funding has been set aside from existing budgets to support PCNs undertaking the PCN accelerator programme.		**Has this been signed off by a finance team member?** Not applicable.

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings** A quality impact assessment will be undertaken with the outcomes included in update reports on implementation. Accelerator sites will undertake QIAs and EIAs as appropriate if/when they make changes to patient services
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings** As above

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

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☒	No☐	N/A☐	Some reference has been made to this model when discussing General Practice at public meetings (e.g. Improvement and Scrutiny Committees and Derbyshire Dialogue). We intend to develop a full engagement programme as we develop concrete plans for changes to services

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

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

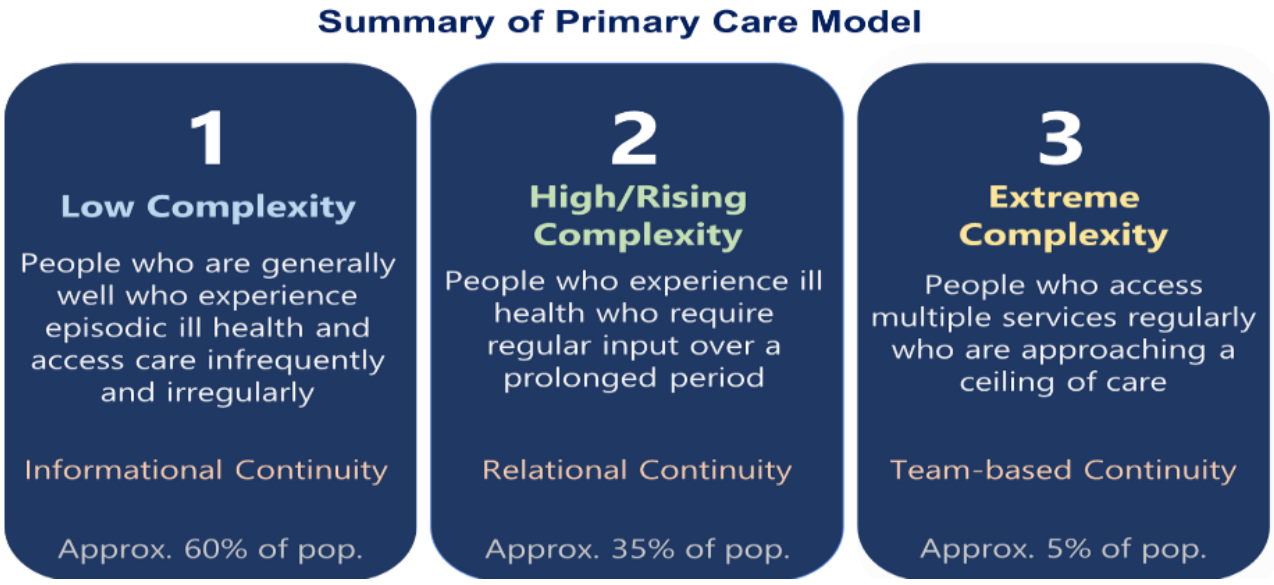
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable.					

[1] https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

Appendix 1

Summary of Primary Care Model

The programme starts by stratifying the population into three cohorts. General Practice then reorganises services around these cohorts, often at scale, to provide effective and sustainable care.



Aims for the Model

- Provide a consistent offer of access to primary care for all people
- Provide responsive care for people with low complexity through a neighbourhood hub model
- Improve the relational continuity for all people with high and rising complexity
- Provide enhanced care coordination for those with extreme complexity
- Support local practices that are under strain and improve primary care staff wellbeing
- Support the achievement of key system objectives, through plans that are integrated with Place, the Provider Collaborative and JUCD Delivery Boards

Progress against the original plan (from ICB Board paper November 2023)

Plan	Progress	RAG
Undertake population stratification and mobilise the Primary Care Model through an operating framework that maximises care quality and staff wellbeing.	DDICB does not currently have a population stratification tool. The federated data platform may provide this in the future. The primary care team are working with the medical directorate, looking at how we might use existing data and looking at how we might adopt the work of other ICBs who are already doing this in primary care.	
Implement a digital triage process in support of our aim for a consistent offer of primary care access for all people.	On track. Procured framework suppliers and beginning to roll out digital triage.	

Appendix 1

Plan	Progress	RAG
Ensure there is access to enhanced care-coordination for all people with extreme complexity.	Partially in place. Further work needed with other community providers in local place alliances to guarantee a systematic and failsafe approach to ensuring access for all.	
Deliver primary and secondary prevention activities for circulatory disease, respiratory disease, and cancer, that have been prioritised by JUCD prevention and inequalities leads.	Already built into standard General Practice work. We haven't done more than this in 24/25, partly because of lack of clarity around the ask, and partly due to lack of capacity and resources to undertake additional work.	
Agree and deliver specific primary care actions that best support Age Well priority actions, releasing benefits from community services transformation including recommendations from the diagnostic review undertaken by Newton Europe.	As above much of what General Practice does already supports age well priority actions. However we haven't done more than this in 24/5 for the reasons set out above.	
Deliver reactive and proactive care that supports key system objectives for UEC and patient flow.	As above.	
Development of a full business case setting out the implementation plan in more detail and the resources and funding needed to deliver it.	Given the significant system financial deficit we decided not to spend additional time and resources developing a full business case which was unlikely to be approved. Instead we have focused efforts on 'bottom up' work as described below.	

Additional Progress

As set out above, it's been difficult to advance some of the original plans. The project team have adapted their approach and progressed elsewhere, as follows:

a) Governance

The Primary Care and Community Delivery Group (PCCDG) has taken formal responsibility for driving the implementation of the Empowering General Practice Programme. The group contains senior leaders from the ICB, primary / community providers and public health and has revised its terms of reference to focus on supporting delivery of the Model.

PCCDG provides monthly updates to the Integrated Place Executive (IPE). A weekly steering group led by the SRO (Dr D Gooch) and programme lead co-ordinate delivery and oversee the approach. The ICB Primary Care Team has also provided a part time programme manager to manage the project, and members of the team have volunteered to support the accelerator programme when it begins in the New Year. Connections with related groups and areas of

work are being strengthened, helping to align resources and capacity. For example, the Primary Care Digital Steering Group and PCN Managers Forum are supporting the digital triage initiative.

Based on recent engagement and the program's growing scale, the steering group conducted a governance review and made recommendations for the program's future. The program will focus on three main goals: improved patient outcomes; enhanced patient care experience; supporting General Practice to thrive. Appendix 5 provides more details on governance and project structure.

b) Implementation

Building on the original engagement to develop the model, the last 6 months have focused on engaging with Place Partnership Boards, PCNs and Local Place Alliances (LPAs) (appendix 2).

The engagement sessions enabled to us start to collate examples of projects that are in line with the future model and are already in place but could be replicated across the county or developed to be run at scale. Examples can be found in appendix 3.

Additionally, three workshops were held during October, bringing together key stakeholders to focus on the model. The workshops were successful in helping us link the resources, activities, outputs, outcomes and goals to assist delivery of the programme. The key themes were:

- Access to data is key to enable informed decisions
- Access to funding would enable at scale working to be further developed to support low complexity patients, allowing for more time to spend with high and extreme complexity patients
- Population stratification is a key component of the model, and the absence of a local tool is one of the limiting factors in our progress.
- Some practices still believe, wrongly, that the programme has been developed by the ICB and is going to be imposed top down. We need to continue to 'myth bust' and address concerns
- We need to continue to work with, and align to, the Place and the Community Transformation Programme to overcome shared obstacles faced.

c) The Empowering General Practice programme: supporting PCNs in becoming 'accelerator sites'

The project team have written out to all PCNs to invite them to participate in an accelerator pilot as part of the programme. The invitation is for PCNs, working with their local place alliances (LPA), who want to try out new ways of working in line with the aims of the programme. Ten PCNs have expressed an interest, as follows:

Primary Care Network/ LPA	Pilot summary
Belper	Creation of a population stratification tool for the whole system
Chesterfield and Dronfield	To improve process working between multi-disciplinary teams to improve patient experience of care and outcomes.

Appendix 1

Derbyshire Dales	To improve the Care Home medication process to reduce workload, optimise care and reduce hospital admissions.
Erewash	To undertake the health economic evaluation of hubs for the delivery of acute illness low complexity care To develop the delivery and coordination of the care for those with LTCs across the whole PCN.
Greater Derby	To focus on housebound patients to reduce unplanned admissions, deprescribing to improve medication safety and patient outcomes and decreased use of rapid response and emergency social care services, leading to improved resource allocation.
North Derbyshire PCN	To reduce number of high impact users and increased number of patients remaining well at home and cared for appropriately in the community
North Hardwick	To develop focus on the reduction in late diagnosis of CVD and high blood pressure To develop focus on the reduction in childhood obesity in the PCN To develop focus on the reduction in late diagnosis of cancer
Oakdale	To improve quality of life, reduce hospitalizations and enhance care coordination for the frail population
PCCO	A greater integrated model of care & seamless experience for patients through a total triage model and a greater focus upon levels of need in PCN and our unique locality.
Swadlincote	To develop Ragsdale House for low complexity patients, to reduce workload on practices, to enable focus on more complex patients. To focus on integrating Team Up and the local Navigation Hub into the PCN

The GP Provider Board and ICB will work with these PCN/LPAs to try out these new ways of working to accelerate progress towards the new model for General Practice. This is a bottom up approach which allows practices to own and lead the change and, hopefully, to create new innovative and sustainable models of care in line with the model. The project will take an iterative approach using PDSA cycles, with PCNs working together in learning sets. We are not able to offer much additional resource to the accelerator sites but the Primary and Community Care Delivery Board and Integrated Place Executive will advise, unblock problems and provide oversight and a link into the wider system. We will report progress monthly, with a formal review after 12 months. More detail can be found in appendices 4 and 5.

4) Conclusion and Next steps

The Empowering General Practice Programme remains a key transformation and has progressed since November 2023, working around gaps such as the lack of a recognised population stratification tool. Our programme was originally developed, in part, as a response to the Fuller Report. Since then Lord Darzi's report has supported this direction of travel. It seems likely that the forthcoming NHS 10 year plan will also see robust, high quality General Practice as central to the long term success of the NHS. The challenges faced by General Practice also remain, particularly regarding increasing demand exceeding available capacity.

Appendix 1

The next steps for the programme are to:

- Work with ICB and system partners to enable population stratification. This has been done in several other ICS, and various tools are available.
- Launch and run the accelerator programme to begin 'real world' change
- Work with our PCNs and practices via the accelerator site work to build a robust implementation plan, and subsequently the planned business case.
- Establish and agree leadership for key work streams identified in appendix 5 focused on the following areas; workforce and leadership, access and continuity, integrated neighbourhood working, digital, data, finance and contracting, public and community involvement.
- Ensure this programme aligns and is part of the wider community transformation programme, and the Neighbourhood Health model being described nationally.
- Ensure that the engagement and learning from the EGPP informs and shapes current work to re frame place and the development of place and neighbourhood health services in Derby and Derbyshire.
- Work with system patient involvement and engagement teams to use our patients to inform the development of the programme.

This programme of work sees General Practice as working together at scale in an integrated way with other community providers. Strategically it aligns with national and local plans to integrate care at a neighbourhood and place level. However, it is important that, as plans develop in a more detailed way we ensure that all of these plans are co-ordinated and align. We aim to do this through the 2025/26 planning round, and through the governance of the Integrated Place Executive, as described above.

Appendix 2

PCN and Place engagement details

Meeting	Date
Amber Valley Place	09/07/2024
Oakdale Park PCN	09/07/2024
North Hardwick and Bolsover	11/07/2024
Chesterfield and Dronfield	24/07/2024
NE Derbyshire & Bolsover Place PCN	30/07/2024
Derby City South	01/08/2024
Derby City Place	06/08/2024
Derby City North	08/08/2024
Chesterfield Place	03/09/2024
South Hardwick PCN	11/09/2024
Derbyshire Dales PCN	18/09/2024
PCCO PCN	19/09/2024
Erewash Place	19/09/2024
High Peak Place	20/09/2024
ARCH PCN	26/09/2024
South Derbyshire Place	08/10/2024
Dales Local Integration Group	10/10/2024
Belper PCN	18/10/2024
Derby City Place	06/11/2024
County Partnership Board	08/11/2024
High Peak PCN	08/11/2024
Swadlincote PCN	19/11/2024
Chesterfield and Dronfield	27/11/2024
NED PCN	18/12/2024

Appendix 3

Case Study Examples

Case Study: ARCH Community Blood Pressure Checks	
Patient type	All
Outcome	Improved patient experience of care and Improved Patient Outcomes
Stakeholder	ARCH PCN and Live Well Derbyshire

- Multi-agency working. One stop shop for everything
- BP's worked well as an engagement opportunity to get people through the door and start a conversation.
- Lots of great BP case finding
- Great interest and showed links for the need for weight management
- GP involvement and texting out to patients helped make the events success.
- Little advertisement on social media – the direct invite engages patients.
- We've tried events previously in Somercotes with little success, showing that a joined up approach like this makes a real difference.
- Funding has supported the roll out of the project to cover room hire costs and refreshments.
- Meeting as a steering group quarterly with key partners gives us the opportunity to reflect and build on the project.
- Challenge to get middle aged men to attend – partly mitigated by having at different times of day/weekends but we still need to work differently to engage this cohort

Case Study: Supporting new arrivals to Derbyshire	
Patient type	All
Outcome	Improved patient experience of care and Improved Patient Outcomes
Stakeholders	Health Protection Derbyshire County Council - West Park surgery, The Moir Medical Centre, Royal Primary care, and Serco. Derby City Council - Wilson St Surgery, Macklin St surgery, Urban housing & Serco

Public Health, Health Protection teams, County & City, led a measles elimination project in 2024 to encourage MMR uptake in the asylum seekers, whilst raising awareness of the importance of registering with a GP and promoting the symptoms of measles.
Contracted GP practices delivered the vaccinations, translation services were funded from NHSE access and inequality funding.
The teams have remained established are now supporting new arrivals to the UK via a multi-agency, Vulnerable Population & Health Inclusion group. The scope of the group is:

- Health assurance for specific vulnerable groups across Derby & Derbyshire
- The group is currently focusing on asylum seekers, which will be prioritised based on level of risk, gaps in provision and level of assurance elsewhere in the system.
- This multi-agency discussion space has allowed the group members to recognise the unpredictability and pace of change that asylum seekers faces when arriving in the UK and continue to face.
- A current priority is to ensure a suitable process is in place for the initial health assessment to take place, so the complexity of their care needs is known.
- Some GPs are already contracted to provide this work under the "Health Assessment Service Specification for Initial Accommodation Centres (IAC) for People Seeking Asylum" contract. For those GP teams that are not providing this service a brief checklist has been created which provides some initial steps to support team's work with new arrivals

Appendix 4

Expressions of interest for Accelerator sites for the Empowering General Practice Programme

December 2024

Accelerator sites

- We are looking for PCNs who want to try out new ways of working in line with the vision for General Practice developed by the GPPB
- Offer is open to anyone
- We can offer some support (but not loads)

Derbyshire GP Provider Board

What are the goals for the programme

- Improved patient outcomes
  - Demonstrated through a variation in clinical practice and increased life expectancy as examples
- Improved patient experience of care
  - Demonstrated through improved Friends and Family Test results, GP patient survey results, call handling and reduced dropped calls rates, for example
- Supporting General Practice to thrive
  - Demonstrated through staff survey results, making Derbyshire an attractive option to work, CQC inspection outcomes and reduced practice closure rates as examples

Derbyshire GP Provider Board

1
Low Complexity

People who are general well who experience episodic ill health and access care infrequently and irregularly

Informational Continuity

Approx 60% of pop.

2
High/Rising Complexity

People who experience ill health who require regular input over a prolonged period.

Relational Continuity

Approx 35% of pop.

3
Extreme Complexity

People who are access multiple services regularly who are approaching a ceiling of care.

Team-based Continuity

Approx 5% of pop.

Derbyshire GP Provider Board

Ask/Offer

- **What we're asking**
- PCNs to come forward to work on ideas in line with the Empowering General Practice Programme
- Identify problems you want to address
- Commit time to develop and work on these projects
- Be willing to trial new approaches
- Participate as a whole PCN, with engagement from all member practices and support from your relevant Place Board/Local Place Alliance (LPA).
- Work with other accelerator sites as part of a learning set
- Report on your progress and share what you learn – good and bad

- **What support you'll get**
- Assistance with population stratification.
- Senior leadership support to resolve systemic challenges.
- Limited funding to provide "head space" for planning and implementation.
- Access to Action Learning Sets, expert advice, and quality improvement tools.
- Change management and project management support.
- Guidance with stakeholder engagement, IT/digital systems, and progress measurement.
- Help in developing business cases for additional funding.

Derbyshire GP Provider Board

What kinds of things could you work on

- The vision sees General Practice services organised around three broad groups of patients:
  - low complexity; those with rising complexity; or those with extreme complexity.
- Accelerator sites will work on new ways of organising services for these groups. You will choose for yourselves but, for example, could work on:
  - New models of care for low-complexity patients, potentially through proactive care or scaling services like screening.
  - Enhanced continuity of care for rising-complexity patients, such as prioritising care for patients with chronic conditions like COPD.
  - Expanded multi-disciplinary teams to address the needs of patients with extreme complexity.
- You would work as part of an Action Learning Set to implement rapid change, fostering a cycle of continuous learning, problem-solving, and iteration within PCNs and between peers.
- As part of this accelerators could also help us with some issues we need to work through:
  - Help to work out how to stratify the population
  - How to share data between organisations and resolve IG issues
  - How to commission and fund organisations working in new integrated ways to deliver care to particular cohorts of patients
  - What else would need to be in place to enable this change (digital tools, premises etc)

Next steps

- Decide whether you want to take part (it's voluntary) and agree it with your PCN and (as necessary) other providers in your place
- Decide what you want to try to do and how that links into the vision
- Submit a short proposal to raki.raya@nhs.net by 18/12/24
- Become part of the first cohort and start working on your idea – meeting monthly to share progress as part of an action learning set
- Progress will be reported to Primary and Community Care Delivery Board then the Integrated Place Executive who will act as senior 'unblocking' groups to solve problems
- Time commitment is up to you but you'll need to be represented at the monthly meeting
- Report progress / problems to the group every month; take stock after six months, and then again December '25 – where we'll agree next steps

Derbyshire GP Provider Board

Expression of interest form for Empowering General Practice Programme Accelerator December 2024	
PCN name	
Link contact	
Brief description of your proposed project	
Hoped for outcomes	
Specific patient group? If so who?	
Other stakeholders? If so who?	
Note that all taking part are committed to work to the rules of the programme i.e. have the commitment of the whole PCN, participate in the action learning set, report on progress and share learning as required etc	

Empowering General Practice Programme: Invitation for your PCN to become an accelerator site

What is the Empowering General Practice Programme?

- The programme has been developed by the **GP Provider Board** to support local PCNs and practices to drive innovation and is **supported by the Integrated Care Board (ICB).**
- This programme involves **stratifying the population into three key cohorts** based on the complexity of their care needs (low, high/rising, extreme).
- Segmentation allows the wider system to lean into General Practice and understand how it may **support practices to focus on their strengths**, creating more time for those patients in the rising complexity cohort, where General Practice can have the greatest impact.

What does it mean for your PCN to be an accelerator site?

Accelerator sites will receive support to enable them to **develop and implement their own plans for achieving accelerated progress** towards the Empowering General Practice Programme.

They will **lead the local transformation of General Practice**, driving forward new ways of working that support practices to focus on their strengths.

What are the benefits of being a PCN accelerator site?

Accelerator sites will receive a **tailored support package**, including:

- Assistance with population stratification.
- Limited funding to provide "head space" for planning and implementation.
- Senior leadership support to resolve systemic challenges.
- Access to Action Learning Sets, expert advice, and quality improvement tools.
- Change management and project management support.
- Guidance with stakeholder engagement, IT/digital systems, and progress measurement.
- Help in developing business cases for additional funding.

How can your PCN apply to become an accelerator site?

To express interest in becoming an **accelerator site for the Empowering General Practices Programme, email raki.raya@nhs.net by 18/12/2024.**

A **short template** will be provided for you to outline your interest.

Before applying, please consider whether the following requirements are possible:

- Engagement from all member practices and support from your relevant Place Board/Local Place Alliance.
- Clear identification of the problems you aim to address and a willingness to trial new approaches.
- Commitment to the principles of the ‘Empowering General Practice Programme’ and the time and leadership required to be an accelerator site, including monthly updates for collective learning (not monitoring). There is no limit to the number of PCNs that can participate, and involvement can last two to five years.

Derbyshire GP Provider Board

Appendix 5

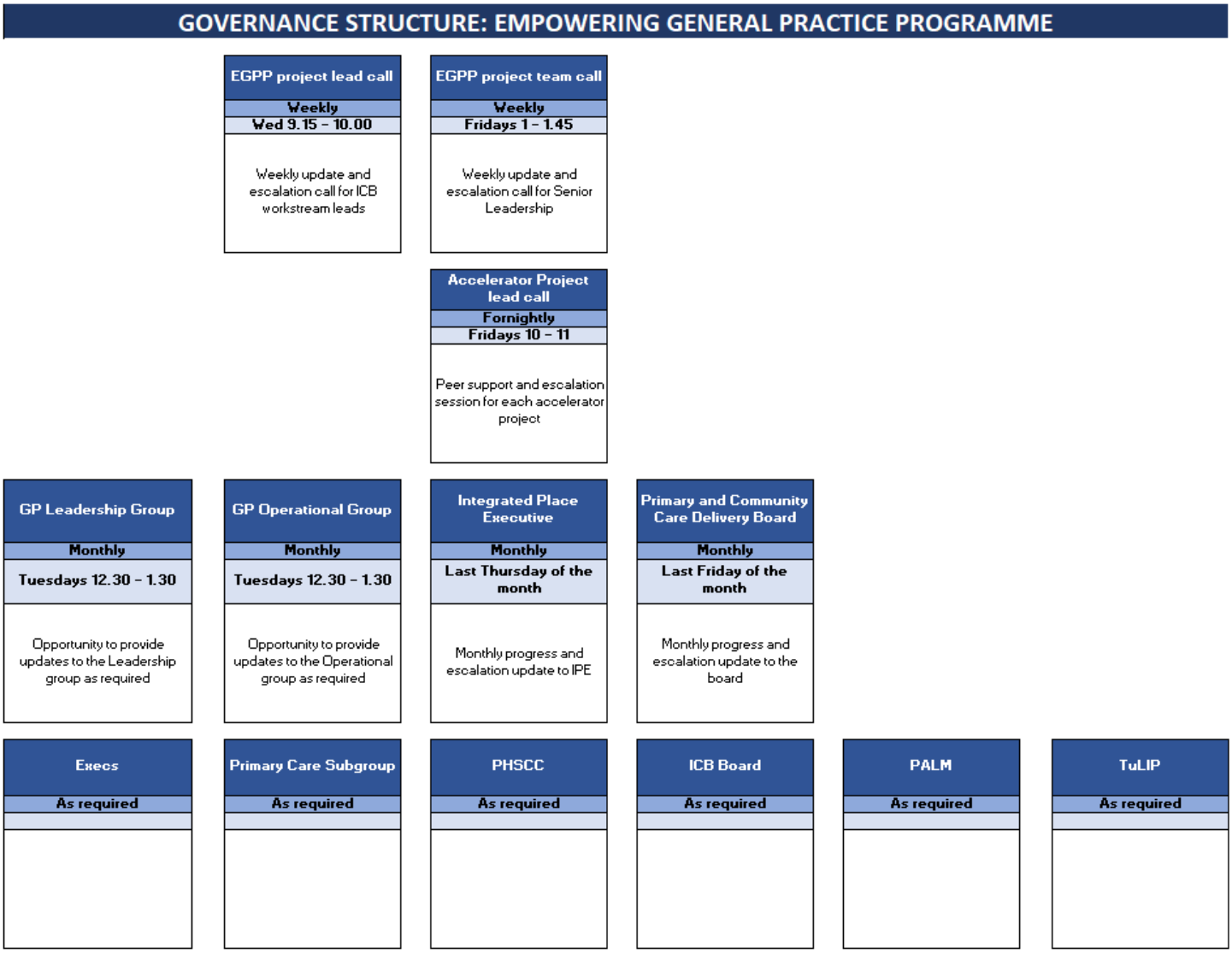
Further details on pilot projects for phase 1

PCN name	Accelerator project summary	Outcomes	Patient group	Focus areas
Belper	Creation of a population stratification tool for the whole system	1. Improved patient experience of care 2 .Improved patient outcomes 3. Supporting General Practice to Thrive	All	1. Data and population stratification
Chesterfield and Dronfield	To improve process working between multi-disciplinary teams to improve patient experience of care and outcomes.	1. Improved patient experience of care 2. Improved patient outcomes	1. High / rising 2. Complex	1. Workforce and leadership 2. Access and continuity
Derbyshire Dales	To improve the Care Home medication process to reduce workload, optimise care and reduce hospital admissions.	1. Improved patient experience of care 2. Improved patient outcomes	1. High / rising 2. Complex	1. Access and continuity
Erewash	To undertake the health economic evaluation of hubs for the delivery of acute illness low complexity care To develop the delivery and coordination of the care for those with LTCs across the whole PCN.	1. Improved patient experience of care 2. Improved patient outcomes	All	1. Access and continuity 2. Integration / neighbourhood working 3. Digital 4. Data and population stratification
Greater Derby	To focus on housebound patients to reduce unplanned admissions, deprescribing to improve medication safety and patient outcomes and decreased use of rapid response and emergency social care services, leading to improved resource allocation.	1. Improved patient experience of care 2. Improved patient outcomes	1. High / rising 2. Complex	1. Access and continuity 2. Integration / neighbourhood working 3. Data and Population stratification
North Derbyshire PCN	To reduce number of high impact users and increased number of patients remaining well at home and cared for appropriately in the community	1. Improved patient experience of care 2. Improved patient outcomes	Complex	1. Access and continuity 2. Integration / neighbourhood working
North Hardwick	To develop focus on the reduction in late diagnosis of CVD and high blood pressure To develop focus on the reduction in childhood obesity in the PCN To develop focus on the reduction in late diagnosis of cancer	1. Improved patient experience of care 2. Improved patient outcomes	1. Low complexity 2. High / rising	1. Access and continuity 2. Integration and neighbourhood working

Oakdale	To improve quality of life, reduce hospitalizations and enhance care coordination for the frail population	1. Improved patient experience of care 2. Improved patient outcomes	Complex	1. Access and continuity 2. Data and population stratification
PCCO	A greater integrated model of care & seamless experience for patients through a total triage model and a greater focus upon levels of need in PCN and our unique locality.	1. Improved patient experience of care 2. Improved patient outcomes	All	1. Data and population stratification
Swadlincote	To develop Ragsdale House for low complexity patients, to reduce workload on practices, to enable focus on more complex patients To focus on integrating Team Up and the local Navigation Hub into the PCN	1. Improved patient experience of care 2 .Improved patient outcomes 3. Supporting General Practice to Thrive	1. Low complexity 2. High / rising	1. Workforce and leadership 2. Access and continuity 3. Integration / neighbourhood working

Appendix 6

EGPP proposed governance structure.



NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

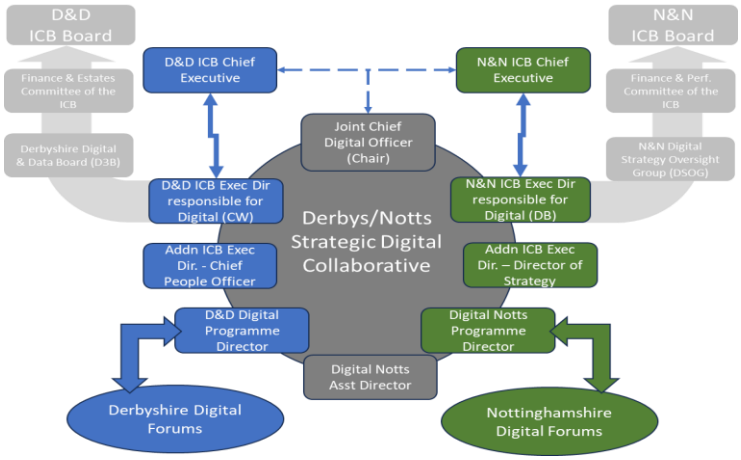
16th January 2025

Item: 109

Report Title	Digital Strategy – Progress and Priorities for 2025/26							
Author	Dawn Atkinson, Programme Director, ICS Digital Programme							
Sponsor (Executive Director)	Dr Chris Weiner, Chief Medical Officer Andrew Fearn, Joint Chief Digital Information Officer							
Presenter	Dr Chris Weiner, Chief Medical Officer Andrew Fearn, Joint Chief Digital Information Officer							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☒	Information	☐
Appendices	Appendix 1 - JUCD Digital and Data Strategy implementation update 'We said – We did'							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	The content has been previously discussed at the Finance, Estates and Digital Committee and has been summarised to this Board previously.							

Recommendations
The ICB Board is recommended to **DISCUSS** and **NOTE** the update on the Digital and Data Programme.
Purpose
The purpose of the paper is to update the ICB Board on progress being made to implement the ICS Digital and Data Strategy and support being delivered to Joined Up Care Derbyshire (JUCD) Delivery Boards.
Background
The Digital and Data Strategy in Derbyshire is a plan to use technology to improve the health and care of people in the city and county. The strategy was developed by JUCD, an Integrated Care System (ICS) that brings together health and care organisations across Derbyshire. The information in this report provides an update on progress being made in key areas identified in the strategy and response to local and national requirements.
Report Summary
Derby and Derbyshire/Nottingham and Nottingham ICBs Strategic Digital Collaborative The ICB and Nottingham and Nottinghamshire Integrated Care Board (N&N ICB) have created a Strategic Digital Collaborative to exploit the digital opportunities across the two systems; whilst embracing the different needs of the populations they individually serve. The purpose of the Collaborative is to provide an over-arching Digital Strategic Vision for Health and Care in the East Midlands Combined Authority (EMCCA) boundary. A governance structure has been established with accountability to each of the systems ICB Boards. The Joint Chief Digital Officer chairs the Collaborative with ICB Executive Director representations from both ICB Chief Medical Officers, ICB Chief People Officer and the N&N Director of Strategy

Derbyshire and Nottinghamshire Strategic Digital Collaborative – governance structure



The Chief Digital Officer, supported by the Digital Programme Directors in each System will be responsible for reporting progress against the separate Digital Strategies and Plans to achieve the shared Digital Vision, through the Digital and Data Delivery Board (D3B) to Finance, Estates and Digital Committee to the Derbyshire ICB Board; and through the Digital Strategy Oversight Group (DSOG) to Finance and Performance Committee to the Nottinghamshire ICB Board.

The Collaborative has met to discuss and agree the purpose of the strategic collaboration and the focus areas for joint working that will strengthen both ICBs. Areas discussed are:

- Cyber Security
- Digital Procurement
- Sharing best practice
- Digital Enablement – benefits realisation

Federated Data Platform

The use of the Federated Data Platform (FDP) has been mandated by NHSE; a letter issued in August 2024 stated trusts must have a plan to adopt the platform in the next two years. JUCD is in a positive position as an early adopter of the FDP following University Hospitals Derby Burton and Chesterfield Royal being designated as 'incubator sites'. Both acute providers are in the process of implementing the following:

- "Referral to treatment validation — facilitates RTT pathway accuracy and progression;
- Inpatients Care Co-ordination Solution (CCS) — streamlines elective care with data insights to improve theatre use and support planning, improves data quality oversight and waiting list validation;
- Outpatients care co-ordination solution — enhances clinic operations with waiting list validation; and
- Discharge planning (OPTICA - Optimised Patient Tracking & Intelligent Choices Application) – real-time tracking and task management for patient discharge processes.

The ICB has also agreed to the implementation of ICB FDP Population Health Management instance. Once fully implemented this will allow improved data sharing to support strategic commissioning and operational service delivery.

Artificial Intelligence and Robotic Process Automation

JUCD health partners have signed up to the national NHSE Microsoft 365 Co-pilot (pilot phase) to test using artificial intelligence in a secure environment. M365 Copilot is Microsoft's AI tool integrated into the Microsoft 365 suite, which includes apps like Word, Excel, PowerPoint, Outlook, and Teams. The aim of the pilot is to test how productivity can be increased by assisting with tasks such as summarising documents, drafting emails, and creating presentations.

During January 2025 organisations will be on-boarded to use Co-Pilot with an evaluation of impact at the end of March 2025. Although the pilot phase is time limited, partners were keen to test the technology in a secure environment, share learning and experiences across organisations.

The JUCD Technical Design Authority (TDA) is leading the development of an Artificial Intelligence and Robotic Process Automation Strategy with supporting guidance that will be informed through the Co-pilot exploration.

Derbyshire Shared Care Record
The implementation and development of the Derbyshire Shared Care Record (DSCR) continues with two significant developments; the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) has been completed and ReSPECT plans are now in the integration environment for testing. Clinically led testing is in progress and a system wide roll out will be directed by the End of Life Clinically Informed Workforce Group following successful user acceptance testing. An implementation plan will be agreed during January 2025 and once live the form will be the first read and write capability in the shared care record and digitisation of a ReSPECT form.

East Midlands Ambulance Service (EMAS)
Following the successful single sign on (SSO) pilot EMAS user accounts have been activated. The 'use cases' from the pilot are demonstrating staff and patient benefits from ambulance crews having access to up-to-date patient record to support clinic on scene decision making.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain an affordable and sustainable workforce supply pipeline and to retain staff through a positive staff experience.	☐	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☒	No☐	N/A☐
Details/Findings A digital budget has been provided with effect from 1 April 2023. Additionally, there is a shared and distributed approach to digital funding across the NHS providers, reflecting the fact that most digital activity is in the provider landscape. GP IT funding is separately and nationally determined. In most cases, digital costs are linked to RPI inflationary pressures, while ICB digital budgets are subject to the 30% RCA reductions and efficiency measures in line with all NHS budget lines. As an ICB and in conjunction with the provider trusts, we regularly and successfully bid for additional national funding for significant programmes (eg NHS Frontline digitisation programme).		**Has this been signed off by a finance team member?** Budget approved through ICB Director of Finance.

Have any conflicts of interest been identified throughout the decision-making process?				
Not applicable in this update.				
Project Dependencies				
Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable				
Yes ☒	No☐	N/A☐	**Summary:** Digital and Data Strategy was developed with public representation and validated in 2022 through a public engagement process. Key stakeholders involved including voluntary sector	

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

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

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☒	Air Pollution	☒	Waste	☒
Details/Findings: Digital (and data) interventions can positively impact all of the above measures. This can be as simple as continuing to exploit remote (MSTeams) meetings and avoiding unnecessary journeys through to carbon reduction as a consideration in the procurement of digital services to ensure providers use renewable energy sources and have a low carbon footprint. Reduction in on premise digital platforms, with a strategic shift to software as a service hosted on the cloud is central to the ICB Digital and Data strategy.					

Appendix 1

Joined Up Care Derbyshire

JUCD Digital and Data Strategy implementation update ‘We said – We did’

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council

The following slides provide a high-level overview of key digital and technology developments that are being implemented across Joined Up Care Derbyshire Integrated Care System

DERBYSHIRE SHARED CARE RECORD (DSCR)

Joined Up Care Derbyshire

2024/2025

WHAT'S NEXT

- Number of admissions that can be reduced through better access to information
- Qualitative impact of data to support continuity and consistency of care for staff and citizens

Partners that will be able to view data:

- Expanding access for Chesterfield Royal Hospital and Treetops Hospice

New data to share from:

- Derby City Council Children's Social Care - Derbyshire County Council Adults & Children's Social Care – Digitised ReSPECT Plans – Reasonable Adjustment Flags

Interoperability to share to and from bordering Shared Care Records using the National Records Locator Service (NRL)

DERBYSHIRE SHARED CARE RECORD (DSCR)

Joined Up Care Derbyshire

The Shared Cared Record enables sharing of health and social care data across partner organisations ensuring a holistic view of a person's health and social care.

WHAT WE HAVE DONE

Interoperability achieved with partner organisations:

View data: · Ashgate Hospice · Blythe House · DHU · Primary Care Networks · Derbyshire County Council Adults · EMAS

Partner organisations

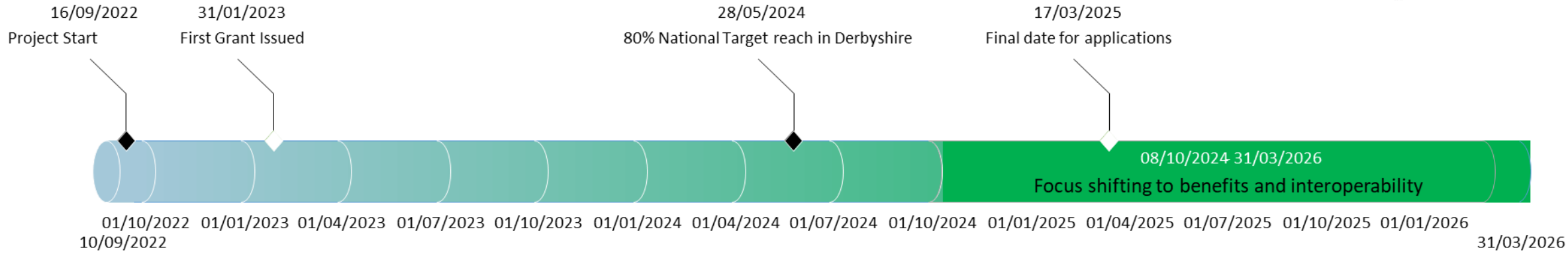
Viewing and sharing data · Derbyshire Community Health Services · Derbyshire Healthcare · Derby City Council Adults· Chesterfield Royal Hospital sharing of data only· University Hospital of Derby and Bu

BENEFITS

- Number of non-contact appointments that could be reduced:
- 2022 (2 teams) 1451 no access visits
- 2023 (same 2 teams - to Nov 23) 1117 no access visits
- Average time that could be saved by reducing non-contact appointments:
- 1.5 hours based on band 5/6 = £42.72 per no access visit

DIGITAL SOCIAL CARE RECORDS (DISC)

Joined Up Care Derbyshire



WHAT WE HAVE DONE

- Carers save up to 20 minutes per day – less time record keeping means more time to care
- 24 hours a year saved on auditing care records
- Handovers more focused and reduce risk
- Sharing of information is better

WHAT'S NEXT

- Monitor local benefits for the provider and service users
- Understand the impact on quality and planning
- Interoperability between different systems

EVALUATING OTHER TECHNOLOGY

Joined Up Care Derbyshire

The Digitising Social Care Fund (DiSC fund) allowed us to support care providers to purchase a range of equipment for evaluation.

WHAT WE HAVE DONE

- Electronic Medication Administration Record
- Robotic ‘pets’
- Smart sockets
- Acoustic monitoring falls detection
- Large interactive tablets for activities and strength building

BENEFITS

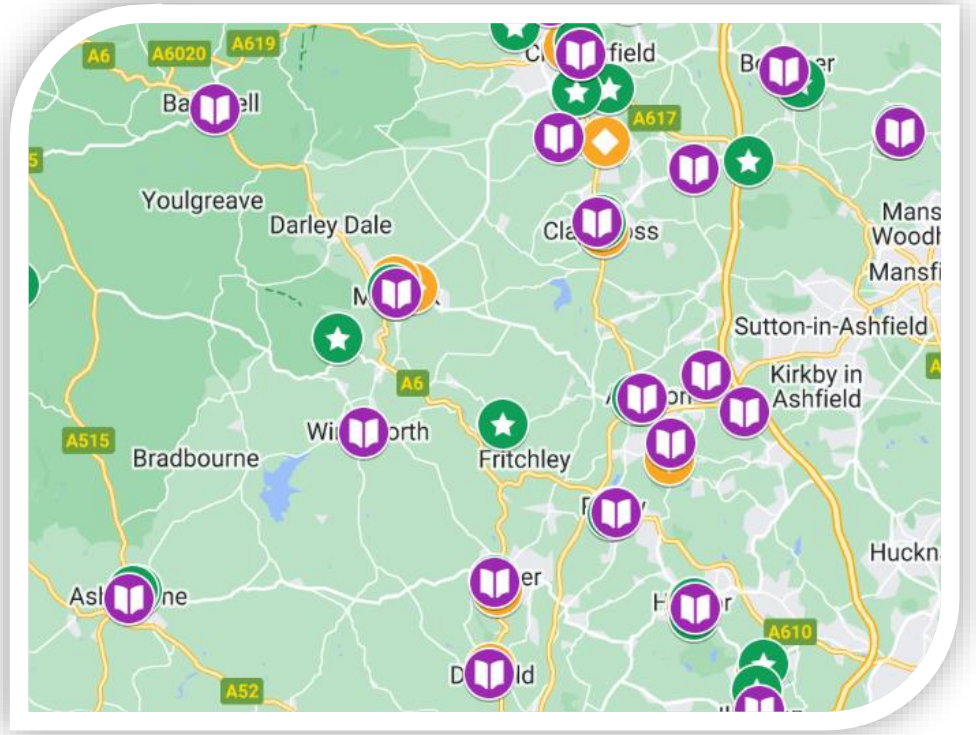
- Improvement in sleep quality for residents, meaning better activity, mood and mobilisation
- Improved quality of life for service users who can switch lights and TVs on and off without needing a carer
- Improved activity and participation by residents in care homes
- Reduction in nighttime checks that can disturb a sleeping resident

DIGITAL INCLUSION FOR HEALTH

Joined Up Care Derbyshire

WHAT IS DIGITAL INCLUSION?

"Equitable, meaningful, and safe access to use, lead, and design of digital technologies, services, and associated opportunities for everyone, everywhere".



WHAT WE HAVE DONE

- Support work led by Derbyshire County Council
- Rural Action Derbyshire have been funded since 2021 and funding will continue until at least 2026
- Creation of Digital Network and Digital Champion list

WHAT'S NEXT

- Specific funding to support to Health initiatives – using the NHS App and supporting Virtual Ward
- Test case to evaluate the impact of supporting people with digital technology

VIRTUAL WARDS

Joined Up Care Derbyshire

- A remote service that facilitates early discharge (step down) from hospital by supporting clinicians, professionals and patients manage health and care at home.

WHAT WE HAVE DONE

- 1104 patients onboarded with remote monitoring
- 11.3k days of remote monitoring undertaken
- Support work led by Derbyshire County Council
- Rural Action Derbyshire have been funded since 2021, funding until at least 2026
- Creation of Digital Network and Digital Champion list
- 7 (soon to be 9) pathways live

- **WHAT'S NEXT**
- Specific funding to support to Health initiatives – NHS App and supporting Virtual Ward
- Test case to evaluate the impact of supporting people with digital technology
- Expansion of the step-down pathways of care and introduction of step-up (admission avoidance) in collaboration with primary care (Royal Primary Care)

Federated Data Platform – incubator sites UHDB and CRH

Joined Up Care Derbyshire

Population health and person insight

Understand, predict and plan for the health and care needs of local (and national) populations.

Enable the tailoring of individual care, the design of sustainable health services, and better use of public resources.

Care coordination

Efficient organisation and management of patient care.

Ensure timely treatment, reducing unnecessary service duplication, and improving communication between healthcare providers.

Supply chain

Sourcing, delivery, and supply of healthcare products and services to support NHS trusts and healthcare organisations across England.

Ensure resource allocation is responsive to surges in demand, and items are delivered to the NHS frontline in a timely and efficient manner.

Vaccination and immunisation

Nationally coordinated and locally executed programmes to deliver vaccine doses to citizens across England.

Equip national and local teams with the necessary tools for managing vaccination and immunisation efforts, enhancing efficiency and programme management.

Elective recovery

Covers a wide range of non-urgent services, with an emphasis on addressing increased waiting times for treatments e.g. diagnostics, outpatient care, surgery, and cancer treatment.

Address service disruption as a result of the COVID-19 pandemic.

OPTICA

Joined Up Care Derbyshire

A real-time end-to-end patient tracking tool for local health and social care systems that enables the multi-disciplinary team to triage individual patients through different stages of their discharge process.

WHAT WE HAVE DONE

- Readiness to implement in both acute trusts
- Technical interoperability achieved and standardised coding structure established
- Access to for all health and social care staff involved in discharge process

WHAT'S NEXT

- Reduce Length of Stay (Los) and avoidable discharge delays
- Improved care collaboration
- Automation of reporting
- Improves focus at Multi-Disciplinary Team (MDT) meetings
- Improved governance
- Easy access to information on handheld devices

- Better patient flow resulting in better bed utilisation to support medical diverts
- More efficient use of MDT staff time
- Improved NHS and Social Care collaboration
- Increased system resilience by accommodating more medical diverts
- Reduction in average length of stay
- Improved patient experience – Less exposure to infections, return home as soon as possible

CARE COORDINATION SERVICE (CCS)

Joined Up Care Derbyshire

To help accelerate inpatient surgical waiting list validation, clinical reprioritisation and theatre scheduling, by providing clinicians, schedulers and operational staff access to a single source of truth to make optimised operational decisions about elective scheduling and theatres.

- process measures and CCS specific deliverables that show the system is working (i.e. actions raised in CCS, booked utilisation, cases per list, feedback)
- outcome measures which CCS will contribute to (i.e. actual utilisation, actual cases) but rely on other things such as timely pre-assessment, theatre workforce

WHAT WE HAVE DONE

Implementation of the waiting list validation, clinical reprioritisation and theatre scheduling at Chesterfield Royal Hospitals(CRH) and University Hospitals Derby and Burton to support elective recovery.

WHAT'S NEXT

Once CCS is embedded in to practice for inpatient theatre sessions it will be deployed into outpatient waiting list and clinic management.

MEDICAL EXAMINERS

Joined Up Care Derbyshire

Digital solution for community referrals into the Medical Examiners across Derbyshire and its borders to enable statutory medical examiners to independently scrutinise the causes of death and to do this they need access to electronic patient records.

This is a statutory requirement.

PATIENT ENGAGEMENT PORTAL (PEP)

Joined Up Care Derbyshire

Enable users to view, book, change and cancel their referrals and secondary care outpatient appointments in the NHS App, various systems have been integrated to enable data flow between the NHS e-Referral Service (e-RS) and hospital Patient Administration Systems (PAS) and the NHS App where patients will access it.

WHAT WE HAVE DONE

- Both Acute Hospitals technically enabled and implementing an enhanced patient engagement portal via their portal providers – University Hospitals Derby and Burton – Patient Knows Best (PKB) and Chesterfield Royal Hospital – Netcall.

ELECTRONIC PATIENT RECORD (EPR)

Joined Up Care Derbyshire

WHAT WE HAVE DONE

- Outline Business Care and Full Business Case approval
- Secured national funding to implement an Electronic Patient Record for Chesterfield Royal Hospital and University Hospitals Derby and Burton

NHS Chesterfield Royal Hospital NHS Foundation Trust

NHS University Hospitals of Derby and Burton NHS Foundation Trust

- EPR procurement process complete and identified as the preferred solution
- Implementation plans developed and stage focus

nervecentre

CYBER SECURITY STRATEGY

Joined Up Care Derbyshire (JUCD) Cyber Security Strategy was developed and signed off November 2023.

WHAT WE HAVE DONE

National Cyber Strategy the JUCD Cyber Strategy will be refreshed and submitted for approval September 2024.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th January 2025

Item: 110

Report Title	2025/26 Operational Plan – Improvement objectives							
Author	Craig Cook, Director of Strategy and Planning							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Presenter	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☐
Appendices	Appendix 1 – overview of draft improvement objectives Appendix 2 – more detailed schedule of improvement objectives							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	none							

Recommendations
The ICB Board are recommended to **DISCUSS** and **NOTE** the report.
Purpose
To set out the areas of NHS provision where we have an ambition to improve the quality of care over the next five years.
Background
A key part of preparing for this planning round, has been establishing those areas of NHS provision where there are opportunities for improving the quality of care and in response, set out specific and measurable objectives for the NHS in Derby and Derbyshire to formulate a plan for delivery.
Report Summary
• Our aim over the next 5 years is clear: (1) improve the quality of the NHS' prevention effort, with a particular focus (but not exclusively) on secondary prevention; (2) close the treatment gap; and (3) make the NHS' care offering more financially sustainable. • A set of objectives have been formulated to add greater definition to the first two aims.

- These objectives are currently in draft form and will further be developed following further consultation with partners and receipt of NHS Planning Guidance which is due in the second half of January 2025.

- Over the coming 8-12 weeks, we will consider how many of these objectives we can practically deliver, given the constraints we have – particularly in relation to financial and workforce resource.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☒
SR5	There is a risk that the system is not able to maintain an affordable and sustainable workforce supply pipeline and to retain staff through a positive staff experience.	☒	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Please indicate above which strategic risk(s) the paper supports and also make reference here to any risks within the ICB's risk register, which can be found here.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

Details/Findings *What is the full cost of this project/commitment/business case? How is this funded? And is the funding recurrent/non-recurrent? Is there a financial benefit expected elsewhere in the System? Is there a clear exit strategy from this project if funding is expected to cease?*	**Has this been signed off by a finance team member?** *Please indicate, by name and job title, the finance lead that has contributed to this paper.*

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

Give details of any instances where staff have been conflicted, or where conflicts have been raised at meetings where the report has been discussed

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

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

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

Details/Findings Not applicable

Appendix 1

The Derby and Derbyshire NHS' Plan

Improvement objectives – 2025/26 to 2028/29

Purpose and approach

- To set out a series of *improvement objectives* that relate to the quality of NHS care over the next 5 years - forming the scope of activity for this planning round.

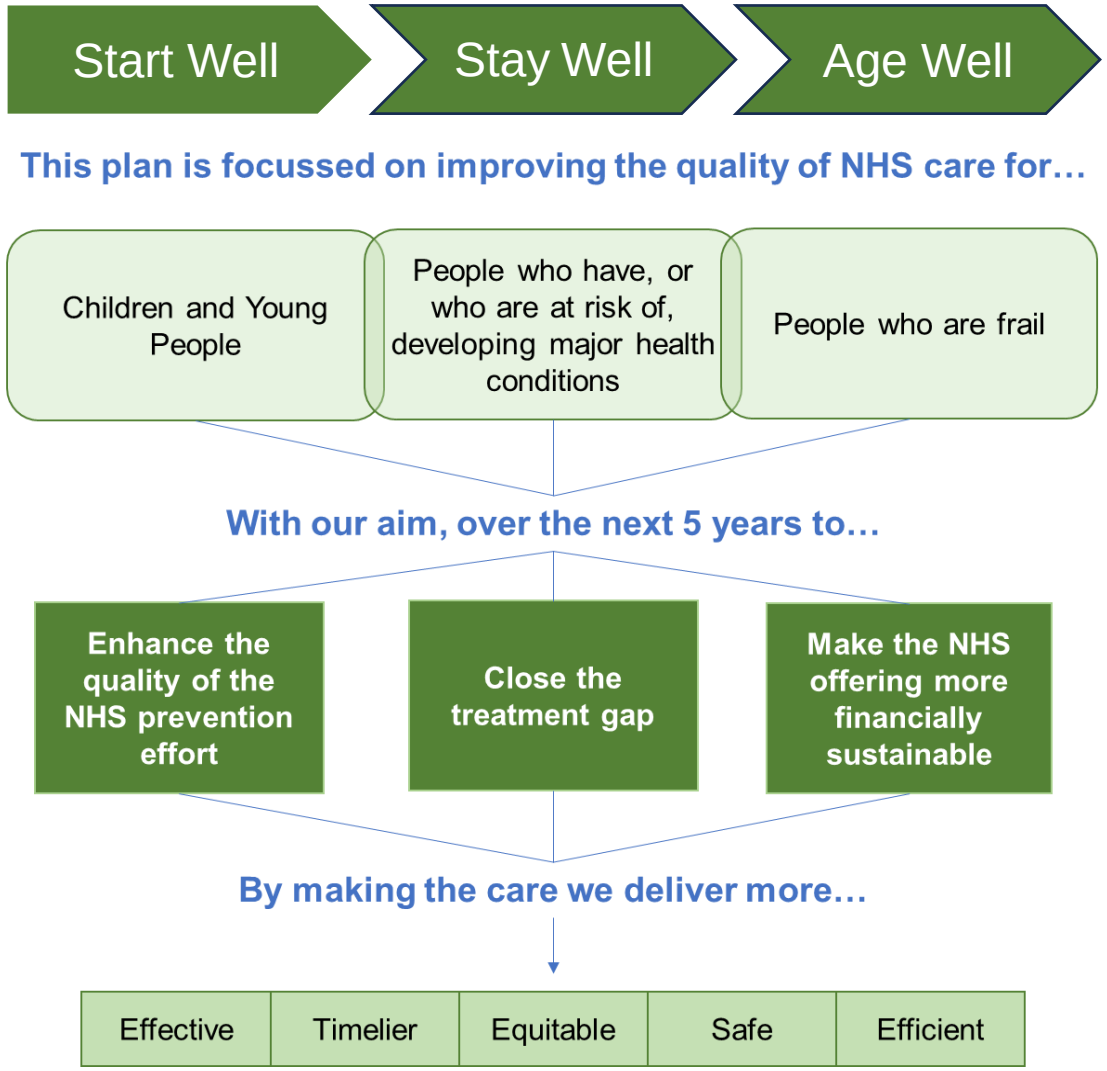
- We’re focussing on areas where (i) our performance has deteriorated and/or (ii) where there is evidence of an opportunity to close the gap relative to peers i.e. a core assumption that is not unreasonable to assume that if other (similar) system are yielding better outcomes, then we can get there too.

- This doesn’t mean that areas not listed aren’t important – it is assumed that our performance for these items remain unchanged, given that we are either achieving targeted levels and/or benchmark well against peers.

- The approach is intelligence led – NHS Model Health System, Fingertips, GIRFT.

- Assume that all other areas of performance remain unchanged.

What this planning round is all about…



In a nutshell, our ambition in 5 years' time…

For adults…

- Who have **diabetes, or at risk of developing diabetes, and/or obese**, you will be able to access the most appropriate treatment quicker and your risk of developing complications reduced.

- Who have **hypertension**, you will be identified as having hypertension earlier and put onto an appropriate treatment plan.

- Who need a **diagnostic and/or consultant led treatment** for general and acute care needs, you will receive care quicker and fewer complications will arise from your treatment.

- Who have a **severe mental illness**, you will receive more regular health checks and if you need inpatient care, you will get it closer to where you live.

- Who are **assessed as being frail**, you will not have to rely on emergency hospital care for your needs to be met.

For children:

- Who need to see a **dentist**, you will be able to access care easier than you do now.
- Who need specialist **speech and language therapy**, you will be waiting less time than you do now to receive the care you need.
- Who need care and support in the community for your **mental health needs**, you will be waiting less time than you do now.
- Who need care for a range of **physical health conditions** e.g. asthma, epilepsy and diabetes, you will

Base case planning assumptions (macro-level)

1. A minimum of 5% cost improvement in 25/26 to support a trajectory of break even by the end of the 5-year period.

2. Funding for any new intervention or technology (nationally mandated or otherwise) to support improvement in quality, must be found from existing budgets.

3. No increase in the supply of adult or children social care capacity.

4. A population that is 1.7% larger in 2028/29 relative to now and within this an elderly population which is 8.0% larger.

5. No break in supply of healthcare due to industrial action.

What this means in practice:

for children and young people

Area	What's the issue - key headline message(s)	Draft Objective
Speech and Language	**Community care -** As at the end of October 24, there were 734 children waiting for speech and language therapy, of which 23% had waited longer than 18 weeks.	Increase access to speech and language therapy care so that 92% of patients receive care within 18 weeks.
Referral to Consultant Led Treatment	**Paediatric Services -** Overall system performance stands at 56%. To achieve the 92% target by 2028/29 means improving performance by ~12% points per annum.	Increase the proportion of the incomplete wating list <18 weeks by 12% in 2025/26.
Community mental health	Improve access rates to children and young people's mental health services is a core aspect of NHS England's 'Core20PLus5' framework. As at the end of October 24, 2641 people were waiting for care, of which 71% had waited longer than 18 weeks.	Increase access to speech and language therapy care so that 92% of patients receive care within 18 weeks.
Dental Care	Dental Access - Just over half (54.7%) of children have seen a dentist in the past 12 months.	Increase the supply of NHS dentistry, so that a higher proportion of children are accessing regular examinations.
Diabetes	NHS England's 'Core 20 plus 5 framework' established diabetes care as a component. We currently do not have a specific improvement objective set against this element.	Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and Increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.
Epilepsy	NHS England's 'Core 20 plus 5 framework' established epilepsy care as a component. We currently do not have a specific improvement objective set against this element.	Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.
Asthma	NHS England's 'Core 20 plus 5 framework' established asthma care as a component. We currently do not have a specific improvement objective set against this element.	Address over reliance on reliever medications and reduce the number of asthma attacks.

What this means in practice:

for people who have, or at risk of developing, major health conditions

Enhance the quality of the NHS' prevention effort

Area	What's the issue - key headline message(s)	Draft Objective
Cancer	**Faster Diagnosis** - At an aggregate level, we have made progress in diagnosing and/or ruling our cancers quicker, but there is significant variation at a tumour site level.	Ensure that on average at least 80% of suspected cancer cases, are diagnosed and/or ruled out within 28 days for every tumour site, by the end of the 2027/28 year.
	Lung cancer detection is too late.	Increase uptake in targeted lung health checks in aggregate terms, with particular focus on sub-population cohorts most at risk.
	Screening - Good performance in overall take-up of bowel, cervical and breast cancer screening, relative to peers. However variation exists at a sub-population level.	Breast, Bowel and Cervical Screening - At a minimum, maintain the relatively good uptake performance in aggregate terms but level up access in areas where there is currently an adverse variance.
Cardiometabolic Health	**Diabetes** - given that only around 3 in 10 of people who are 'pre-diabetic' are offered and accept access to the Diabetes Prevention Programme, there is an opportunity to increase to match at least the national average and ideally go much further.	Increase the proportion of people with pre-diabetes who are offered and don't decline access to the diabetes prevention programme by 10 percentage points on current outturn so as to match the national average.
	Obesity - almost half of the patients waiting for tier 3 weight management services have been doing so for longer than a year.	Reduce the number of long waits by 75% over the course of the next 3 years.
	Hypertension - 15% of adults with hypertension are not receiving treatment and the prevalence of untreated hypertension is similar across the area deprivation quintiles.	Increase the proportion of people with hypertension who are treated.
Dementia	**Diagnosing dementia early** - At a minimum, maintain the relatively good diagnosis rate in aggregate terms but level up access in areas/sub-population cohorts, where there is currently an adverse variance.	At a minimum, maintain the relatively good diagnosis rate in aggregate terms but level up access in areas/sub-population cohorts, where there is currently an adverse variance.
Mental Health	**SMI health checks** - this is a key feature of NHS England's 'Core20Plus5' framework, which sets an expectation of ICB's to ensure annual physical health checks for people with SMI to at least nationally set targets. Currently, 58% of people with a SMI are receiving a health check so there is some way to go still to hit the 75% target.	Increase the proportion of people with a SMI who receive a physical health check.

Close the treatment quality gap

Area	What's the issue - key headline message(s)	Draft Objective
Cancer	**62 day treatment -** At an aggregate level, we have made progress in initiating treatment quicker, but there is significant variation at a tumour site level.	Ensure that on average at least 85% of people with cancer receive their first definitive treatment within 62 days, for every tumour site, by the end of the 2027/28 year.
	Utilisation of emergency care - People with cancer living in Derby and Derbyshire are u**sing** emergency service resources more than people who live in other similar areas - a difference equivalent to 21 beds.	Reduce the emergency admission rate for people with cancer by 13% over the next 2 years to bring this system in line with its regional peers.
Cardiometabolic Health	**Diabetes** - there is an opportunity to increase the proportion of young people with type II diabetes who meet the HbA1c treatment target, to match at least the national average.	Match national average performance over the next two years.
	Diabetes - there is an opportunity to reduce the risk of person with type II diabetes needing hospital care for Diabetic ketoacidosis to at least the national average and ideally what is was before the pandemic.	Match national average performance over the next two years.
	Cardiology - All other things being equal, we need to increase the proportion of incomplete pathways with 18 weeks, by 10 percentage points per year over the next 4 year period, to deliver the constitutional standard. As we recover access to services we need to do so in way which is equitable.	Increase the proportion of the incomplete wating list <18 weeks by 10% in 2025/26.
	Stroke Care - There is an opportunity to improve the quality of stroke care so that on a range of metrics the Derby and Derbyshire Health System is performing in line with peers and the overall national average position.	Over the next 2 years enhance the quality of acute and community based stroke care, so that we are operating in line with evidence based standards.
Mental Health	The plan to reduce **inappropriate out of area placements** is tracking behind trajectory.	Reduce inappropriate out of area placements to zero.
	There is an opportunity to reduce the rate of mental health presentations (due mainly to self-harm and attempted suicide) to ED by 20%, so as to match the average of our demographic peers.	Reduce the number of mental health presentations to ED by enhancing the quality of care people receive in the community.

Close the treatment quality gap

Area	What's the issue - key headline message(s)	Draft Objective
Musculoskeletal Health	**Podiatry and podiatric surgery** - Almost half of the people waiting for care have been doing so for longer than 18 weeks.	Ensure that nobody is waiting longer than 52 weeks for treatment by September 2025.
	T&O referral to treatment - All other things being equal, we need to increase the proportion of incomplete pathways with 18 weeks, by 10 percentage points per year over the next 4 year period, to deliver the constitutional standard. As we recover access to services we need to do so in way which is equitable.	Increase the proportion of the incomplete wating list <18 weeks by 10% in 2025/26.
	The 30 day emergency readmission rate following a primary total hip replacement is double the size of the benchmarked standard. Furthermore, the 30 day emergency readmission rate following a primary total knee replacement, is double the size of the benchmarked standard at UHDB and 1.7 time higher at the CRH.	Reduce the readmission rate following a total knee and hip replacement in line with the benchmarked standard over the next 18 months
	Rheumatology referral to treatment - All other things being equal, we need to increase the proportion of incomplete pathways with 18 weeks, by 10 percentage points per year over the next 4 year period, to deliver the constitutional standard. As we recover access to services we need to do so in way which is equitable.	Increase the proportion of the incomplete wating list <18 weeks by 10% in 2025/26.
	Spinal Care - There is an opportunity to improve the quality of spinal care against for a range of metrics.	Over the next 2 years, reduce (i) the use of injection therapy for people with non-specific low back pain without sciatica; (ii) The 30 day emergency readmission rate for 3 spinal surgery procedures where we are operating significantly higher than the benchmarked level; (iii) the length of time people are spending in hospital for emergency back or radicular pain.
Other	**Referral to Treatment (all other treatment functions)** All other things being equal, we need to increase the proportion of incomplete pathways with 18 weeks, by 10 percentage points per year over the next 4 year period, to deliver the constitutional standard. As we recover access to services we need to do so in way which is equitable.	Increase the proportion of the incomplete wating list <18 weeks by 10% in 2025/26 and do so in a way that closes the "deprivation gap".
	Diagnostic Care - In aggregate terms, around 70% of patients on a **diagnostic waiting list have been wating less than 6 weeks**. This is short of the 95% target that we should be delivering. There is significant variation at modality level which needs to be addressed to improve overall performance -with a particular focus on audiological assessments, cardio echography, neurophysiology, MRI and NOUS.	By the end of the 2028/29, ensure that 95% of people are waiting less than 6 weeks for a diagnostic test.
	4 hour performance - On a like for like basis, the System's **4hr performance** has deteriorated in 2024/25 and a significant number of ambulance time is being lost to handover delays.	Move the UEC performance back to 2023/24 levels in 2025/26.

What this means in practice:

For people who are frail

Area	What's the issue - key headline message(s)	Draft Objective
Frailty Care	Improving the health and care offering for this segment of the population is the most critical aspect of our plan, given the projected growth in the older adult population over the next 5 years and the high level of resource consumed by people who are frail - in particular, expensive hospital care.	Over the next 5 years, reduce the reliance on emergency hospital care - equivalent to 111 beds.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th January 2025

Item: 111

Report Title	Integrated Performance Report
Authors	Phil Sugden, Assistant Director of Quality Sam Kabiswa, Assistant Director, Planning and Performance Jennifer Leah, Director of Finance – Strategy & Planning Sukhi Mahil, Associate Director – Workforce Strategy, Planning and Transformation and CPLG Management Lead
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer
Presenters	• Quality – Prof Dean Howells, Chief Nurse Officer and Deji Okubadejo, Clinical Lead Member • Performance – Michelle Arrowsmith, Chief Strategy and Delivery Officer and Maragaret Gildea, Non-Executive Member • Finance – Claire Finn, Interim Chief Finance Officer and Jill Dentith, Non-Executive Member • Workforce – Lee Radford, Chief People Officer and Margaret Gildea, Non-Executive Member

Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐

Appendices	Appendix 1 – Performance Report
Assurance Report Signed off by Chair	Not applicable
Which committee has the subject matter been through?	Quality & Performance Committee Population Health & Strategic Commissioning Committee Finance, Estates & Digital Committee Executive Team

Recommendations
The ICB Board are recommended to **NOTE** the Performance Report and Committee Assurance Reports.

Purpose
To update the ICB Board on the Month 8 performance against: • quality standards in areas like planned, cancer, urgent and emergency and mental health care; • the 2024/25 operational plan objectives/commitments; • the position against the 2024/25 financial plan including income and expenditure, efficiencies, capital and cash; and • the workforce plan position.

Background

Quality & Performance

The 2024/25 Operational Plan set clear measurable objectives which are fundamental to the NHS' contribution to improving health outcomes. The Plan was submitted to NHSE on 2nd May.

In summary, our plan:

- commits the NHS in Derby and Derbyshire to delivering operational performance that is compliant with the national ask, in most cases;
- from a workforce perspective, the combined effect of CIP across the 4 JUCD Foundation Trusts generates a reduction in WTEs of 3.6% (927 WTEs) when comparing March 2025 to March 2024. However, when accounting for the effect of funded initiatives (e.g. Dormitory Eradication, Community Diagnostic Centres and transfer of staff from Local Authority (DCHS specific) the overall workforce is planned to be 0.02% higher in March 2025 relative to March 2024; and
- from a financial perspective, JUCD has submitted a 2024/25 financial plan to deliver a £50.0m deficit in line with the system Revenue Financial Plan Limit set by NHSE, which was agreed through system CEOs. This is underpinned by a 5% CIP across all organisations.

The report attached represents assessment of progress against our 24/25 planning objectives as at Month 7 (Urgent Care) and Month 6 (all other areas). It is based on published data which, for some objectives/measures, is still limited due to data time lags. Where the plans are not being met the key interventions have been outlined in the accompanying annex by the ICB Delivery Teams.

Finance

On the 12th June 2024 JUCD submitted a financial plan to deliver a planned deficit of £50.0m, in line with the Revenue Financial Plan Limit set for the ICS. Non-recurrent deficit funding has been received in Month 06 to enable the system to deliver a breakeven position for the year.

Workforce

Whilst the system needs to monitor the position against the workforce plan submitted to NHSE earlier this year, a more rounded understanding of the position, through alignment of the Whole Time Equivalent (WTE) numbers and the finance pay bill is necessary. This report, is therefore summarised in three parts:

- M8 WTE position against plan; and
- Actual workforce position compared to pay-bill.

In addition, given the increasing level of scrutiny on agency spend and usage the report includes a breakdown against the four main KPIs.

Report Summary

Quality

The following headlines from the Quality slides should be noted:

- National Oversight Framework (NOF) Change of Segmentation: Quarter 1 of 2024/25, DHcFT - CQC Inspection report published 11th December 2024. No change to Trusts overall CQC ratings, however ratings for the acute wards for adults of working age and psychiatric intensive care units changed to Requires Improvement Overall and for the domains of Safe and Well Led. Follow up CQC Inspection conducted with no immediate quality concerns.
- National Ambulance Culture Review - NHS England commissioned an independent review to support improvement of the culture within ambulance services. The review identified six actionable recommendations for improvement with identified actions for a range of stakeholders including NHS England, Integrated Care Systems and Ambulance Trusts. A review of the EMAS position against each of the recommended actions has been undertaken. A People Strategy Delivery Plan has also been developed, and quarterly

updates are provided to the Workforce Committee to provide assurance of progress. The first quarterly report was submitted in November 2024.

Performance

Performance is generally not in line with planned trajectory for most objectives. Annex 1 provides a snapshot of performance for key areas of the operational plan including risks to delivery and actions being taken to mitigate these.

Key points actions and issues:

Urgent and Emergency Care

A&E 4-hour performance:

- Both Acute providers are behind trajectory in delivering the 4-hour target.
- As a system, the first half of the year has seen a 5% lag against our intended trajectory for all commissioned UEC provision.
- ED demand at the two Acute Trusts are close to plan in the first 8 months of this year (UHDB 0.3% below plan and CRH 0.9% above plan).
- DCHS' UTC activity was 25% below plan in the first 8 months of this year, due in the main to the fact that the Ilkeston service is still subject to business continuity measure and continues to be appointment only 8am until 8pm 7 days a week with plans in place to work towards a return to both appointments and walk in by end of January 2025

Category 2 ambulance response:

- In November EMAS achieved an average Category 2 Ambulance Response Time of 56 minutes. This is still significantly above the local target time of 35 minutes.
- 45-minute Handover initiative – JUCD has committed to adopt and implement the regional 45-minute Handover initiative, with dynamic risk assessment to ensure timely ambulance releases and shared system risk. This will see ambulance crews transferring a patient into ED no later than 45 minutes after arrival.

General and Acute Beds:

- Both Acute Trusts have supplied more G&A beds than planned (+17 on average across UHDB and +49 on average at the CRH).
- During November CRH have had average occupancy at 96% and UHDB 95%.
- On average, the number of people who do not meet the criteria to reside is lower this year across both Trusts, relative to the same time last year.

Handover delays: As a system we have lost 11,275 hours to handover delays during the first 8 months of the year. This is significantly higher than planned.

Winter/Seasonal Plan: We have produced our winter plan. The plan details oversight and escalation processes to ensure a collective and dynamic management of risk is in place throughout the winter period. The plan includes these key elements:

- Demand and capacity profiling – all organisations have undertaken a capacity and demand assessment. This has informed the mitigation plans that have been put in place ensuring there is enough planned capacity to meet surges in demand over winter.
- Trusts have reviewed their general and acute core and escalation bed numbers, and this is included as part of the system seasonal plan as well as internal mitigation plans for any areas of pressure.
- A commitment to maintain fundamental care standards throughout winter has been made and the principles for providing safe and good quality care in temporary escalation spaces will be adhered to.

- Organisations have confirmed that there will not be a reduction in the number of General & Acute beds throughout this winter and will maintain the Q4 position of last winter.
- Acute Trusts regularly review and test their Full Capacity Plans (FCP).
- Individual organisations have reviewed internal triggers and actions. The ICB Urgent & Emergency Care Team are working with partner organisations to refresh the system escalation plan, agreeing thresholds and the arrangements for command and control during heightened pressure.
- Demand, and the delivery of plans to create additional capacity, will be tracked and monitored weekly throughout the winter period to ensure system partners have a shared understanding and awareness; and enabling the system to respond dynamically to emerging risk. Delivery of the system UEC Rapid Action Plan will support with preparedness ahead of winter.

The plan will be regularly reviewed and updated to reflect changing needs and plans as they continue to develop. In line with the seasonal plan, the system will conduct scenario stress testing on the 29th of November.

Planned Care, Cancer, and Diagnostics

Referral to treatment waiting times:

- The overall waiting list is slightly higher than planned at CRH but within plan at UHDB. However, both Trusts are behind schedule in meeting the 65-week target.
- NHS England have requested a route to zero by 22nd December for 65 week waits from both providers.
- Risks to achieving this target remain at both Trusts, with pressures relating to the potential impact of winter induced demand, capacity issues in some specialities, and patient choice.

Diagnostic waiting times:

- The overall waiting list is higher than plan at CRH but within plan at UHDB.
- Within the overall waiting list, the proportion of people waiting longer than 6 weeks is consistently higher than planned.

Cancer waiting times:

- Taken cumulatively, both trusts have achieved their 62 -day treatment target – CRH achieved 79% vs a target of 73% in Q1 while UHDB achieved 65% vs a target of 59% in the same quarter. In Q2 CRH has achieved 73% vs a target of 73% (despite some marginal reductions during Aug/Sept) while UHDB achieved 70% vs a target 62%.
  In October both Trusts again managed to achieve their performance target CRH achieved 74.1% vs a target of 73.6% and UHDB achieved 69.9% vs a target of 64.9%.
- For the 28-day faster diagnosis target, both trusts fell short of achieving the planned performance in September, October shows an improvement in performance.
- UHDB have been removed from Tiering by NHS England for Cancer, reflecting an improvement in performance.

Mental Health, Autism and Learning Disabilities

- The MH/LDA service remains extremely pressured.
- Most of the performance trajectories in the 24/25 plan had assumed maintenance of 23/24 performance levels. However, there are challenges with IAPT performance and SMI health checks.
- Out of area placements have increased following a review of how the data was being captured/recorded. The position at October is 37 against a plan of 24.

Primary and Community Care

GP Appointments: Our 2024/25 plan assumed that General Practice would deliver the same level of appointments as in the previous year. October numbers are significantly above plan, mainly due to the Flu vaccination programme starting this month. The activity is 5% above plan for the year to date.

Adult Community Service Waiting Times: At the end of September 24, the number of 52 weeks waits is tracking higher than plan. The 2024/25 plan did assume that the number of 52+ week waits would be higher at the end of the year than the start, due to the known issue about tier 3 weight management. However, Community Paediatrics are also tracking much higher than plan. The plan at October was 923 but the waiting list has reached 1,401. The team is currently revisiting the work plans although this area is recognised to be a significant challenge nationally.

Finance

At Month 08 the system reported a year-to-date adverse variance of £4.3m against a plan of £19.3m. The annual forecast is to deliver the updated planned breakeven position by the end of the financial year. Key drivers of the YTD position include Urgent & Emergency Care Demand and Non-Elective Pressures. This variance has been partly offset by mitigations in other areas.

Workforce

The total workforce across all areas (substantive, bank and agency) was 107.62 WTE below the 2024/25 workforce plan (as submitted on 2 May 2024). Whilst the net WTE position is below plan, there are some areas that are slightly above plan; CRH (Substantive, 63.22 WTEs), DCHS (Substantive, 86.70 WTEs, Bank, 14.93 WTEs and Agency, 7.79 WTEs), DHcFT (Bank, 12.53 WTEs), EMAS (Bank, 3.56 WTEs and Agency, 2.84 WTEs), UHDB (Bank, 14.42 WTEs and Agency, 29.13 WTEs).

Compared to M7, there was an increase in substantive positions (86.52 WTE), bank (29.02 WTE) and agency usage (10.64 WTE). The increase in substantive positions was from Registered Nursing, Midwifery and Health Visiting (63.54 WTE), Registered/Qualified Scientific, Therapeutic and Technical (45.73 WTE) and Medical and Dental (17.64 WTE). Whereas there were decreases in Support to Clinical (23.78 WTE) and NHS Infrastructure Support (16.61 WTE).

The substantive growth was mainly observed from an increase in newly qualified nurses which will fill vacancies in future months and reduce variable spend.

For Primary Care, the M7 total workforce was 209 WTE below Q3's plan. The gap was observed mainly from Direct Patient Care roles (ARRS funded) (81WTE), Other – admin and non-clinical staff (61WTE) & Direct Patient Care roles (Non-ARRS funded) (35 WTE).

Actual M8 workforce position compared to pay-bill position: The M8 position is demonstrating an overspend of £2.5m (YTD £1.8m overspend). The M8 position is driven by overspends in CRH (£1m), DCHS (£0.2m), and UHDB (£2.7m). The positions are mainly due to:

- CRH: pay efficiency delivery is £3.9m adverse to plan, partly offset by other pay costs being favourable to plan. The trust has exceeded the agency ceiling YTD due to required support for fragile services. A director-led quality impact assessment of bank and agency usage continues to identify areas where costs can be safely reduced.
- DCHS: Agency costs are overspent to date due to higher levels of sickness than expected in the Urgent Treatment Centre.
- DHcFT: Agency costs were above plan up to M6 due to a patient with complex needs. These additional costs have now ceased. Agency reduction plans are being implemented to help costs align to plan for the rest of the year.
- UHDB: Substantive costs have increased in M8 due to newly qualified nursing staff starting and increased recruitment to vacant posts. Higher levels of bank staff costs continue to be incurred due to backfill for staff covering UEC activity.

The overall pay-overspend position is being investigated further through the ask of finance colleagues to unpick non-contractual pay elements. This is important, particularly due to the WTEs planned position as it is thought that overtime, WLIs and other hidden pay-costs could be inflating the position.

Agency Usage: The 2024/25 priorities and operational planning guidance set out clear expectations with regards to agency usage reductions; these were to:

- reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill in 2024/25
- improve agency price cap compliance and eliminate off-framework agency use (where this exceeds national framework rates) by July 2024.

We continue to submit weekly returns to NHSE in relation to the four KPIs. These returns are monitored and reviewed regularly, with ongoing discussions taking place where particular issues are identified. The M8 position against the 4 KPIs are:

Agency KPI	M8 Position
Total Agency Spend	The total system agency spend is £21m, which is 82.6% of our planned spend of £27.7m and 54.8% of the annual cap £41.7m In M8, JUCD planned to spend £2.2m on agency staff. The actual spend was £2.9m This is an overspend against the M8 plan of -£700k (YTD overspend of -£3.8m). As of the end of M8, JUCD have reached 82.6% of planned agency spend.
Agency spend as a % of total staff spend	Agency cost amounted to 2.1% of the total pay costs, which is 1.1% under the national target of 3.2%. YTD the position remains below the national target at 2.0%.
% of Off Framework shifts	Significant efforts have been made to eliminate Off-Framework usage and in M8 there were 26 shifts (compared to an average of 120 off-framework shifts at the start of the year), 0.5% total agency shifts. The reasons for M8 use relate to: • 17 shifts relate to 1 WTE Oncology Consultant at UHDB. Notice was served to the agency and the individual is now on-framework since 26 November 2024 • Nursing and Midwifery shifts at DCHS which were 'true break glass' due to clinical demand to provide urgent cover which bank could not fill at short notice. • Healthcare Assistants & Other Support Shifts at DCHS due to the On-Framework HCA not arriving for the shift but support was needed due to increased clinical activity. 3 other on-framework agencies were contacted but could not assist resulting in processes being followed to break glass. • Healthcare Assistants & Other Support Shifts at DHCFT due to human error in the process, the issue has been addressed and a reminder has gone out to all managers. The position continues to be monitored to ensure any future usage is true break glass and by exception.
% Non-price cap compliant shifts	2,187 shifts, which is 44.8% of total agency shifts. The next significant area of focus in the agency reduction programme is on non-price cap compliance reductions; working towards the national requirement to eliminate all non-price cap general nursing shifts by the end of January 2025

	and all specialised nursing by the beginning of April 25. All providers are working with agencies to achieve this.

Actions:

- As well as the plans to hold substantive workforce growth to year end, all Trusts continue to make concerted efforts to reduce agency usage.
- Breakdown of non-contractual pay elements such as waiting list initiatives, overtime, sickness, maternity, study leave, etc, is important in developing the understanding of where such costs are masking the pay-bill position. Discussions are taking place with finance colleagues to undertake this piece of work as the data will need to be extracted through the ledger systems.
- Further work is underway to align the WTE positions to the pay-bill. This includes focusing on temporary staffing usage and associated costs in fragile services. The aim is to identify opportunities for improvements where there may be inappropriate temporary staffing usage and to support the identification of workforce transformation opportunities.

Risks:

- Ongoing re-banding issues (Bands 2 to 3 and potentially other bands) resulting in significant increases in the pay bill.
- Any potential further industrial action, impacting on the pay-bill position, particularly with regards to the ability to significantly reduce the need for temporary staffing which will incur greater costs.
- Increased seasonal workforce sickness levels due to flu, norovirus and covid could further increase bank and agency spend to maintain safe staffing levels.
- Continued increase in UEC demand could further increase temporary staffing costs to maintain patient care and support surge and super surge capacity.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☒
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☒	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

Any other risks are detailed within the report.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

Not applicable to this report.

Project Dependencies						
Completion of Impact Assessments						
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**		
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**		
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**		
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable						
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**		
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable						
Yes ☐	No☐	N/A☒	**Summary:**			
Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:						
Better health outcomes	☒	Improved patient access and experience	☒			
A representative and supported workforce	☒	Inclusive leadership	☒			
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?						
Not applicable to this report.						
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?						
Carbon reduction	☐	Air Pollution	☐	Waste	☐	
Details/Findings Not applicable to this report.						

Derby and Derbyshire Integrated Care Board

Performance Report

January 2025

Dr Chris Clayton ICB Chief Executive Officer
Prof Dean Howells, Chief Nurse Officer
Michelle Arrowsmith, Chief Strategy and Delivery Officer
Claire Finn, Interim Chief Finance Officer
Lee Radford, Chief People Officer

Quality

Prof Dean Howells, Chief Nurse Officer
Dr Deji Okubadejo, Clinical Lead Member

How are we doing?

Derby and Derbyshire Integrated Care Board

The following are noted as headlines

1	DHcFT CQC Inspection report published 11th December 2024. No change to Trusts overall CQC ratings, however ratings for the acute wards for adults of working age and psychiatric intensive care units changed to Requires Improvement Overall and for the domains of Safe and Well Led. Follow up CQC Inspection conducted with no immediate quality concerns.
2	National Ambulance Culture Review: NHS England commissioned an independent review to support improvement of the culture within ambulance services. The review identified six actionable recommendations for improvement with identified actions for a range of stakeholders including NHS England, Integrated Care Systems and Ambulance Trusts. A review of the EMAS position against each of the recommended actions has been undertaken. A People Strategy Delivery Plan has also been developed, and quarterly updates are provided to the Workforce Committee to provide assurance of progress. The first quarterly report was submitted in November 2024.

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

Derby and Derbyshire Integrated Care Board

Key Messages					
	Concern/Issue New or Ongoing and Escalation Level	Programme/Specialty	Organisation/Place/ System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
1	Ongoing Enhanced Surveillance	Safer Maternity Care	Maternity Service	Assurance	UHDB • A CQC reassessment for UHDB is expected early 2025 to review service user and staff experience • Perinatal mortality rates remain below the national average • NHSE and NHS Midlands support continues for the QI work. Work is progressing well with UHDB taking a lead as the offer moves into phase 4. • CNST Maternity Incentive Scheme year 6 compliance is expected to be 9/10 safety actions which is an improvement from 2 in year 5. CRH • CRH have commenced a QI project for Obstetric Anal Sphincter Injury management and Perinatal Pelvic Health Service pathway implementation following a support visit from NHS Midlands perinatal pelvic health lead. • NHS Midlands perinatal team are supporting CRH with QI skills training and a 30/60/90 day support package to be agreed • Sherwood Forest Hospitals Trust and Nottinghamshire LMNS are conducting a peer review in January for 10 stillbirths from August 2023 to September 2024 to provide external assurance. A report will be shared early 2025 on any themes or learning. All cases are being reviewed internally using the NHSE extended perinatal review tool for assurance.
2	Ongoing	Urgent & Emergency Care	System	Reducing Ambulance Handover Delays	• The plan and timeline for the 45-minute handover initiative, developed through the system working group, was approved by the UECC Board and the NHS Executives meeting. • The test week/soft launch for the 45-minute handover initiative at CRH and UHDB (RDH and QHB) was scheduled to run from Monday, 9th December, through to Sunday, 15th December. Initiative was impacted due to a lack of bed/off load capacity at the UHDB ED sites. Category 1 handovers are now prioritised and have noticeably improved • Data monitoring will be conducted by the ICB UEC and EMAS teams, with findings to be shared on Monday, 16th December. • Going forward a more detailed monthly data set will be produced.

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

Derby and Derbyshire Integrated Care Board

Key Messages					
	Concern/Issue New or Ongoing and Escalation Level	Programme/Specialty	Organisation/Place/ System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
3	Ongoing Enhanced Surveillance	IPC	System	As a Derbyshire System at 30/11/2024: • CDI cases YTD for DDICB system are 281 (predicted 61% over threshold). CRH - 40 cases (predicted 20% over threshold) and UHDB 136 cases (predicted 14% over threshold). • MRSA blood stream infections – 13 cases reported against a zero tolerance (CRH 1 VRSA, UHDB 7 MRSA cases) • Number of Gram-negative infections continue to present a stabilising picture with the exception of klebsiella	• UHDB & CRH continue to implement PSIRF methodology for IPC related events eg HCAIs. DCHS are currently reviewing their approach due to low number of incidences • UHDB & CRH remain on enhanced monitoring and support as per the NHSE Midlands IPC escalation matrix. Recovery plans remain in place at both Trusts and assurance obtained relating to the implementation of Trust focused recovery plans is obtained at each Trust's internal IPC Committees, and IPC System Assurance Group. • UHDB have reported an outbreak of MRSA within their Special Care Baby Unit. Weekly Outbreak meetings are overseeing actions. All babies affected remain well and ongoing screening continues to identify any additional cases. • UHDB have reported an incident affecting their renal dialysis unit. A patient returning from overseas was found to be Hepatitis C positive. An incident meeting was convened by the trust and actions are being overseen by this group. No additional patients have been affected to date. • UHDB, CRH and DCHS are reviewing their approaches to introducing universal masking, particularly in the UEC pathways on a daily basis. This will be a risk-based decision which will consider community prevalence, occupancy/acuity in the trust, staff sickness and ability to deliver effective transmission-based precautions.

4		Adult MH In-Patient Wards	DHcFT	Following CQC Inspection in April 2024, regulators-imposed conditions under Section 31 of the Health and Social Care Act 2008. This was with respect to, the assessment or medical treatment for persons detained under the Mental Health Act 1983 and the treatment of disease, disorder, or injury.	• CQC Inspection report published 11th December 2024. No changes to Trusts overall CQC ratings. Ratings - Acute wards for adults of working age and psychiatric intensive care units as follows:
					  • Overall – Requires Improvement
					  • Safe – Requires Improvement
					  • Effective – Good
					  • Caring – Good
					  • Responsive – Good
					  • Well-Led – Requires Improvement
					• CQC Follow up Inspection to Kingsway and Hartington Units conducted 17th December. No immediate quality concerns identified.
					• Section 31 admission restrictions removed.
					• Trust currently still in NoF3.
					• Extraordinary Rapid Review CQRG Meeting held with DDICB DN. Monthly meetings held to monitor progress.
					• DDICB regular attendance at DHcFT Quality & Safeguarding Committee.
					• Monthly DDICB Quality Visits to Radbourne & Hartington Units.
					• Regular NHSE/DDICB Quality Meeting for assurance and information sharing.
					• NHSE IPC team visit identified a number of required actions. Final report received.

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

Derby and Derbyshire Integrated Care Board

LEARNING AND SHARING - best practices, outcomes
National Ambulance Culture Review: NHS England commissioned an independent review to support improvement of the culture within ambulance services. The review identified six actionable recommendations for improvement with identified actions for a range of stakeholders including NHS England, Integrated Care Systems and Ambulance Trusts. The report provides a summary of the anticipated metrics that are likely to be used to measure cultural progression within ambulance services. A review of the EMAS position against each of the recommended actions has been undertaken. A People Strategy Delivery Plan has also been developed, and quarterly updates are provided to the Workforce Committee to provide assurance of progress. The first quarterly report was submitted in November 2024.

Performance

Michelle Arrowsmith, Chief Strategy and Delivery Office
Margaret Gildea, Non-Executive Member

Planning Compliance with Operational Plan – Cancer and Planned Acute Care

NHS Derby and Derbyshire Integrated Care Board

Area	Objective	Level	Actual	Plan	Actual	Plan	actual	plan
			Qtr 1 24/25		Qtr 2 24/25		Oct-24	
Planned Acute Care and Cancer	No person waiting longer than 65 weeks on an RTT pathway at the end September 2024.	CRH	259	177	146	0	119	0
		UHDB	924	436	345	0	236	0
		DDICB	1,050	571	480	0	381	0
	Total RTT incomplete waiting list	CRH	29,173	29,390	28,956	28,701	28,546	28,489
		UHDB	107,470	113,440	107,539	113,055	107,171	111,578
		DDICB	125,944	132,189	124,763	131,204	123,025	130,102
	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	CRH	70%	78%	64%	83%	63.5%	87.5%
		UHDB	75%	81%	76%	83%	79.4%	84.5%
	Total diagnostic waiting list	CRH	7,178	6,121	7,926	6,499	7,918	6,419
		UHDB	22,862	20,306	20,162	21,997	20,481	21,207
		DDICB	27,413	24,693	26,237	26,042	24,703	25,445
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	CRH	76%	77%	71%	75%	74.6%	76.5%
		UHDB	74%	75%	76%	75%	75.0%	75.8%
	Improve performance against the headline 62-day standard to 70% by March 2025	CRH	79%	71%	73%	73%	74.1%	73.6%
		UHDB	65%	59%	70%	62%	69.9%	64.9%

Referral to treatment waiting times

- We have continued to see a small number of 78-week breaches in the system but expect to reach a sustainable zero for Jan-24.
- Both Trusts face risks related to the 65-week target as we approach the new year, with breaches expected into January.
- Risks remain at both Trusts, especially around the impact of Christmas due to capacity and patient choice.

Diagnostic waiting times

- Both trusts are non-compliant with the 6-week performance trajectory, but have plans in place to mitigate risks
- The overall waiting list is higher than plan at CRH and within plan at UHDB.

Cancer waiting times

- Both Trusts had been achieving their plan for 62-day treatment. CRH missed the planned target in August and September but are back on plan in October.
- For the 28-day faster diagnosis target, both trusts fell short of achieving the planned performance in September, October shows an improvement in performance but still below plan.

Cancer, Diagnostics and Planned Acute Care

NHS
Derby and Derbyshire
Integrated Care Board

Issues

- Waiting lists have grown at acute providers and Elective Recovery Fund opportunities need to be maximised.
- As a system we will not be compliant with route to zero for 65weeks by 22/12/2024. Breaches will continue until the new year.
- Diagnostic capacity is lower than expected due to workforce issues.

Performance Requirements	Actions Being Taken, Risks & Mitigations
No person waiting longer than 65 weeks on an RTT pathway by Dec-24	➢ Both Trusts face risks related to the 65-week target as we approach the new year, with breaches expected into January. ➢ Risks remain at both Trusts, especially around the impact of Christmas due to capacity and patient choice. ➢ Development of an elective strategy is needed to support a strategic view to address waiting list growth over the past four years and develop a system approach to managing demand sustainable delivery. ➢ Focus on clearing the 78-week and 65-week RTT breaches, considering the impact of Independent Sector and Mutual Aid spending on performance. ➢ Develop the Waiting Well agenda to validate and manage patients on waiting lists. Progressing work on a Community Gynaecology Model through collaboration with the Women's Health Hub and GP Provider Board ➢ Explore opportunities to develop Advice & Guidance to support the system's Value Weighted Activity and Elective Recovery Fund positions – pending confirmation of ERF in 2025-26. ➢ Implement Getting It Right First Time (GIRFT) productivity plans across trusts, managed through the new Elective Improvement Group. ➢ UHDB remains in Tier Two for elective recovery.
Diagnostics	➢ End-of-year forecast: Both trusts working to deliver the 95% performance position but due to risk level, CRH are also advising of a likely case position of 91%. ➢ Performance challenges in dexa, echo, and audiology due to workforce, capacity, and estates issues. ➢ Regional focus on demand management tools for accurate first-time testing and peer learning for improvement. ➢ System Diagnostics planning workshop next week on endoscopy, audiology, and direct access to diagnostics.
Cancer Waiting Times	➢ Refresh of the Cancer Improvement Group to deliver a system-wide cancer improvement plan aligned with the National Cancer Plan. ➢ Improvement teams at UHDB and CRH are developing diagnostic and treatment pathways to implement the Best Practice Timed Pathways (BPTP) for key tumour sites, aiming for cancer diagnosis within 28 days of referral. ➢ Provider operational recovery and improvement plans are in place to meet Cancer constitutional standards. ➢ Develop strategies to achieve the Long Term Plan Objective of diagnosing 75% of cancers at Stage 1 or 2 by 2028 (currently 53%), including Targeted Lung Health Checks and targeted funding for the Prevention (Health Inequalities) agenda. ➢ Improved performance has led to removal from national tiering. ➢ ICB governance will use EMCA funding to support acute improvement plans, with confirmation to be presented at PHSCC in January.

Planning Compliance with Operational Plan – Urgent and Emergency Care

Derby and Derbyshire Integrated Care Board

Objective	Level	Actual	Plan	Actual	Plan	actual	plan	actual	plan
		Qtr 1 24/25		Qtr 2 24/25		Oct-24		Nov-24	
Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	CRH	65%	70%	62%	72%	57%	73%	58%	74%
	UHDB	66%	70%	65%	72%	63%	72%	62%	70%
	One Medical	100%	100%	100%	100%	100.00%	100%	100%	100%
	DCHS	99%	100%	99%	100%	99%	100%	100%	100%
	DDICB	75%	78%	74%	80%	71%	80%	71%	79%
Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	ICB	00:36:53		00:34:30		00:57:28		00:53:55	
	EMAS	00:35:34	00:30:34	00:36:01	00:24:15	00:58:01	00:35:00	00:56:22	00:33:00
Increase virtual ward capacity.	ICB	168	181	170	181	170	181	165	181
Increase virtual ward utilisation.	ICB	50%	41%	57%	59%	75%	80%	66%	81%
Average general and acute bed occupancy rate (adult & paeds)	CRH	96%	95%	95.8%	95.6%	95.6%	96.5%	96%	98%
	UHDB	94%	92%	93.4%	91.7%	94.3%	93.7%	95%	94%
Percentage of beds occupied by patients no longer meeting the critera to reside - adult	CRH	16%	20%	17%	16%	18%	13%	15%	15%
	UHDB	8%	7%	8%	7%	7%	6%	7%	6%

AE 4-hour performance

Both Acute providers are behind trajectory in delivering the 4-hour target.
Across the Acute ED service, demand has been close to plan in the first 8 months of the year, CRH showing a 1% increase and UHDB on plan.
DDICB YTD performance, April to November, is 73% (Providers included are CRH, UHDB, DCHS and One Medical).

Ilkeston UTC continues to be appointment only 8am until 8pm 7 days a week, plans are in place to work towards a return to both appointments and walk in.

EMAS

For the period Apr – Nov, EMAS has achieved an average performance of 41 mins. The average CAT 2 response time has declined in October (58 mins) and November (56 mins).

General and Acute Beds

Both Acute Trusts have supplied more G&A beds than planned (+17 on average across UHDB and +50 on average at the CRH).
During the period CRH have had average occupancy at 96% and UHDB 95%.

Urgent Care

NHS
Derby and Derbyshire
Integrated Care Board

Performance Requirements	Actions Being Taken, Risks & Mitigations
System Performance – **Seasonal Plan** and **High Impact Interventions**	The **Seasonal Plan** has been shared and highlights include: ➢ Capacity and demand profiling has been undertaken by all organisations; mitigation plans are in place to address any shortfall over winter. This plan details oversight and escalation processes to ensure a collective and dynamic management of risk is in place throughout the winter period. ➢ Trusts have reviewed their general and acute core and escalation bed numbers and this is included as part of the system seasonal plan as well as internal mitigation plans for any areas of pressure. A commitment to maintain fundamental care standards throughout winter has been made and the principles for providing safe and good quality care in temporary escalation spaces will be adhered to. ➢ Organisations have confirmed that there will not be a reduction in the number of General & Acute beds throughout this winter and will maintain the Q4 position of last winter. ➢ Acute Trusts regularly review and test their Full Capacity Plans (FCP). The implementation of the FCP is considered and discussed via their x3 daily operational meetings, and this will continue throughout the winter period. Within these escalation areas, alternative pathways and ways to de-escalate are all considered. As part of Business As Usual, our System Coordination Centre (SCC) commander's seek assurance from Acute colleagues regarding de-escalation plans for any patients in unconventional spaces ensuring this is not normalised. ➢ Individual organisations have reviewed internal triggers and actions. The ICB Urgent & Emergency Care Team are working with partner organisations to refresh the system escalation plan, agreeing thresholds and the arrangements for command and control during heightened pressure. ➢ Demand, and the delivery of plans to create additional capacity, will be tracked and monitored weekly throughout the winter period to ensure system partners have a shared understanding and awareness; and enabling the system to respond dynamically to emerging risk. Delivery of the system UEC Rapid Action Plan will support with preparedness ahead of winter. ➢ The system seasonal plan is under continual review and will change to reflect system plans as they continue to develop. In line with the seasonal plan, the system will conduct scenario stress testing. ➢ The Winter Room is set up and ready to be used by the SCC and UEC team Linking into the Seasonal Plan, we have actions ongoing in line with the **High Impact Interventions**: Specific system High Impact Intervention actions not included in the individual performance requirements for UHDB, CRH or System include: Inflow ➢ Taking opportunities to increase Virtual Ward and Clinical Navigation Hub utilisation, review Same Day Emergency Care models for consistency, and expanding the High Intensity Users project beyond the City. *HII VW.* ➢ Derby and Derbyshire have several admission avoidance pathways to manage patients with complex needs and long-term conditions, providing alternatives to hospital attendance. High Intensity Users are supported within the community to avoid ED and the joint EMAS Paramedic and Mental Health Nurse See and Treat Model will operates daily. *HII SPoA.* Flow ➢ Plans to minimise ED crowding and support timely ambulance releases include specialist in reach, additional senior decision-makers in ED & assessment areas, and support from DHU clinicians for appropriate triage and care settings. *HII In hospital flow.* Outflow ➢ OPTICA system rolled out in both acute hospitals providing real time information on discharge delays. The care transfer hub will work to collate a view of delays for citizens in OOA hospitals. HII Discharge. ➢ There is a Care Transfer Hub working group established to lead the development of one system Care Transfer Hub. The development of this will be an incremental process – with the current hubs operating out of CRH and UHDB continuing to do so until confidence in a new way of working is established. The hub aims to improve equity of access to intermediate care pathways for Derbyshire citizens with one Multi-Disciplinary Team having oversight of all referrals. System partners are represented within the working group. Monthly highlight reports are shared with the Discharge Planning and Improvement Group (DPIG) for monitoring of progress. *HII Care Transfer Hub.* ➢ Providers have internal improvement plans to ensure that discharge processes are as effective as possible. *HII In-Patient Flow* ➢ DCHS and both Acute trusts undertake weekly 'Long Length of Stay' Meetings to identify and address opportunities to improve Length of Stay. ➢ DCHS have regular meetings with Local Authority colleagues to support with onward care. *HII In-Patient Flow* ➢ The ICB also has a Pathways Operations Group (stood up as required) and a Discharge Pathways Improvement group (weekly) that meet regularly. Members include all NHS partners including local authority to streamline the discharge processes and support UEC flow. *HII Discharge.* ➢ Taking opportunities to undertake Multi-Agency Discharge Events (MADE) in community, mental health, and Acute settings. *HII Intermediate Care*

Urgent Care

NHS
Derby and Derbyshire
Integrated Care Board

Performance Requirements	Actions Being Taken, Risks & Mitigations
UHDB 78% within 4 hours	➢ Improving Patient Transport Service workflow requests to avoid delayed/aborted journeys. ➢ Regular internal P78 and Tier 3 meetings with regional and ICB team to review and agree remedial actions. These include: ▪ Reviewing the detailed project plan developed to address performance gaps. ▪ Increased focus on 4 hour breaches by admitted/non-admitted using BI data and tools. ▪ Improvements identified for streaming to assessment areas and in-reach pathways. ▪ Plans to increase Same Day Emergency Care capacity. ▪ Aligned to both the Non-Elective Care Performance Group and the Operational Performance Group for governance, oversight and escalation.
CRH 78% within 4 hours	➢ Same Day Emergency Care (SDEC) pathways –Work underway to increase the activity pushed through to SDEC from ED and UTC daily, Reviewing the benefit of moving SDEC to the front door. *Link to HII SDEC* ➢ Ambulatory Redesign - Increased beds waits and resus activity has adversely impacted on maintaining a flow enhancing staffing profile within Ambulatory. Plans are in place to trial an extra HCA in Triage area to speed up triage of patients. ➢ Urgent Treatment Centre Capacity – Continued embedment of System One to support increased throughput of activity and performance. Daily focus to maximise GP Out Of Hour diversions once UTC closes at 23:00. Discussions taken place with DHU re: maximising all service capacity. ➢ Escalation beds – Reprovision of these beds to temporarily accommodate patients for inpatient wards (Beds identified as being available later) and later discharges from Emergency Medical Unit and Medicine Short Stay. ➢ Overnight breaches – Focussed work continues ensuring the department is on top of the waits in the afternoon and that all patients requiring admission have plans. Thresholds for breaches for evening and overnight are now set and communicated. ➢ Other – Stand up of a weekly Exec-led Taskforce to understand short, medium and longer terms work plan for UEC improvement.
System 78% within 4 hours	➢ Continued integration with Place and Urgent Community Response, through Doing Hubs Once focus on Central Navigation Hubs (CNH), Care Transfer Hubs and Local Navigation Hubs and enhanced frailty/falls provision and automated code sets. Increasing direct referrals from NHS111 and 999 through CNH. ➢ Continuation of clinical call validation through our Clinical Navigation Hub (CNH) SPoA, Right Care First Time. The CNH continues to deflecting >70% CAT 3 & 4 ambulances to alternative appropriate pathways with care closer to home, including Call Before Convey from October 2024. CNH is also deflecting >92% of NHS111 calls with PC Validation to either closure of care, self-care, pharmacy or UTC. CNH to support 45-minute handover plans. *Links to HII & Seasonal Plan* ➢ Call Before Convey Coordination of SPoA (CNH) baseline and first month data completed and submitted to NHSE Midlands (only ICB to complete full data pack in the region). Supporting NHSE and EMAS PDSA with weekly data and case studies. Supporting DHU with crew engagement on scene at RDH and CRH. Discussion with NHSE Midlands on further cohort opportunities care homes, LD and palliative care. ➢ Primary Care Validation DoS enabled in early November for "Speak to 1 hour" and "Contact 2 hours" for 111 online via the Derbyshire In-Hours Primary Care Validation DOS profiles. First system to deliver this. . ➢ NHSE Sprint calls have been taking place weekly with Acutes reviewing performance and actions to deliver P78. ➢ Supporting prevention, improved population health and High Intensity Use scheme continues. ➢ Improving P1 and D2A capacity to ensure speedier discharges. ➢ Improving Acute internal pathways. ➢ Implementation of SHREWD for system-wide monitoring of pressures and improved escalation procedures. ➢ Continue to support Community Same Day Urgent Care . ➢ A project is underway to analyse the causes of the rise in demand.

Urgent Care

Performance Requirements	Actions Being Taken, Risks & Mitigations
NHS 111/DHU	➢ Continuation of NHS111 good performance ➢ Undertake a review on the number of ED referrals
45-minute handover process	➢ All system partners have committed to supporting this initiative and its implementation of the regional 45-minute Handover initiative, with dynamic risk assessment to ensure timely ambulance releases and shared system risk. The system plan is currently in development. *Summary: Ambulance crews to transfer the patient into ED by a maximum 45 minutes after arrival if not off loaded with crew having done handover with ED team. Links to HII.*

Planning Compliance with Operational Plan – Mental Health, Autism and Learning Disabilities

NHS Derby and Derbyshire Integrated Care Board

Objective	Level	Actual	Plan	Actual	Plan	actual	plan
		Qtr 1 24/25		Qtr 2 24/25		Oct-24	
Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025	ICB	68%	68%	68%	68%	69%	68%
Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	ICB	59%	68%	58%	69%		Quarterly Target
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement	ICB	70.1%	68.5%	69.3%	66.8%	68.5%	66.1%
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 48% achieving reliable recovery	ICB	49.0%	51.0%	48.7%	49.3%	48.0%	48.6%
Increase the number of people accessing transformed models of adult community mental health in 2024/25 (Quarterly Target).	ICB	12,040	7,984	12,505	8,131		Quarterly Target
Increase the number of women accessing specialist perinatal services in 2024/25 (12 month rolling).	ICB	1,200	1,111	1,240	1,111	1,280	1,111
Increase the number of children and young people accessing a mental health service in 2024/25 (12 month rolling).	ICB	14,435	13,600	14,465	13,565	14,480	13,700
Ensure that 75% of individuals listed on GP registers as having a learning disability will receive annual health check (Quarterly Target).	ICB	10%	12%	14%	13%	6%	Quarterly Target
Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults for every 1 million population	DHCFT	31	34	30	32	30	Quarterly Target
Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 12–15 under 18s for every 1 million population	DHCFT	3	3	4	3	4	Quarterly Target
Reduce out of area placements - National Data	ICB	10	26	10	26	15	24
Reduce out of area placements - Local Data	DHcFT	21	26	19	26	37	24

Most of the performance trajectories in the 24/25 plan had assumed maintenance of 23/24 performance levels.
There are challenges in achieving the SMI health check target and the Commissioning team is working jointly with Public Health colleagues to look at next steps to improve the position.
While the talking therapies reliable recovery is slightly under the planned performance percentage, in activity terms, actual activity is significantly higher than planned and the national 48% target has been achieved.

The national reporting of Inappropriate Out Of Area Placements is being investigated to ensure accuracy, in the interim the DHcFT local position is included.
An uptick has been noticed from October 2024 (local reporting is showing 46 for November). DDICB and DHcFT will agree a revised OAP Recovery Action Plan, to be submitted to NHSE by 18 December 2024.

Mental Health

Derby and Derbyshire Integrated Care Board

Area	Performance Requirements	Actions Being Taken, Risks & Mitigations
Adult MH Community Services	Talking Therapies Increase in access	➢ Procurement exercise for a new contract beyond 1 July 2025 is currently live. Decision-making due to be concluded shortly followed by standstill period. ➢ ICB TT oversight group are overseeing a number of priority issues relating to Talking Therapies including quality, performance, and the transition to new contracting arrangements to mitigate risks. ➢ Focus on quality measures through above structure will include understanding of excessive time lags between 1st and 2nd treatments (over 90 days). Work with providers to understand the issues and risks for patients is ongoing.
	Recover dementia diagnosis rate to 66.7%	➢ Considering the impact of the new Disease modifying treatments on the service. ➢ New dementia strategy should be ready by February 2025. ➢ The Dementia Palliative Care service is working to integrate knowledge and skills with community nursing services.
	Improve Access to Perinatal Services	➢ Agreed CPN Job Plans and introduction of the Specialist Assessor Role within the North Team. ➢ Additional assessment clinics continue to be offered with inpatient staff supporting.
	Community MH Services increase in access	➢ All sites have now mobilised Phase One of the Living Well CMHF Transformation. The Living well social care workforce has been af=greed across 2024/25 and 25/26.
	SMI Annual Health Checks increase in access	➢ The Health Positive Pilot is operational – to date 875 patients have been contracted and 135 APHCs delivered. This has resulted in 67 new conditions being diagnosed and treatment being offered. To date 43 supported vaccination appointments have been carried out. ➢ SMI APHC Strategic Group to consider the actions suggested by NHSE to improve performance measures.
Adult MH Urgent Care Services	Reduction in use of Out of Area Placements	➢ Making Room for Dignity programme which is aimed at providing PICU provision in Derbyshire and improving inpatient environments. This will enable patients to be admitted to an appropriate unit of care within the patient's usual local network of services in a location which helps the patient retain contact with carers, family and friends; maintaining familiarity as much possible within their local area. ➢ A PICU provision in Derbyshire should improved flow, admission capacity in adult acute inpatients, enabling associated community teams to work closely with the inpatient team, creating capacity to repatriate PICU patients when appropriate to do so and further resulting in a potential reduction for the requirement of psychiatric intensive care. ➢ A Transformational Delivery Board is in place to oversee the workstreams making changes to impact patient flow. These cover a range of issues both within the community and inpatient areas. Some of these are longer standing whereas others are informed by the recent MADE event. The action plan is available separately. ➢ There has been an uptick in inappropriate OAP since October 2024. A revised RAP will be submitted jointly agreed by DHCFT and DDICB to NHSE by 18 December 2024.

Learning Disabilities and Autism

Derby and Derbyshire Integrated Care Board

Area	Performance Requirements	Actions being taken, Risks & Mitigations
Children & Young Peoples Services	CYP Increase in Access	➢ Commissioners have completed an ARFID project review outlining progress to date and current barriers. This will be escalated to key decision makers to determine a way forward with the pathway. Concerns over capacity in dietetic services within community and acute health teams has also been escalated to head of children's physical health commissioning. ➢ Clinicians from across DHcFT, CRHFT and UHDB are now meeting to outline a pathway for CYP with disordered eating presentations. This aim is to develop a more coordinated, timely response for this cohort, improving access, experience and outcomes. The view is to dovetail this and the ARFID work through the remainder of 24/25. ➢ Adult medical monitoring data has been made available for modelling and earlier CYP data has been verified to allow the LES to progress to Primary Care review.
Inpatient services	Number of adults in ICB commissioned beds	➢ There has been an admission reported within ICB commissioned beds however plans are in place for discharges to keep to the inpatient trajectory
	Number of adults in Secure inpatient care	➢ The Secure inpatient admissions have been increasing, this increase has been seen nationally and regionally. The commissioning team are working with ND Alliance colleagues to manage the future discharges accordingly.
	Number of CYP In Specialised /secure inpatient care	➢ There has been 1 CYP above target admission, however there are two CYP on S117 leave, with an imminent discharge pending. System will continue with recovery action plan approach to performance management and assurance for 24/25.
Reduction in health inequalities	Number of annual health checks	➢ Primary Care are working with the ICB Digital Lead to resolve ongoing coding challenges with TPP System 1. They're unable to remove incorrect LD codes from GP records if they're added by another organisation that no longer exists or does not respond to request to remove code. This is falsely inflating the LD QOF list and impacting the Investment & Impact funding. An interim solution for cleansing the data has been agreed by the GP clinical lead, signed off at Delivery Board and has had oversight from NHSE.
LeDeR Program	Achievement of LeDeR timescales & standards	➢ A request was made for volunteer LeDeR Reviewers, but no offers were made. Funding for external reviewers has now been spent. ➢ These have been escalated to LeDeR Steering Group/Governance Panel and Mental Health Delivery Board. ➢ A paper has been prepared for ICB Executive Team Meeting.

Planning Compliance with Operational Plan – Primary and Community Care

Derby and Derbyshire Integrated Care Board

Objective	Level	Actual	Plan	Actual	Plan	actual	plan
		Qtr 1 24/25		Qtr 2 24/25		Oct-24	
Increase General Practice appointment activity	ICB	1,706,118	1,579,396	1,722,370	1,721,539	773,189	684,853
% of appointments delivered on same day	ICB	41%		41%		33%	0%
% of appointments delivered within 2 weeks	ICB	75.5%	75%	75%	75%	66%	75%
Increase dental activity - improving units of dental activity (UDAs) towards pre-pandemic levels	ICB	274,827	381,960	607,341	763,920	*743,408*	Quarterly Target
Community Waiting List - Over 52 Weeks	ICB	2,281	2,226	2,885	2,247	2,804	Quarterly Target
Community Waiting List - total size	ICB	25,510		25,626		25,202	

GP Appointments

The 2024/25 plan assumed that General Practice would deliver the same level of appointments as in the previous year. At the end of October 2024, the activity is 5% above plan.
In October there has been a notable increase (approx. 35% for DDICB) in the volume of appointments recorded (nationally it is an increase of 30%).
This has been raised with NHS Digital, who have confirmed October has seen the highest number of appointments ever recorded and while they are unable to identify flu vaccinations within GPAD data it is believed this is the likely explanation.

Community Services Waiting Times

At the end of October 2024, the number of 52 weeks waits is tracking higher than plan.
The 2024/25 plan did assume that the number of 52+ week waits would be higher at the end of the year than the start – due to the known issue about tier 3 weight management. However, Community Paediatrics are also tracking much higher than plan, the plan was a consistent 923 through the year but by October the actual waiting list has reached 1,401. The team is currently revisiting the work plans although this area is recognised to be a significant challenge nationally.

Primary Care/Dental Recovery Plan Update

Derby and Derbyshire Integrated Care Board

Performance Requirements/Theme	Actions Being Taken, Risks & Mitigations:
Primary Care Access Recovery Plan 24/25	➢ Primary Care Access Recovery Plan work is on target and a summary of the initiatives and their progress was presented to the ICB Board in November 2024. ➢ DDICB is in discussion with the Regional Deputy Medical Director to try and progress access to patient records for those practices who remain concerned about clinical safety and legal risk. ➢ We are combining work on the Primary Care Access Recovery Plan with the new GP clinical model which has been developed by General Practice and agreed by the ICB. Both of these aim to develop a sustainable model that will improve access for the long term. ➢ As of Month 7 there is a forecasted position of 93% spend against the ARRS budget for 24/25. ➢ We have approved 5 new direct patient care roles under ARRS (Interpreter, Care Navigator, Health Care Assistant, Senior Pharmacy Technician and Pharmacist Clinical Lead. We have also recruited to 7 GP ARRS posts ➢ Previously, the ARRS allocation for each PCN has significantly increased each financial year. However, for 2024/25 allocations have only increased by 2.2%. NHSE have advised that any PCN forecasted to spend 98% of their budget will be under pressure to pay the uplift for the remaining six months of the contract. In Derbyshire there are four PCNs forecasted to spend 98% or more of their ARRS allocation. This is creating inequity of pay across staff employed in general practice and individual PCNs. Some PCNs may be at risk of losing staff to other networks that can afford to pay the uplift or PCNs may have to make redundancies in order to pay the uplift to remaining staff.
Primary Care – Dental Commissioning	➢ The Derbyshire Oral Health Needs Assessment is now finalised. We are using it to inform our plans to improve access, particularly our 3 year plan. East Midlands Dental Commissioning Principles have been developed and agreed by the East Midlands Joint Commissioning Group ➢ Draft Dental Commissioning 3 year Plans have been developed and is due to have final sign off by system Executives week commencing 16th December 2024. The plan focusses on areas of greatest need, areas where access is particularly poor, and key cohorts of patients who have specific issues accessing services. ➢ We have implemented the national dental recovery plan for 24/5, including uplifting UDA rates and new patient premiums ➢ We are awaiting national guidance following the Government's announcement to provide an additional 700,000 urgent dental appointments however in the meantime have been going out to our dental workforce with Expressions of interest in providing additional urgent provision in-year. ➢ We are planning to utilise the non-recurrent investment for 24/5 whilst longer term plans are finalised and implemented e.g. 110% over performance, increased commissioning of urgent care dentistry and the development of a dental service for people living in care homes. ➢ We held in early December, a Dental Summit bringing together stakeholders and partners across JUCD to understand the current position, identify gaps and ultimately have a shared vision for the future; with an emphasis on "Oral Health" as this is wider than purely Dentistry.

Constitutional Standards – Urgent Care

Derby and Derbyshire Integrated Care Board

ICB Dashboard for NHS Constitution Indicators					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
					NHS Derby & Derbyshire ICB				Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England		
Urgent Care	Area	Indicator Name	Standard	Latest Period													
	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	76%	Nov-24	↑	74.1%	75.0%	7	78.1%	76.3%	0	72.6%	74.5%	7	72.1%	74.2%	110
		A&E 12 Hour Trolley Waits	0	Nov-24					192	1019	52	1228	7413	32	45791	322302	52

EMAS Dashboard for Ambulance Performance Indicators				Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25	Current Month	YTD	consecutive months non-compliance
				East Midlands Ambulance Service Performance (NHSD&DICB only - National Performance Measure)				EMAS Performance (Whole Organisation)			EMAS Completed Quarterly Performance 2024/25				NHS England		
Area	Indicator Name	Standard	Latest Period														
Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Sep-24		00:00:00	00:09:03		00:09:37	00:09:11	52	00:09:02	00:09:02			00:08:38	00:08:21	43
	Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Sep-24		00:00:00	00:15:34		00:17:02	00:16:10	9	00:15:58	00:15:54			00:15:22	00:14:52	2
	Ambulance - Category 2 - Average Response Time	00:18:00	Sep-24		00:00:00	00:35:42		00:56:22	00:41:13	53	00:35:42	00:36:09			00:42:26	00:34:55	52
	Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Sep-24		00:00:00	01:13:57		01:58:27	01:26:39	52	01:15:05	01:16:10			01:30:47	01:13:58	44
	Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Sep-24		00:00:00	05:41:34		09:33:10	06:26:33	52	05:20:47	05:23:13			06:32:23	04:59:41	44
	Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Sep-24		00:00:00	04:31:21		13:52:44	06:33:42	44	04:06:36	04:53:55			07:31:42	05:40:38	44

Key:			
	Performance Meeting Target	Performance Improved From Previous Period	↑
	Performance Not Meeting Target	Performance Maintained From Previous Period	→
	Indicator not applicable to organisation	Performance Deteriorated From Previous Period	↓

Constitutional Standards – Planned Care & Cancer

Derby and Derbyshire Integrated Care Board

Key:			
	Performance Meeting Target	Performance Improved From Previous Period	↑
	Performance Not Meeting Target	Performance Maintained From Previous Period	→
	Indicator not applicable to organisation	Performance Deteriorated From Previous Period	↓

ICB Dashboard for NHS Constitution Indicators					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Planned Care	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Oct-24	↑	58.5%	57.4%	81	56.5%	54.4%	66	54.1%	54.1%	82	58.9%	58.7%	104
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-24	↑	3924	34886	57	1268	9437	55	3366	28864	56	234885	1970000	210
		Number of 78 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-24	↔	19	131	43	10	8	2	8	68	43	2446	23453	43
		Number of 104 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-24	↔	0	3	0	0	1	0	0	2	0	148	1146	43
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Oct-24	↓	27.05%	27.95%	77	36.02%	33.56%	55	20.97%	23.61%	56	20.69%	22.52%	134
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of All Referrals	75%	Oct-24	↑	74.2%	74.3%	2	72.1%	73.5%	1	76.1%	75.0%	0	73.5%	75.7%	1
	31 Days Cancer Waits	First & Subsequent Treatments Administered Within 31 Days Of Decision To Treat	96%	Oct-24	↑	91.2%	88.3%	28	94.7%	94.4%	4	92.3%	87.4%	28	91.5%	91.1%	28
	62 Days Cancer Waits	First Definitive Treatment Administered Within 62 Days Of All Referrals	85%	Oct-24	↑	70.0%	68.2%	28	74.1%	75.5%	28	69.9%	67.8%	28	67.3%	67.3%	27

Mental Health Scorecard

Derby and Derbyshire Integrated Care Board

Pathway	Indicator	Target	ICB Actual	National Benchmark	Latest period	Provider Breakdown										RAP Date Agreed	RAP Recovery Date
						DHcFT	DCHS	CRH	Everyturn	Trent	Vita	UHDBFT	Action for Children (Build Sound Minds)	Compass	Kooth		
NHS Talking Therapies (IAPT)	Reliable Recovery rate (E.A.4a)	48.6%	48.0%	47.1%	Oct-24	42%			55%	49%	52%						
	Reliable improvement rate (E.A.4b)	66.1%	69.0%	67.4%	Oct-24	64%			75%	69%	71%						
	Waiting times - 6 weeks	75%	89%	92.0%	Oct-24	92%			69%	93%	92%						
	Waiting times - 18 weeks	95%	100%	99.0%	Oct-24	100.0%			100%	100%	100%						
	1st to 2nd treatment >90 days	10%	23%	24.9%	Oct-24	53%			50%	*	61%						
	Reliable Recovery Rate - White	48%	49%	49%	Q2 24/25												
	Reliable Recovery Rate - BAME	48%	46%	44%	Q2 24/25												
CYP Community	Access - 1+ Contact (E.H.9)	13,700	14,480		Oct-24	3,280		1,875				2,305	2,000	3,185	1,195		
CYP Eating Disorder	Waiting Time - Urgent - 1 week *	95.0%	100%		Sep-24	100.0%											
	Waiting Time - Routine - 4 weeks *	95.0%	100%		Sep-24	100.0%											
Dementia	Diagnosis Rate (E.A.S1)	68.4%	68.8%	65.7%	Oct-24												
Perinatal	Access Rate (rolling 12 months)	10.0%	11.4%	8.5%	Sep-24	11.4%											
Perinatal and Maternal Mental Health Services	12-month rolling access number (E.H.15)	1,111	1,280		Oct-24	1,280										✓	***
EIP	2 week waits	60%	83.0%	72.4%	Sep-24	81.0%											

* Unvalidated, provisional data

Please note:

- Indicators that can't be updated this month due to the data being unavailable nationally are shown by having *red text* in the 'Indicator' and 'Latest period' columns.
- Blank cells show data items that are still being sourced.Grey cells show data items that are not relevant due to that service not being provided by that provider, no agreed target or no national benchmark.

Data Source

Derby and Derbyshire Integrated Care Board

Area	Objective	Data Source
Primary and Community Care	Increase General Practice appointment activity	Appointments in General Practice - NHS England Digital
	% of appointments delivered on same day	
	% of appointments delivered within 2 weeks	
	Increase dental activity - improving units of dental activity (UDAs) towards pre-pandemic levels	eDEN Dental data via NHSBSA
	Community Waiting List - Over 52 Weeks	Statistics » Community Health Services Waiting Lists (england.nhs.uk)
	Community Waiting List - total size	
Mental Health, Autism & Learning Disabilities	Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025	https://future.nhs.uk/MHRH/view?objectID=43647696
	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	https://www.england.nhs.uk/statistics/statistical-work-areas/serious-mental-illness-smi/
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement	https://digital.nhs.uk/data-and-information/publications/statistical/nhs-talking-therapies-monthly-statistics-including-employment-advisors
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 48% achieving reliable recovery	
	Increase the number of people accessing transformed models of adult community mental health in 2024/25 (Quarterly Target).	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set
	Increase the number of women accessing specialist perinatal services in 2024/25 (12 month rolling).	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set
	Increase the number of children and young people accessing a mental health service in 2024/25 (12 month rolling).	https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics
	Ensure that 75% of individuals listed on GP registers as having a learning disability will receive annual health check (Quarterly Target).	https://digital.nhs.uk/data-and-information/publications/statistical/learning-disabilities-health-check-scheme
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults for every 1 million population	Local data used from DHcFT
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 12–15 under 18s for every 1 million population	
	Reduce out of area placements	https://future.nhs.uk/MHRH/view?objectID=26200112
Planned Acute Care and Cancer	No person waiting longer than 65 weeks on an RTT pathway at the end September 2024.	https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
	Total RTT incomplete waiting list	
	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
	Total diagnostic waiting list	
	Value Weighted Activity relative to 19/20 base	https://future.nhs.uk/NHSEPaymentsystemsupport/groupHome
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	Data from the CWT-Db on a monthly and quarterly basis.
	Improve performance against the headline 62-day standard to 70% by March 2025	
Urgent and Emergency Care	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fstatistics%2Fstatistical-work-areas%2Fae-waiting-times-and-activity%2F&data=05%7C01%7Cmatt.whitston%40nhs.net%7C77d55a7e84d54e8d9ec008daf21af378%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638088494801862708%7CUnknown%7CTWFp
	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	Local Data https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators).
	Increase virtual ward capacity.	Foundry (Virtual Ward Dashboard)
	Increase virtual ward utilisation.	
	Average general and acute bed occupancy rate	Statistics - NHS England - Critical care and General & Acute Beds – Urgent and Emergency Care Daily Situation Reports 2023-24
	Percentage of beds occupied by patients no longer meeting the critera to reside - adult	Statistics » Discharge delays (Acute) (england.nhs.uk)

Finance

Claire Finn, Interim Chief Finance Officer
Jill Dentith, Non-Executive Member

Month 8 System Finance Summary – Financial Position

Derby and Derbyshire Integrated Care Board

JUCD submitted a financial plan to deliver a deficit of £50m, in line with the Revenue Financial Plan Limit set for the ICS. £50m Non-recurrent Revenue Deficit Support funding was received in M06 resulting in a revision to the plan and a new breakeven position for the year.

At M08 the system is reporting a year-to-date adverse variance of £4.3m (22.1%) against the YTD planned deficit of £19.3m.

Key driver of the year-to-date financial position is Urgent and Emergency Care Demand pressures with £5.7m of unplanned cost year to date attributed to the continued reliance on escalated beds at UHDB. Total UEC costs are significantly higher than this, however these have been mitigated within organisational positions.

All organisations remain committed to supporting the system to deliver the updated overall breakeven plan by the end of the year. This may result in variances across organisations upon outturn to achieve an overall delivery of plan.

Organisation	YTD Plan £'m	YTD Actual £'m	Variance £'m	Variance %	Full Year plan £'m	Forecast Outturn £'m	Forecast Outturn Variance £'m
ICB	9.7	9.8	0.1	0.8%	23.8	23.8	(0.0)
CRH	(4.1)	(5.9)	(1.8)	(43.8%)	(5.0)	(5.0)	0.0
DCHS	(1.2)	(0.5)	0.8	61.8%	(0.0)	0.0	(0.0)
DHcFT	(5.2)	(3.2)	2.1	39.5%	(6.4)	(6.4)	(0.0)
EMAS	2.1	1.5	(0.5)	(25.9%)	0.0	0.0	0.0
UHDB	(20.5)	(25.3)	(4.8)	(23.6%)	(12.4)	(12.4)	0.0
JUCD ICS Surplus/ (Deficit)	**(19.3)**	**(23.6)**	**(4.3)**	**(22.1%)**	**(0.0)**	**(0.0)**	**0.0**

Month 8 System Finance Summary – Efficiencies

NHS
Derby and Derbyshire
Integrated Care Board

The system is £3.3m behind the planned £94.2m to date. The annual efficiency plan is to deliver £169.7m. All organisations are forecasting to achieve their full efficiency targets by the end of the year.

Efficiency plans are weighted towards the end of the financial year. At M08 only 55% has been planned to be delivered rather than 67% on a straight-line basis.

The level of recurrent efficiencies is behind plan to date with 49% delivered recurrently against the planned 61%. This puts pressure on future financial years.

Organisation	YTD Plan £'m	YTD Actual £'m	Variance £'m	Full Year plan £'m	Recurrent YTD Actual £'m	Non-Recurrent YTD Actual £'m	Total YTD Actual £'m
ICB	24.9	24.9	(0.0)	47.0	18.9	6.0	24.9
CRH	9.6	7.1	(2.5)	19.8	3.0	4.1	7.1
DCHS	6.2	6.3	0.1	11.6	2.7	3.7	6.3
DHcFT	7.8	8.0	0.2	12.5	3.9	4.0	8.0
EMAS	10.7	9.6	(1.1)	16.1	6.4	3.2	9.6
UHDB	35.1	35.1	(0.0)	62.7	9.8	25.3	35.1
JUCD Total	**94.2**	**91.0**	**(3.3)**	**169.7**	**44.6**	**46.4**	**91.0**

Month 8 System Finance Summary – Capital

Derby and Derbyshire Integrated Care Board

At month 8 the year to date spend is £13.8m behind plan, largely resulting from the timing of major construction projects and schemes which have not commenced as planned.

Boards were asked to provide assurance that capital forecasts will be delivered in line with allocation as part of M8 reporting. JUCD have been unable to provide this assurance, the most significant pressure is due to eradication of dormitories which is forecasting circa £5m overspend.

Work is in progress to fully quantify risks in relation to the capital programme and identify mitigations for these risks. If providers are unable to identify further underspends to manage the system forecast deficit to zero, provider control totals may be imposed.

	Year to Date			Full Year			
	Original Plan £m	Actual £m	Variance £m	Original Plan £m	Revised Allocation £m	Forecast £m	Variance £m
ICB	-	-	-	1.8	1.8	1.6	0.2
CRH	4.0	2.2	1.9	7.4	12.0	12.0	- 0.0
DCHS	15.3	9.7	5.7	19.0	19.8	18.8	1.0
DHcFT	7.0	6.0	1.0	9.2	9.2	14.4	- 5.2
EMAS	2.1	3.2	- 1.1	22.0	13.8	13.9	- 0.1
UHDB	24.3	17.9	6.4	107.3	81.2	80.5	0.6
TOTAL Fore	**52.8**	**38.9**	**13.8**	**166.7**	**137.7**	**141.2**	**- 3.5**

Month 8 System Finance Summary – Cash

Derby and Derbyshire Integrated Care Board

The cash balances at month 8 include £16.8m held for capital commitments.

The revenue deficit support funding received in M06 has been allocated across the system according to cash need and has therefore reduced the requirement for additional cash support at CRH and UHDB

The in-year cash flows for all organisations will be significantly impacted if the expected cash-releasing efficiencies are not delivered.

Organisation	November 2024 Cash Balance Net of Subsidiaries £'m
Chesterfield Royal Hospital NHSFT	29.9
Derbyshire Community Health Services NHSFT	26.1
Derbyshire Healthcare NHSFT	34.4
East Midlands Ambulance Service NHS Trust	13.3
University Hospitals of Derby and Burton NHSFT	19.5
Derby and Derbyshire ICS Total	**123.3**

Workforce

Lee Radford, ICB Chief People Officer
Margaret Gildea, Non-Executive Member

2024/25 Workforce Plan Position Month 8 (NHS Foundation Trusts including EMAS)

Derby and Derbyshire Integrated Care Board

ICB Total	Reporting Period: Nov-24					
	Month 8			Trend		
	Plan	Actual	Variance From Plan	Previous Month	Actual - Direction of Change from Previous Month	Actual - Trend (Previous 12 Months)
Workforce						
Total Workforce (WTE)	30,511.85	30,404.23	-107.62	30,278.05	↑	
Substantive (WTE)	28,767.49	28,623.46	-144.03	28,536.94	↑	
Bank (WTE)	1,485.64	1,511.51	25.87	1,482.49	↑	
Agency (WTE)	258.72	269.26	10.54	258.62	↑	
Pay Cost						
Pay Cost (£'000)	138,274	140,804	2,530	167,925	↓	

- The total workforce across all areas (substantive, Bank and Agency) was **107.62 WTE below plan.**
- Whilst the net position is below plan, there are some areas that are slightly above plan. See slides 8 and 9 for further details and Provider narratives to explain the positions.
- Compared to M7, there was an increase in substantive positions (86.52 WTE), Bank (29.02 WTE) and Agency usage (10.64 WTE). The increase in substantive positions was from Registered Nursing, Midwifery and Health Visiting (63.54 WTE), Registered/Qualified Scientific, Therapeutic and Technical (45.73 WTE) and Medical and Dental (17.64 WTE). Whereas there were decreases in Support to Clinical (23.78 WTE) and NHS Infrastructure Support (16.61 WTE).

2024/25 Workforce Plan Position M8: Provider Summary

2024/25		M8 Plan	M8 Actual	Variance from plan
ICB	Workforce (WTE)			
	Total Workforce	30,511.85	30,404.23	-107.62
	Substantive	28,767.49	28,623.46	-144.03
	Bank	1,485.64	1,511.51	25.87
	Agency	258.72	269.26	10.54
	Cost (£)			
	Pay Cost (£'000) ^	£138,274	£140,804	£2,530
CRH	Workforce (WTE)			
	Total Workforce	4,993.24	5,025.37	32.13
	Substantive	4,593.61	4,656.83	63.22
	Bank	302.86	283.29	-19.57
	Agency	96.77	85.25	-11.52
	Cost (£)			
	Pay Cost (£'000) ^	£21,999	£23,022	£1,023
DCHS	Workforce (WTE)			
	Total Workforce	3,833.32	3,942.74	109.42
	Substantive	3,710.73	3,797.43	86.70
	Bank	95.16	110.09	14.93
	Agency	27.43	35.22	7.79
	Cost (£)			
	Pay Cost (£'000) ^	£14,837	£15,010	£173
DHcFT	Workforce (WTE)			
	Total Workforce	3,359.94	3,216.83	-143.11
	Substantive	3,159.17	3,021.23	-137.94
	Bank	164.16	176.69	12.53
	Agency	36.61	18.91	-17.70
	Cost (£)			
	Pay Cost (£'000) ^	£14,983	£14,306	-£676
EMAS	Workforce (WTE)			
	Total Workforce	4,489.66	4,434.05	-55.61
	Substantive	4,416.00	4,353.99	-62.01
	Bank	52.66	56.22	3.56
	Agency	21.00	23.84	2.84
	Cost (£)			
	Pay Cost (£'000) ^	£19,548	£18,887	-£661
UHDB	Workforce (WTE)			
	Total Workforce	13,835.69	13,785.24	-50.45
	Substantive	12,887.98	12,793.98	-94.00
	Bank	870.80	885.22	14.42
	Agency	76.91	106.04	29.13
	Cost (£)			
	Pay Cost (£'000) ^	£66,907	£69,578	£2,671

- The total system position is 107.62WTE below the M8 plan. Despite there being a below plan total WTE position, the M8 pay position is showing a -£2.5m overspend.
- CRH were above plan on the substantive WTEs by 63.22WTE but below plan on both Bank and Agency.
- DCHS were above plan in all areas, with an associated marginal overspend against the pay-bill plan.
- Both DHcFT and EMAS were below the planned total WTE positions and pay-spend position for M8.
- UHDB continued to be below the planned substantive WTEs but above planned Bank and Agency WTEs, with an associated pay-bill overspend of -£2.7m
- See slides 5-6 for additional details.

2024/25 Workforce Plan Position M8: Provider Narratives

NHS Derby and Derbyshire Integrated Care Board

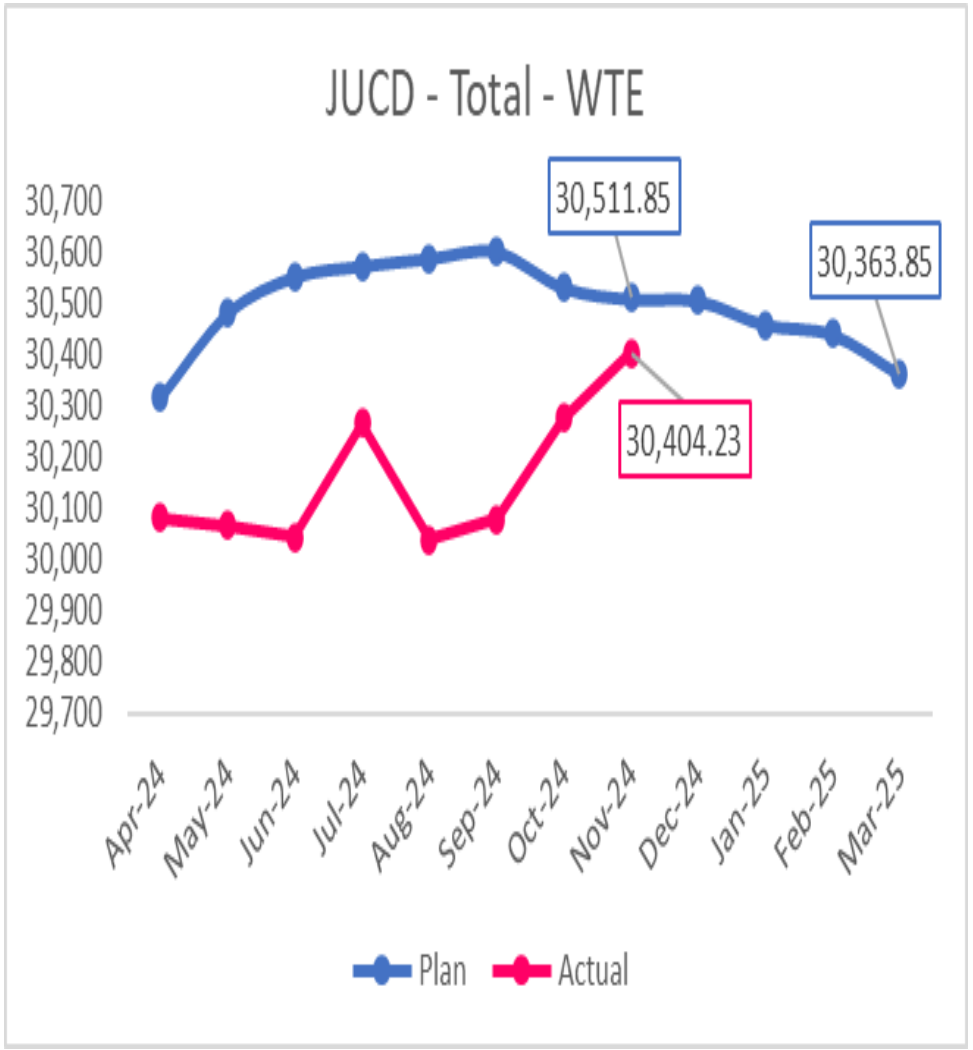
Organisation	M8 Narrative	Actions	FOT	Risks	Service Specific Issues
CRH	• Substantive increase - newly qualified nurses & midwives. Corresponding decrease in nursing Bank • Increase in registered ST&T Agency due to recruitment issues and available workforce. • Increase in medical Agency due to acuity/clinical demand. • Bank and Agency remain below plan, with Agency % at lowest this year • Drift to plan is due to unrealised workforce CIP, acuity, activity including surge capacity, recruitment to vacancies, additional resident doctors as mandated by NHSE and LTFT resident doctors to mitigate the need for temporary staffing.	• Training roles in place to support staffing and mitigate requirement for temporary staffing. • Continue with workforce controls • Focus on medical workforce through EMAP rate card • Continue to explore international recruitment into specialities • Continue focused work on long term sickness	Similar to M8, difference will be in balance between substantive, Bank and Agency in effort to reduce premium pay costs.	• Impacts on staff morale and wellbeing • Biggest risk is loss of staff engagement and loss of focus of workforce as people and our colleagues, including resilience of leaders due to heighten pressure and risk. • UEC, Theatres, surge capacity, ability to deliver CIP.	• ED, UEC pathways, Theatres, Gen Med (medics), midwifery, Paeds • Difficulties to recruiting to CDC expansion posts in cardio respiratory
DCHS	• The plan has been updated to reflect 16.62wte TUPE on the infrastructure workforce from DCHS to DHcFT and planned TUPE from DHcFT approx. 10 – 15 WTE. (M1 growth of 135wte due to TUPE service from DCC) • Good triangulation between WTE and pay costs • Impact of backloaded CIP contributing to wte increase. • Overall vacancy rate 5.65% • Staff turnover 9.29%	• Continued focus on recurrent CIP. • Working with national team to standardise costs across midlands • Target dates to stop paying over cap – January 25 for general nursing and March 2025 for specialist nursing • Reducing sickness absence: Increase focus and reporting, earlier intervention around longer-term absence – absence remains above regional average. • UTC recovery plan is in place and is reliant on successful recruitment and improving absence	• Total WF nos. will remain broadly as at M7 with some potential movement between increased substantive nos. with corresponding reduction in Bank and/or Agency. • Forecast on current run rate suggests will end the year broadly to FYE of plan • M12 numbers likely to be around c.80-90fte higher than M12 plan making 25/26 incredibly challenging	• Impacts on staff morale and wellbeing • Fragility of UTCs • Cost pressure of Afc pay uplift on Public Health commissioned services and gap to public health grant uplift c.2-3%. • Sustained high absence both at Trust level and very high in some local teams • Sustained pressure on Community Teams [OPEL 3/4], • Unknown impact of GP industrial action, • Impact of NR vacancy savings on teams, • Impact on engagement from cost control actions e.g. No annual leave carryover [one off provision will support 24/25 out-turn] • Agency risk associated with UTC staffing challenges. • Continued use of over cap agencies whilst we work through with regional and local teams to mitigate • Spend on Bank and Agency, mostly associated with UTCs which is anticipated to be ongoing whilst working through mitigation plans. • Not hitting WTE CIPs in 24/25, next year presents a bigger planned reduction and recurrent CIPs plus new CIPs in 2025/2026 (Darzi shifting care into the community impacts). Pay-bill position is a controlled risk for 24/25. Recurrent risk into 25/26. • No provision made for additional staffing or costs for winter	• UTCs are biggest risk as fragile service - ACPs biggest staffing group risk (leave to DHU – preferential pay rates)

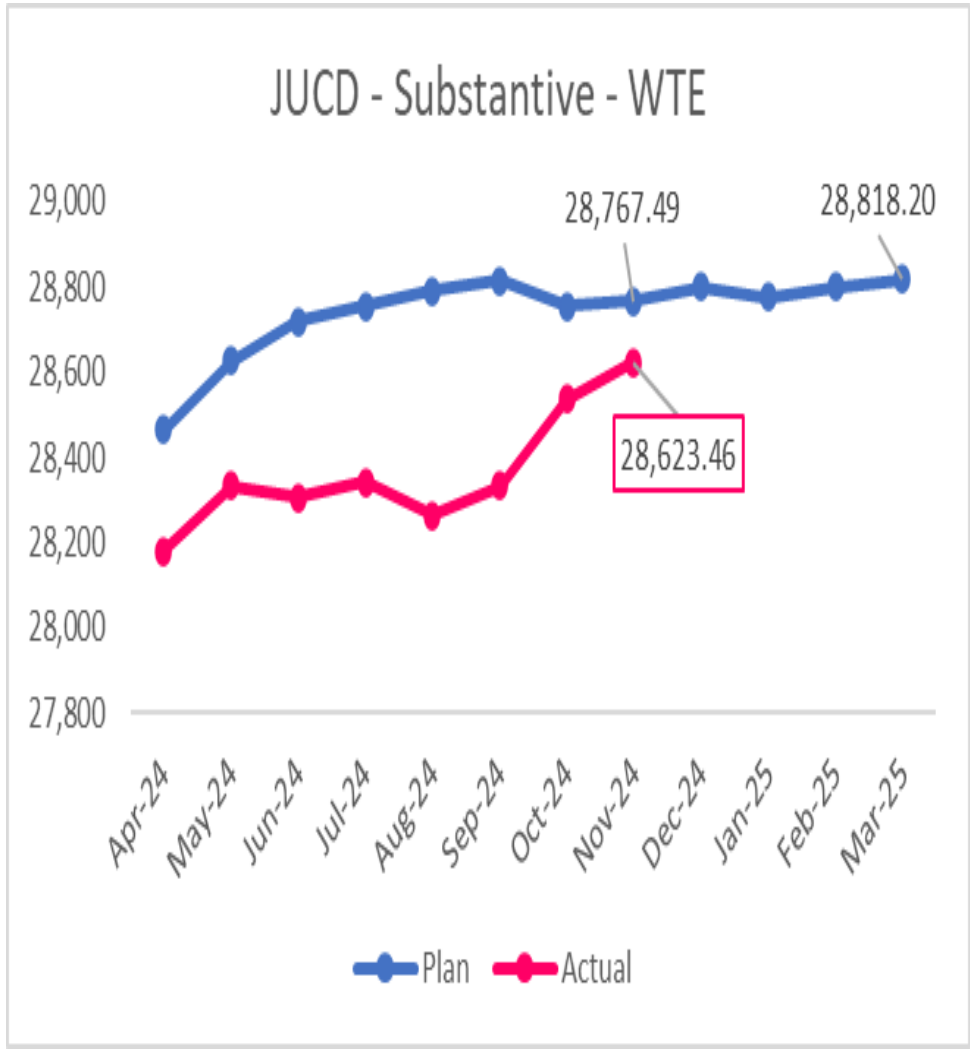
2024/25 Workforce Plan Position M8: Provider Narratives

NHS
Derby and Derbyshire
Integrated Care Board

Organisation	M8 Narrative	Actions	FOT	Risks	Service Specific Issues
DHcFT	• Bank usage position partly due to zonal obs which are continuing longer than forecast. Plan was for Agency, actually using Bank. This is resulting in a below plan position for Agency WTEs along with , stricter actions in place for Agency has resulted in additional reductions • Agency costs were above plan up to M06 due to a patient with complex needs. These additional costs have now ceased, with the Agency cost % expected to align to the plan for the rest of the year. • Dorms recruitment trajectory slightly differs to initial plan	• Rostering Steering group – • Recruitment fayres • Fast track recruitment • International recruitment • Internal apprenticeship programmes/nearly qualified • Weekly Agency meetings to review/challenge status of existing bookings and any new requests • Agency summit meetings arranged, focusing on high usage areas and booking patterns – CAMHS consultants and inpatient nursing/HCSWs • Direct engagement – being investigated for current Agency locums (potential VAT savings) • Establishing links with NHSP - there will be less need to fill emergency shifts through Agency	• Currently forecasting to catch-up and achieve forecasted staffing levels by Mar-25. • Will review this regularly and report back should it change	• Zonal/additional observations going on for longer than forecast • Dorms – risks to recruitment • Agency – forecasting at similar levels to current status. There's a risk should this increase due to the high costs involved	• Dorms recruitment trajectory slightly differs to initial plan • Zonal/additional observations • CAMHS Consultants – very high proportion of workforce is through Agency
EMAS	Funded WTE 4,490.66 v Contracted WTE 4,319.11 giving 171.55 vacancies across the Trust.	• Ongoing PTS recruitment • Assumes other trust areas remain reasonably consistent with M07 position	FOT of 4,368 WTE	• PTS recruitment lower than expected. • Attrition levels lower or higher than expected.	None
UHDB	• The substantive change in month is driven predominantly by WTE increase in registered nurses and midwives, registered allied health and scientific staffing, and an increase in newly qualified nurses which will fill vacancies in future months and reduce variable spend.	• New winter ward to open to help relieve pressure of winter pressures but this will result in additional workforce increase and temporary staffing usages • Vacancy controls are to be tighter to manage increases against plan.	Similar to M8 but with a further driver of the increase is the planned recruitment for Community Diagnostic Centres, maternity services and oncology services in line with the plan.	• Increase of Agency on framework use for specialist AHPs to support winter plan.	• Agency usage has increased in month due to the backfill of nurses in specialist areas such as ED, paediatrics and orthopaedic theatres. • UEC pressures continue to be a challenge

JUCD YTD WTE Position

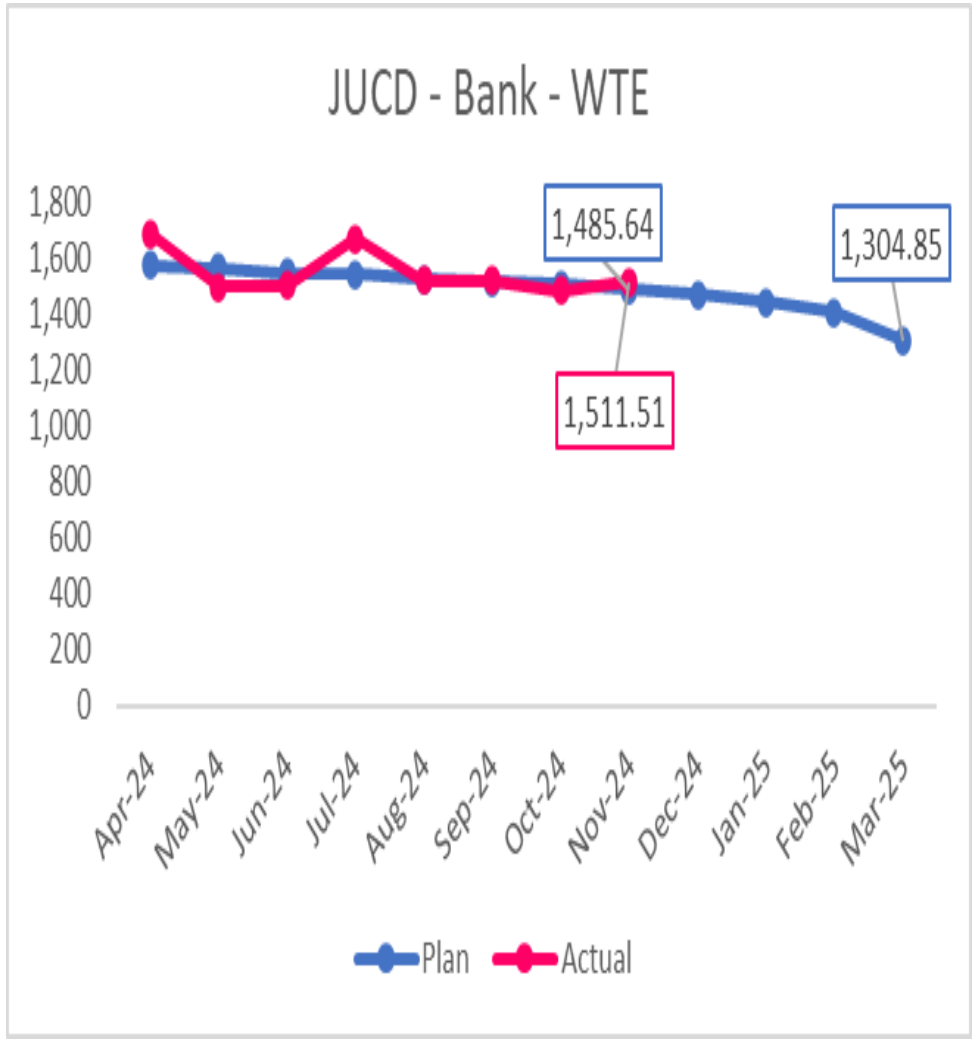




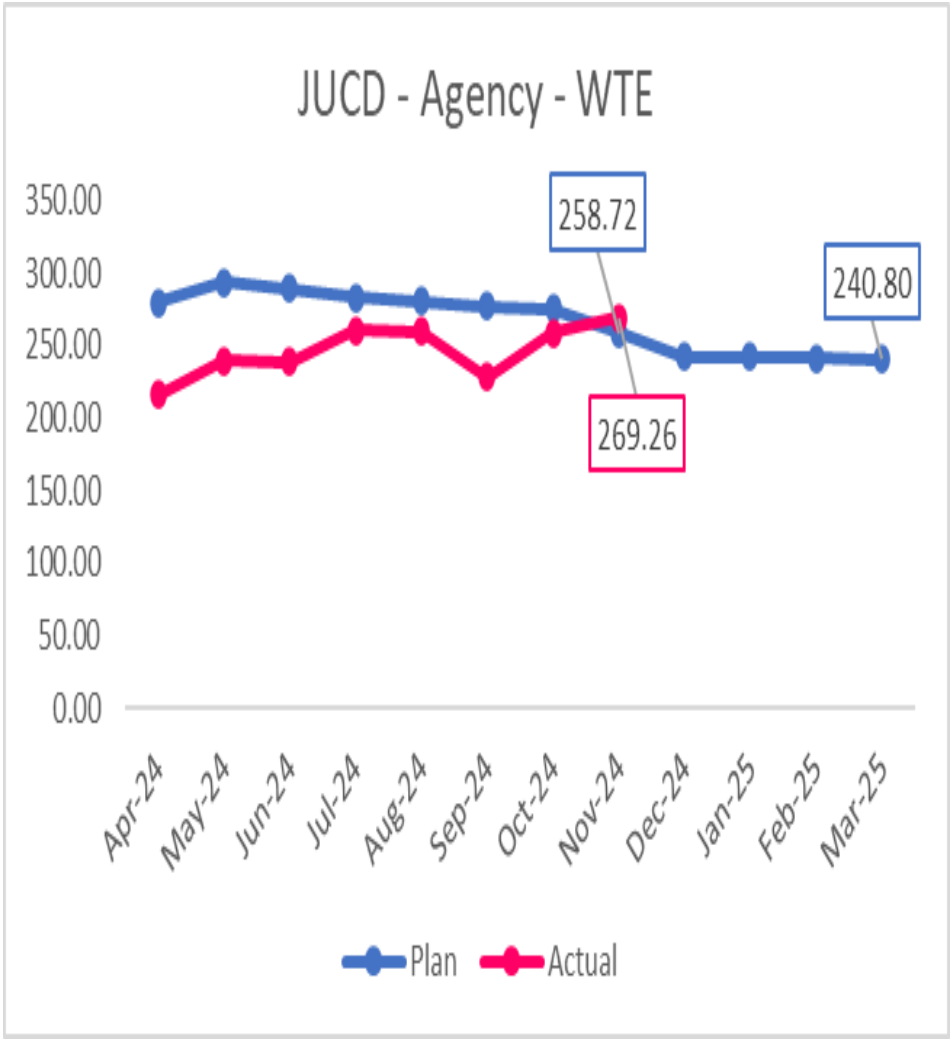
All Providers except CRH and DCHS are below plan for the total workforce, resulting in the system position at M8 being (107.62 WTE) less than plan.

All Providers except CRH and DCHS are below plan on substantive workforce. The total system position at M8 is (144.03 WTE) below plan.

JUCD Workforce Forecast



CRH (19.57 WTE) are under plan, whereas DCHS (14.93 WTE), DHcFT (12.53 WTE), EMAS (3.56 WTE) and UHDB (14.42 WTE) are over plan. This results in the total system position for the Bank workforce at M8 as (25.87 WTE) over plan.

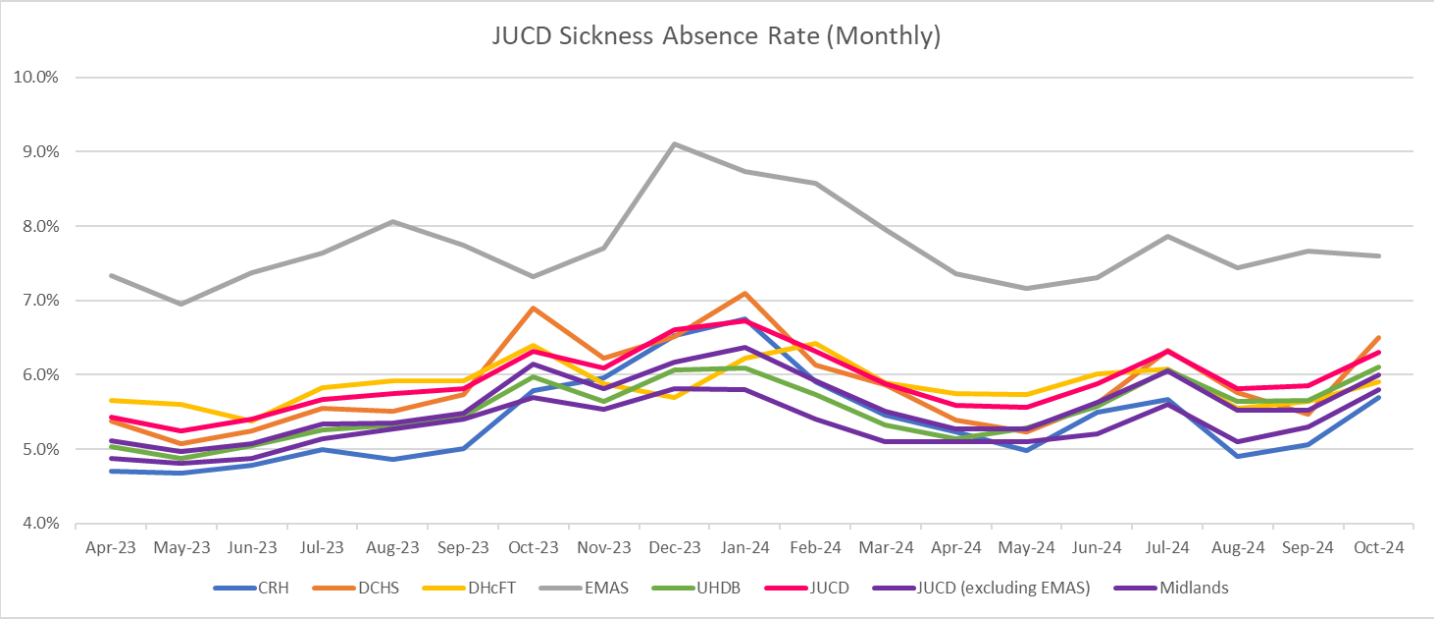


CRH (11.52 WTE) and DHcFT (17.70 WTE) are under plan, whereas DCHS (7.79 WTE), EMAS (2.84 WTE) and UHDB (29.13 WTE) are over plan. Therefore the aAgency workforce position for the system at M8 is (10.54 WTE) over plan.

Workforce Plan KPIs: Sickness (M7)

Note: HEE ESR Data is only available at present to M7

Derby and Derbyshire Integrated Care Board



- Source: HEE Portal ESR
- Note CRH only commenced with ESR in November 2020 so data is only from that point
- Since January 2021 the sickness trends are consistent across all Trusts with the exception of EMAS
- The Derbyshire position is slightly higher that the Midlands position, which is mainly due to the EMAS position. Further understanding of sickness and the actions being taken is required to understand the impact on the temporary staffing usage
- Whilst sickness was showing a downward trend in the early part of this year the position has been showing an upward trend in recent months

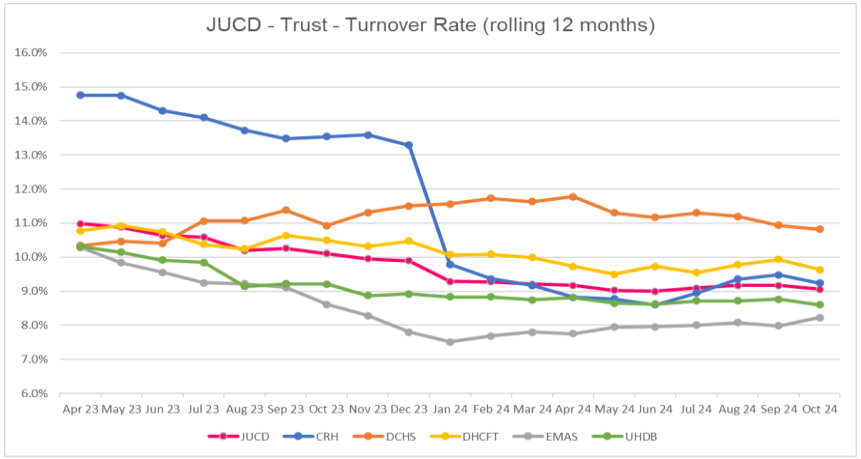
Monthly Absence Rate	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
CRH	4.7%	4.7%	4.8%	5.0%	4.9%	5.0%	5.8%	6.0%	6.5%	6.8%	5.9%	5.5%	5.2%	5.0%	5.5%	5.7%	4.9%	5.1%	5.7%
DCHS	5.4%	5.1%	5.2%	5.6%	5.5%	5.7%	6.9%	6.2%	6.5%	7.1%	6.1%	5.9%	5.4%	5.2%	5.6%	6.3%	5.8%	5.5%	6.5%
DHcFT	5.7%	5.6%	5.4%	5.8%	5.9%	5.9%	6.4%	5.9%	5.7%	6.2%	6.4%	5.9%	5.7%	5.7%	6.0%	6.1%	5.6%	5.6%	5.9%
EMAS	7.3%	7.0%	7.4%	7.6%	8.1%	7.7%	7.3%	7.7%	9.1%	8.7%	8.6%	8.0%	7.4%	7.2%	7.3%	7.9%	7.4%	7.7%	7.6%
UHDB	5.0%	4.9%	5.1%	5.3%	5.3%	5.4%	6.0%	5.6%	6.1%	6.1%	5.7%	5.3%	5.1%	5.3%	5.6%	6.1%	5.6%	5.7%	6.1%
JUCD	5.4%	5.2%	5.4%	5.7%	5.7%	5.8%	6.3%	6.1%	6.6%	6.7%	6.3%	5.9%	5.6%	5.6%	5.9%	6.3%	5.8%	5.9%	6.3%
JUCD (excluding EMAS)	5.1%	5.0%	5.1%	5.3%	5.4%	5.5%	6.1%	5.8%	6.2%	6.4%	5.9%	5.5%	5.3%	5.3%	5.6%	6.0%	5.5%	5.5%	6.0%
Midlands	4.9%	4.8%	4.9%	5.1%	5.3%	5.4%	5.7%	5.5%	5.8%	5.8%	5.4%	5.1%	5.1%	5.1%	5.2%	5.6%	5.1%	5.3%	5.8%

Workforce Plan KPIs: Turnover and Leaver Rates

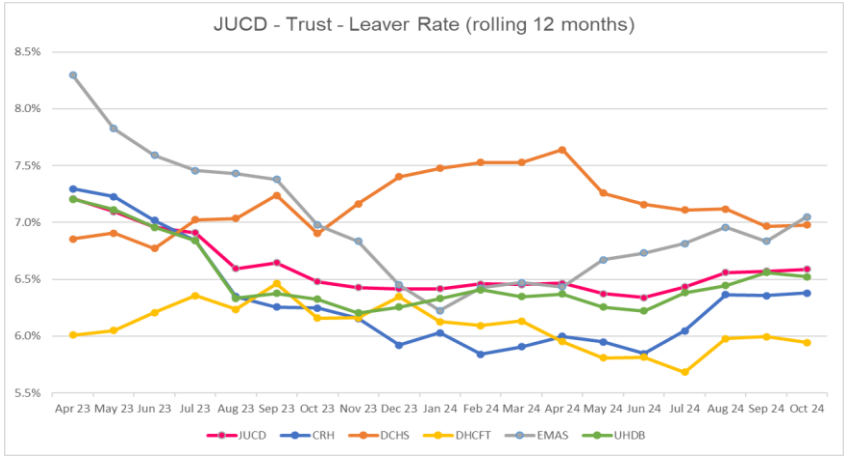
Source: Midlands Regional NHSE Workforce Team

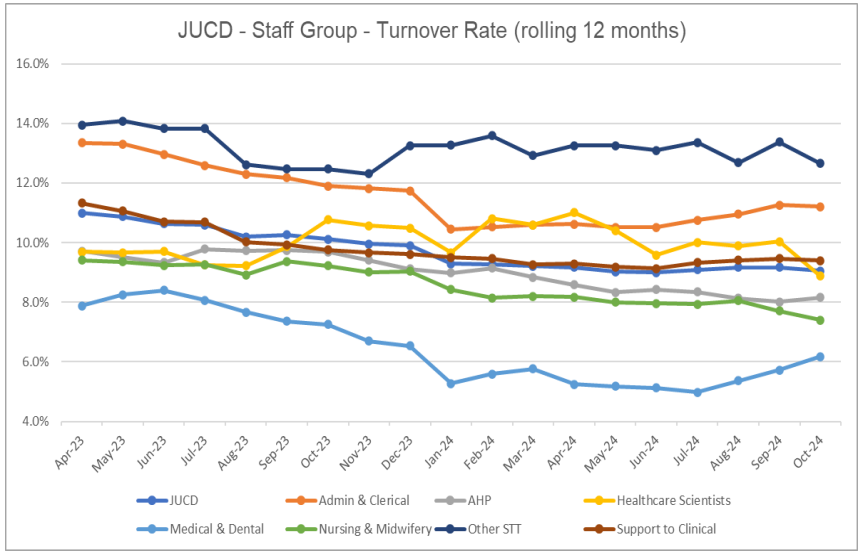
Derby and Derbyshire Integrated Care Board

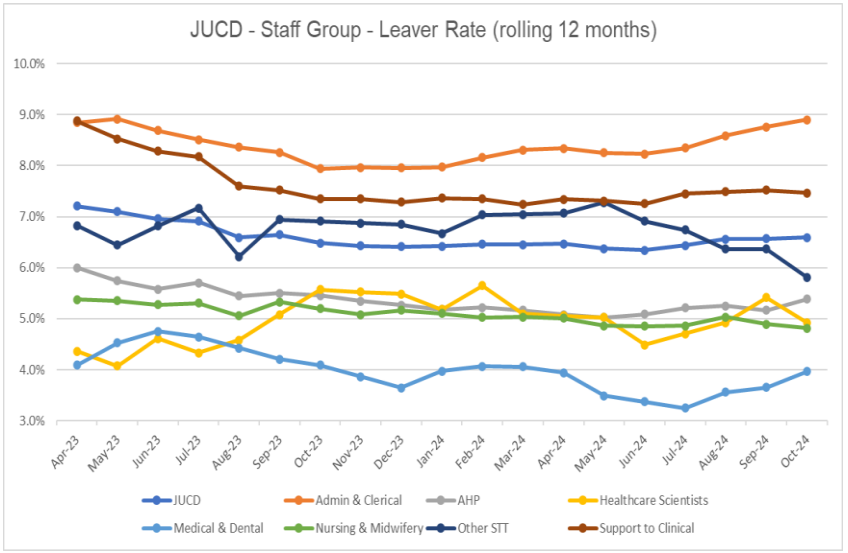
- **Turnover Rate** Definition:
  - Sum of leavers over the previous 12 months, divided by the average staff in post over the previous 12 months.
  - Leavers are staff who have left the Trust



- **Leaver Rate** Definition:
  - Sum of leavers over the previous 12 months, divided by the average staff in post over the previous 12 months.
  - Leavers are staff who have left the NHS







2024/25 Primary Care Workforce (M7)

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

NHS Derby and Derbyshire Integrated Care Board

Data Source: GP Commissioning Team	Baseline	Actual			Plan	Actual			Plan	Actual			Plan	Actual			Plan
Primary Care	Staff in post outturn	Q1			Q1	Q2			Q2	Q3			Q3	Q4			Q4
Joined Up Care Derbyshire	Year End	As at the end of			As at the end of	As at the end of			As at the end of	As at the end of			As at the end of	As at the end of			As at the end of
	(31-Mar-24)	Apr-24	May-24	Jun-24	Jun-24	Jul-24	Aug-24	Sep-24	Sep-24	Oct-24	Nov-24	Dec-24	Dec-24	Jan-25	Feb-25	Mar-25	Mar-25
Workforce (WTE)	Total WTE	Total WTE			Total WTE	Total WTE			Total WTE	Total WTE			Total WTE	Total WTE			Total WTE
Total Workforce	**3,670**	**3,466**	**3,477**	**3,484**	**3,646**	**3,466**	**3,510**	**3,511**	**3,700**	**3,516**	**0**	**0**	**3,725**	**0**	**0**	**0**	**3,750**
GPs excluding registrars	770	743	748	742	759	741	779	781	788	777			785				775
Nurses	380	343	344	344	369	342	342	341	367	343			367				365
Direct Patient Care roles (ARRS funded)	686	597	592	605	667	600	598	599	674	608			689				713
Direct Patient Care roles (not ARRS funded)	281	271	270	271	286	266	265	259	291	260			295				299
Other – admin and non-clinical	1,552	1,512	1,523	1,521	1,566	1,517	1,526	1,531	1,580	1,529			1,590				1,598

Summary

- At M7, the total workforce was **209 WTE below Q3's plan**. The gap was observed mainly from Direct Patient Care roles (ARRS funded) (81WTE), Other – admin and non-clinical staff (61WTE) & Direct Patient Care roles (Non-ARRS funded) (35 WTE).

Caveats to the data:

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

Actual Workforce Position Compared to Pay-Bill

	Total Workforce						Vacancy	Vacancy Rate **
	WTE			Pay Spend (£,000)				
	Plan	Actual	Variance	Plan	Actual	Variance	WTE	%
JUCD Total	30,511.85	30,404.23	-107.62	£138,273.99	£140,803.63	£2,529.64	1,673.16	5.48%
CRH	4,993.24	5,025.37	32.13	£21,999.00	£23,022.18	£1,023.18	193.41	3.93%
DCHS	3,833.32	3,942.74	109.42	£14,837.02	£15,010.00	£172.98	294.48	7.33%
DHcFT	3,359.94	3,216.83	-143.11	£14,982.81	£14,306.45	-£676.36	143.11	4.21%
EMAS	4,489.66	4,434.05	-55.61	£19,548.00	£18,887.00	-£661.00	135.67	3.02%
UHDB	13,835.69	13,785.24	-50.45	£66,907.17	£69,578.00	£2,670.83	906.49	6.61%

** Based on year-end establishment as reported in PWR

	Substantive						Bank					
	WTE			Pay Spend (£,000)			WTE			Pay Spend (£,000)		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
JUCD Total	28,767.49	28,623.46	-144.03	£130,976.41	£131,203.93	£227.53	1,485.64	1,511.51	25.87	£4,635.46	£7,349.29	£2,713.83
CRH	4,593.61	4,656.83	63.22	£20,933.00	£21,483.38	£550.38	302.86	283.29	-19.57	£599.00	£1,335.46	£736.46
DCHS	3,710.73	3,797.43	86.70	£14,345.72	£14,292.00	-£53.72	95.16	110.09	14.93	£401.80	£528.00	£126.20
DHcFT	3,159.17	3,021.23	-137.94	£13,687.52	£13,202.56	-£484.97	164.16	176.69	12.53	£719.66	£770.83	£51.17
EMAS	4,416.00	4,353.99	-62.01	£19,191.00	£18,428.00	-£763.00	52.66	56.22	3.56	£213.00	£280.00	£67.00
UHDB	12,887.98	12,793.98	-94.00	£62,819.17	£63,798.00	£978.83	870.80	885.22	14.42	£2,702.00	£4,435.00	£1,733.00

	Agency						Other					
	WTE			Pay Spend (£,000)			WTE			Pay Spend (£,000)		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
JUCD Total	258.72	269.26	10.54	£2,238.82	£2,892.85	£654.03	0.00	0.00	0.00	£423.31	-£642.44	-£1,065.75
CRH	96.77	85.25	-11.52	£426.00	£1,012.79	£586.79	0.00	0.00	0.00	£41.00	-£809.44	-£850.44
DCHS	27.43	35.22	7.79	£89.50	£190.00	£100.50	0.00	0.00	0.00	£0.00	£0.00	£0.00
DHcFT	36.61	18.91	-17.70	£512.32	£276.06	-£236.26	0.00	0.00	0.00	£63.31	£57.00	-£6.31
EMAS	21.00	23.84	2.84	£75.00	£102.00	£27.00	0.00	0.00	0.00	£69.00	£77.00	£8.00
UHDB	76.91	106.04	29.13	£1,136.00	£1,312.00	£176.00	0.00	0.00	0.00	£250.00	£33.00	-£217.00

In order to align with financial reporting 'other' pay costs (other staff costs and employee benefits) are now reflected in the total pay-bill costs. The underspend in the other pay costs of £1.1m are offsetting overspends elsewhere, bringing the total M8 pay position to -£2.5m overspent. This is despite the total WTE position being 108WTEs below plan.

Both CRH and DCHS are above the planned total WTE position and both have corresponding overspends on the planned pay, although the ratio of over plan on WTEs to over plan on pay-spend varies significantly. For UHDB the position demonstrates a below total WTE plan position of 50.45WTEs but there is an overspend of -£2.7m.

The M8 combined Bank and Agency planned pay-spend is overspent by £3.4m. This is due to overspends in all organisations in both Bank and Agency, except for DHcFT who have an underspend on Agency of £236k with a corresponding below plan position of 18WTEs. In WTE terms CRH are below planned Bank and Agency but this is not matched in pay-spend where the position is -£1.3m overspent. DCHS, EMAS and UHDB are over on both WTE and pay.

There will be various factors driving this position, including non-contractual pay costs such as waiting list initiatives and overtime. The need to layer up the pay-costs to develop a deeper understanding, is becoming more crucial and the work that will now be led through finance colleagues will aid in this understanding.

Data Source:
Provider Workforce Return(PWR)
Provider Finance Return(PFR)

Year To Date Pay Bill Position

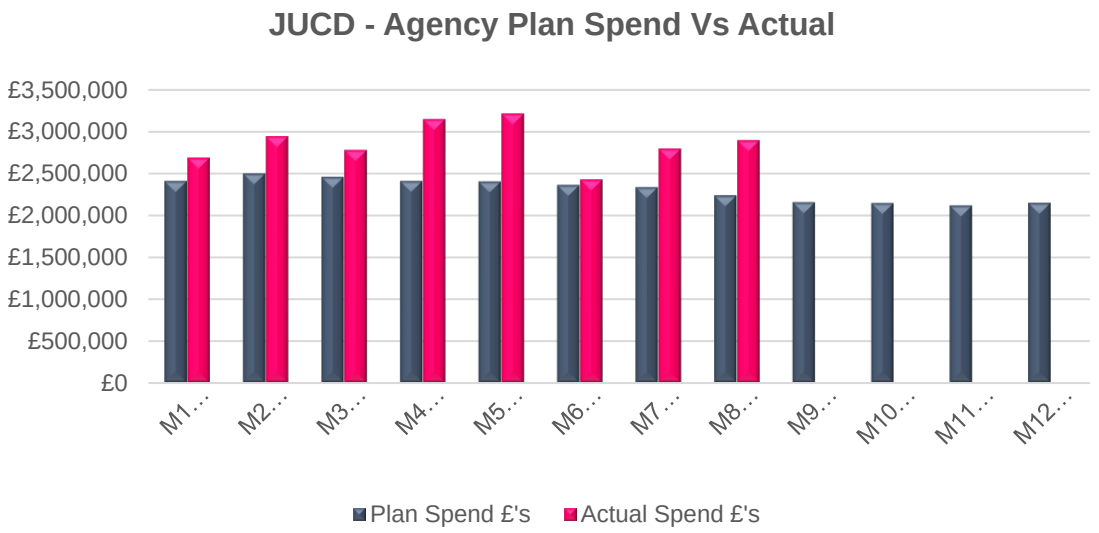
	Total			Substantive			Bank			Agency			Other		
	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ICB Total	£1,112,895	£1,114,724	**£1,828**	£1,050,804	£1,030,796	**-£20,008**	£37,378	£58,956	**£21,578**	£19,122	£22,877	**£3,755**	£5,591	£2,095	**-£3,496**
CRH	£181,668	£184,577	**£2,909**	£170,258	£166,172	**-£4,086**	£4,865	£10,345	**£5,480**	£4,000	£7,815	**£3,815**	£2,545	£245	**-£2,300**
DCHS	£121,729	£120,304	**-£1,425**	£117,706	£115,901	**-£1,805**	£3,248	£3,359	**£111**	£776	£1,044	**£268**	£0	£0	**£0**
DHcFT	£117,465	£113,371	**-£4,095**	£106,705	£102,534	**-£4,172**	£5,764	£6,328	**£563**	£4,504	£4,073	**-£431**	£492	£436	**-£56**
EMAS	£149,879	£148,696	**-£1,183**	£146,970	£145,416	**-£1,554**	£1,704	£2,011	**£307**	£651	£668	**£17**	£554	£601	**£47**
UHDB	£542,153	£547,776	**£5,623**	£509,165	£500,773	**-£8,392**	£21,797	£36,913	**£15,116**	£9,191	£9,277	**£86**	£2,000	£813	**-£1,187**

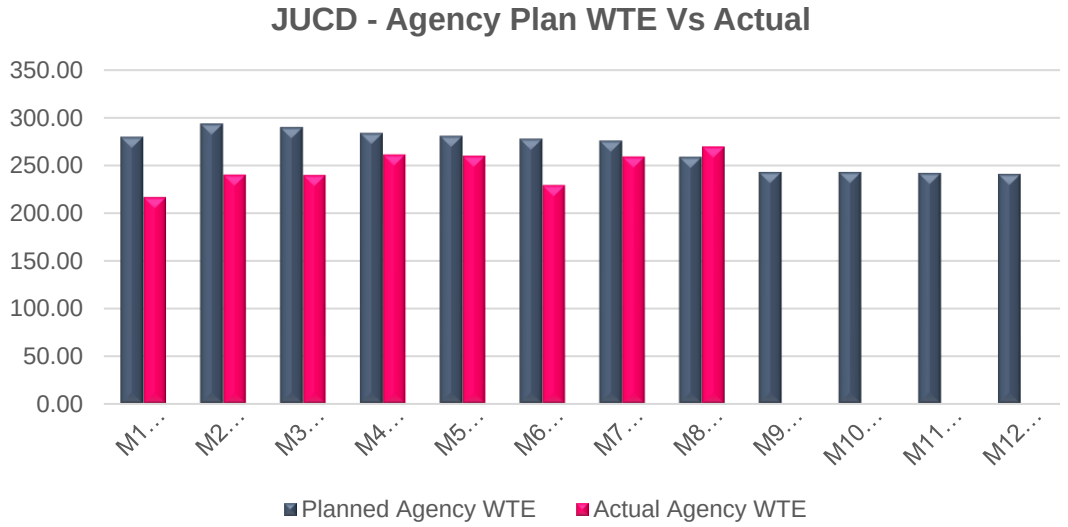
The YTD total overspend **is -£1.8m overspent**, this is due to overspends in temporary staffing (Bank and Agency) of -£25.3m being offset by underspends in substantive and other pay costs of £23.5m.

All organisations are overspent on Bank and Agency YTD with DHcFT being the exception where there is an underspend of £0.4m in Agency spend, however there is an overspend on Bank usage due to increased zonal observations (planned for Agency but using Bank).

The two acute Trusts are driving the overall system position and have overspends in substantive, Bank and Agency workforce.

2024/25 M8 JUCD Agency KPI Summary





Total Agency Spend:

- JUCD planned to spend £2.2m on Agency staff in M8. The actual spend was £2.9m This is an overspend against plan of £700k
- YTD JUCD have a current overspend of £3.8m on Agency staff.
- As of the end of M8, JUCD have reached 82.6% of planned Agency spend.

Agency spend as a % of total staff spend:

- In M8 JUCD Agency cost amounted to 2.1% of total pay costs,1.1% under the national target of 3.2%. YTD 2.0%.

% of Off Framework shifts:

- Significant efforts have been made to eliminate Off-Framework usage and in M8 there were 26 shifts, 0.5% total Agency shifts.
- 17 of these shifts relate to 1 WTE Oncology Consultant at UHDB. Notice was served to the Agency and the individual is now on-framework since 26 November 2024
- Nursing and Midwifery shifts at DCHS - reason for usage was 'true break glass' due to clinical demand to provide urgent cover which Bank could not fill at short notice
- Healthcare Assistants & Other Support Shifts at DCHS - reason for usage was due to the On-Framework HCA not arriving for the shift but support was needed due to increased clinical activity. 3 other on-framework agencies were contacted but could not assist resulting in processes being followed to break glass.
- Healthcare Assistants & Other Support Shifts at DHCFT - reason for usage was due to human error. The issue has been addressed and a reminder has gone out to all managers.

% non price cap compliant shifts:

- Non-Price Cap Compliant shifts amounted to 2,187 shift in M8 44.8% of total Agency shifts.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th January 2025

Item: 112

Report Title	Remuneration Committee Assurance Report – December 2024							
Author	Kathryn Durrant, Executive Board Secretary							
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer							
Presenter	Margaret Gildea, Senior Non Executive Member and Chair of the Remuneration Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Not applicable							
Assurance Report Signed off by Chair	Margaret Gildea, Chair of the Remuneration Committee							
Which committee has the subject matter been through?	Remuneration Committee, 5th December 2024							

Recommendations		
The ICB Board are recommended to **NOTE** the Remuneration Committee Assurance Report.		
Board Assurance		
Level of Assurance	**The report demonstrates that:**	***Please select***
Full	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required by the Board.	☐
Adequate	• Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required by the Board.	☒
Partial	• Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or	☐

	• Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required by the Board.	
Limited	• Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required by the Board.	☐

Items to escalate to the ICB Board

None.

Purpose

This report provides the Board with a brief summary of the items transacted at the meeting of the Remuneration Committee on the 5th December 2024.

Background

The Remuneration Committee ensures that the ICB effectively delivers the statutory functions of the ICB.

Report Summary

This report highlights to the ICB Board any:

- matters of concern or key risks to escalate;
- decisions made;
- major actions commissioned or work underway;
- positive assurances received; and
- comments on the effectiveness of the meeting.

Remuneration Committee on 5th December 2024

The Committee:

- APPROVED the recommended salary for the Deputy Chief Medical Officer (0.8WTE);
- NOTED the update on the VSM recruitment process for the Joint Chief Finance Officer role;
- NOTED the appointment of an Interim Chief Finance Officer;
- APPROVED the recommended principles for consideration of VSM functional director pay ranges; and
- NOTED the update on the ICB restructure and the formal serving of redundancy notice to displaced employees.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☒

SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☒	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

Any other risks are detailed within the report.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

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

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

Not applicable to this report.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable to this report.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th January 2025

Item: 113

Report Title	ICB Risk Register – December 2024							
Author	Rosalie Whitehead, Risk Management & Legal Assurance Manager							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Corporate Risk Report Appendix 2 – ICB Corporate Risk Register (see link to website) Appendix 3 – Movement in risk summary – December 2024							
Assurance Report Signed off by Chair	Not applicable.							
Which committee has the subject matter been through?	Finance, Estates and Digital Committee Population Health and Strategic Commissioning Committee System Quality Group Public Partnerships Committee Audit and Governance Committee							

Recommendations

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

- Appendix 1, the risk register report;
- Appendix 2, which details the full ICB Corporate Risk Register (see link to website);
- Appendix 3, which summarises the movement of all risks in December 2024;
- New Risk 33 relating to the current contractual dispute with Midlands and Lancashire CSU.

APPROVE CLOSURE of**:**

- Risk 20 relating to asylum seekers and an increase in demand and pressure placed upon Primary Care Services and Looked After Children Services;
- Risk 22 relating to national funding for pay awards.

Purpose

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

Background

The ICB Risk Register is a live management document which enables the organisation to understand its comprehensive risk profile and brings an awareness of the wider risk environment. All risks in the Risk Register are allocated to a committee who review new and existing risks each

month and agree the latest position on the risk, advise on any further mitigating actions that might be required, or approve removal of fully mitigated risks.

Report Summary

The report summarises any movement in risk scores, new risks to the organisation and any risks approved for closure by the relevant committee.

Click here for the link to Appendix 2, the full corporate risk register.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and poorer health outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☒
SR5	There is a risk that the system is not able to maintain an affordable and sustainable workforce supply pipeline and to retain staff through a positive staff experience.	☒	**SR6**	Risk merged with SR5	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

The report covers each strategic risk.

Financial impact on the ICB or wider Integrated Care System

Yes ☒	No☐	N/A☐

Details/Findings Strategic risk SR4 describe the system's financial risk. *There is a risk that the NHS in Derby and Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move to a sustainable financial position and achieve best value from the £3.4billion available funding.*	**Has this been signed off by a finance team member?** Claire Finn, Interim Chief Finance Officer

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

No conflicts of interest have been identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

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

CORPORATE RISK REGISTER REPORT

INTRODUCTION

The purpose of this report is to present the ICB Board with a summary of the current risk position, including any movement in risk scores, new risks to the organisation and any risks approved for closure by the relevant committee owning the risk.

The ICB currently has 9 very high risks, 8 high and 2 moderate scoring risks on the corporate risk register.

RISK MOVEMENT

Decreased risks

No risks were decreased in score during November and December 2024.

Increased risks

No risks were increased in score during November and December 2024.

CLOSED RISKS

One risk was proposed for closure in November 2024:

Risk 22: *(Finance, Estates and Digital Committee) National funding for pay awards and the application to staff who are not on NHS payrolls. Consequently there is an increasing risk of legal challenge as well as real, emerging loss of morale for over 4,500 staff across the Derbyshire system which could affect recruitment and retention of critical frontline colleagues.*

The reason for the closure of this risk is that national pay award funding has been received and following review, it was considered that the funding was sufficient. This was formally agreed at the Finance, Estates and Digital Committee meeting on 26th November 2024.

One risk was proposed for closure in December 2024:

Risk 20: *(System Quality Group) Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.*

At the December Quality and Safety Forum, this risk was discussed to consider whether the risk should remain a risk, as there are no changes in relation to the four hotels closing in the near future, together with the ongoing risk of if more hotels are required to be stood up in line with Home Office decisions and guidance.

Members agreed that this risk should be proposed for closure as this is 'business as usual' and as an ICB, we would work with the Primary Care Team in the community, other partners, health providers and the Home Office should any issues arise.

This decision was ratified at the System Quality Group meeting held on 7th January 2025.

NEW RISKS

One new risk was proposed in December:

Risk 33: *There is a risk that the current contractual dispute with Midlands and Lancashire CSU (MLCSU) may result in a failure to deliver against national statutory performance and financial targets leading to a reputational risk for the ICB.*

The risk was proposed to be scored at a very high score of 16 (probability 4 x impact 4). This new risk was approved at the System Quality Group meeting held on 7th January 2025.

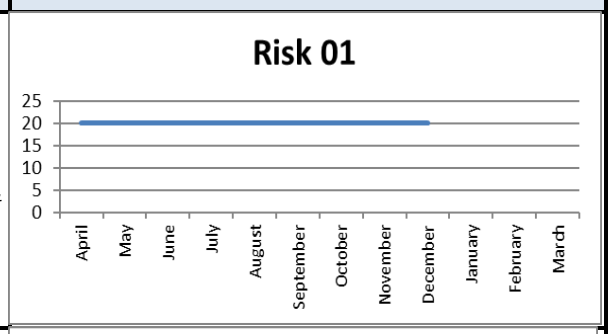
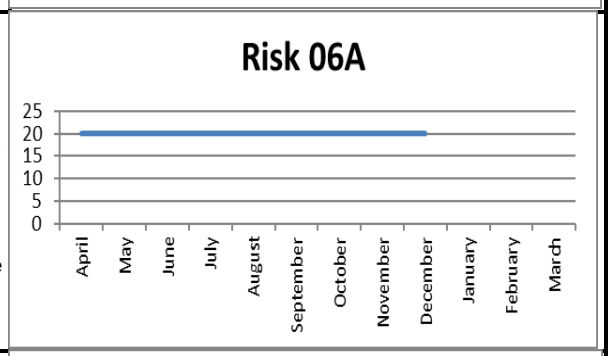
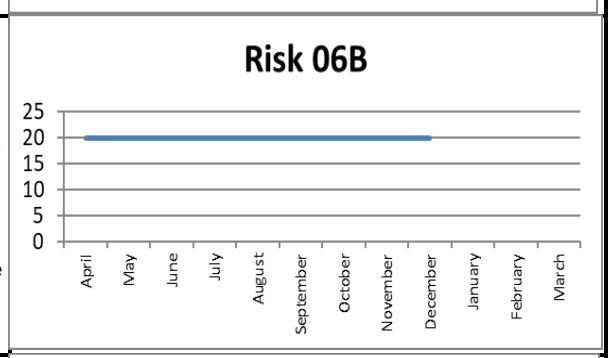
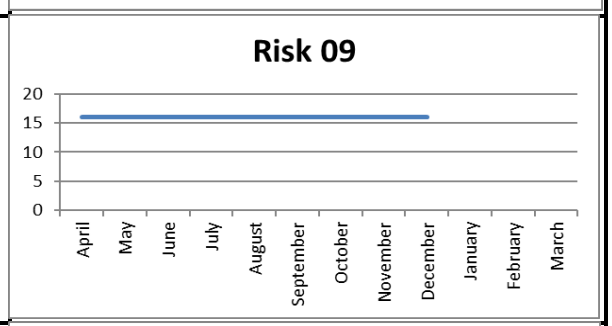
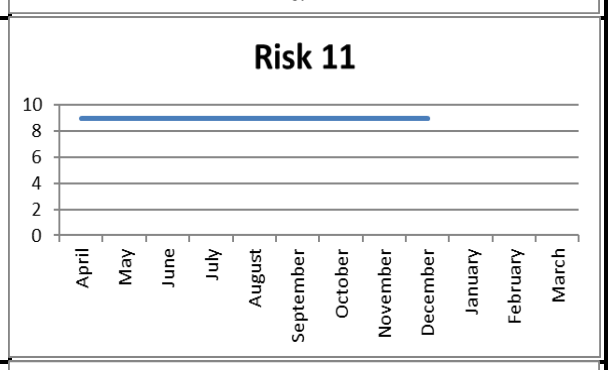
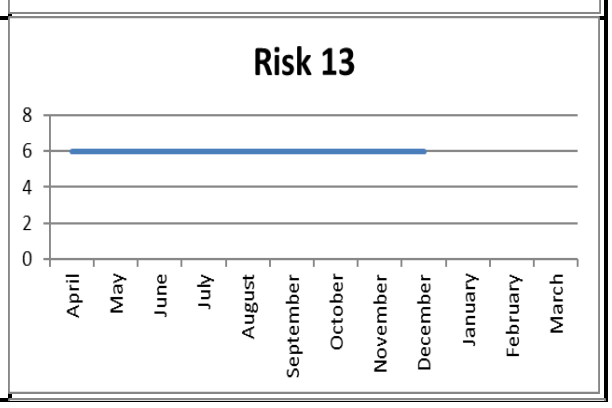
There have been no changes to the remaining risks on the ICB corporate risk register.

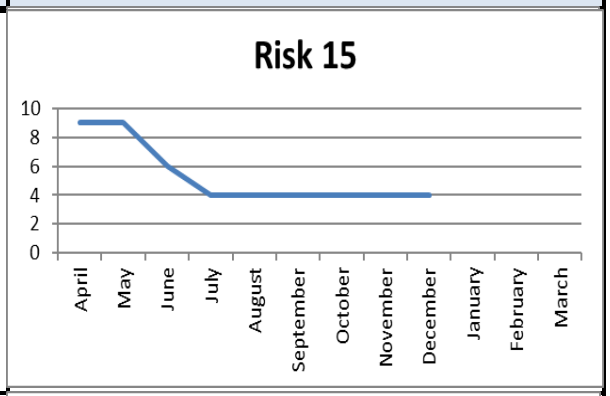
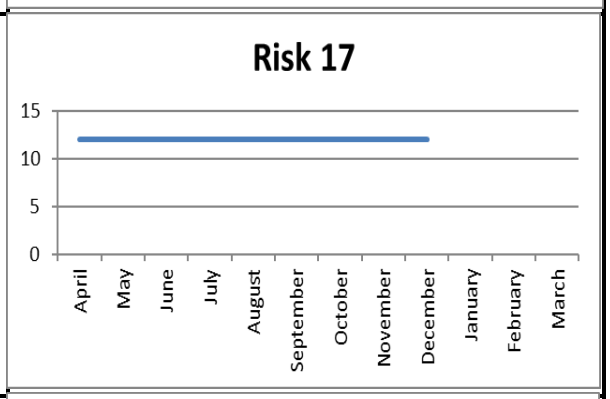
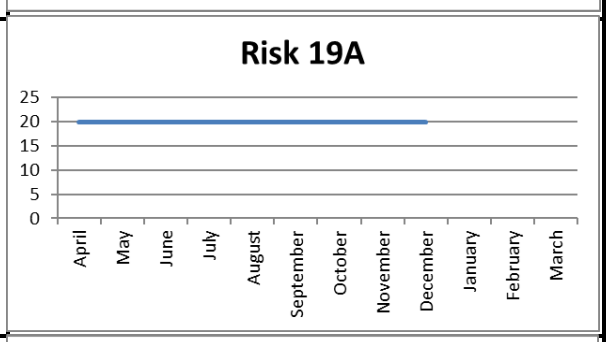
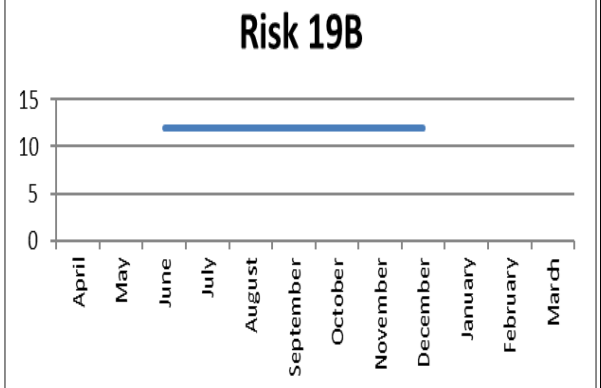
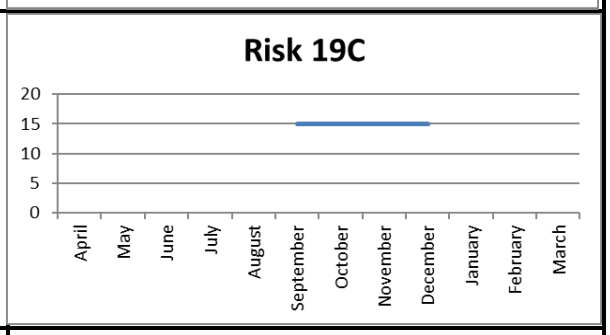
Population Health and Strategic Commissioning Committee (PHSCC)

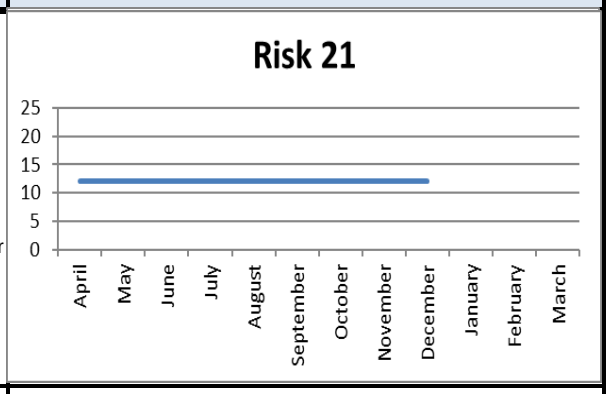
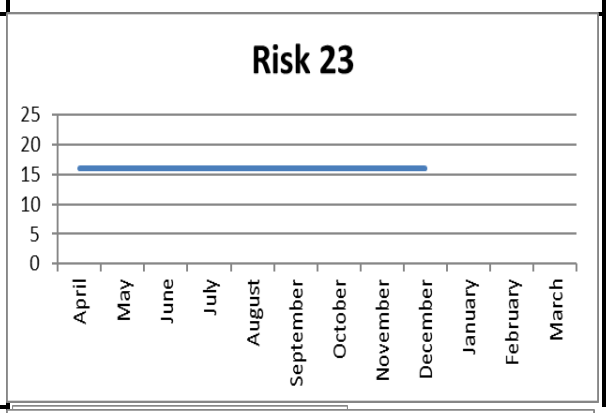
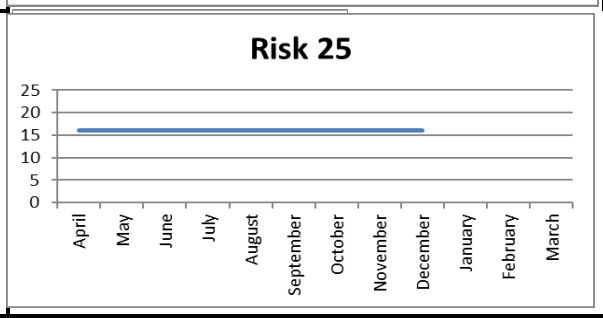
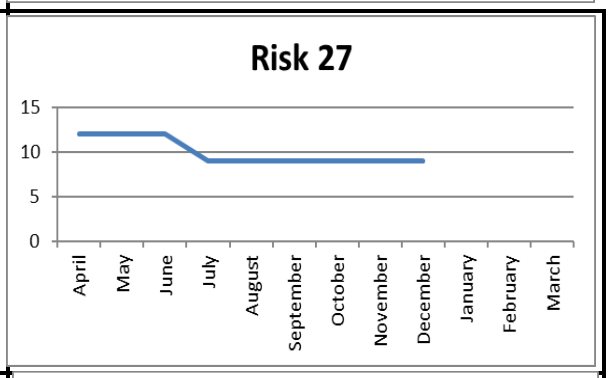
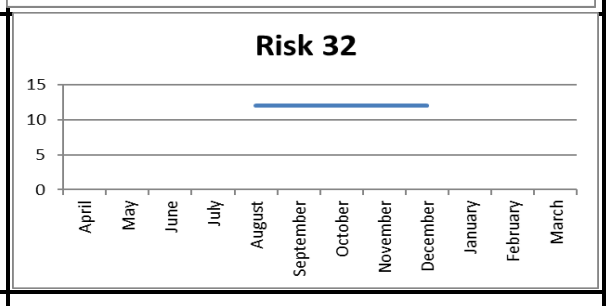
Further work continues to populate several proposed new risks including the initial, current and target risk scores, actions and mitigations along with assigning a risk owner for each of the new risks.

Appendix 3

ICB Risk Register - Movement - December 2024

Risk Reference	Risk Description	Previous Rating (Nov)			Residual/ Current Risk Rating (Dec)			Movement - December	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
01	The Acute providers may not meet the new target in respect of 78% of patients being seen, treated, admitted or discharged from the Emergency Department within 4 hours by March 2025, resulting in the failure to meet the ICB constitutional standards and quality statutory duties, taking into account the clinical impact on patients and the clinical mitigations in place where long waits result.	5	4	20	5	4	20	⇔	The score remains at 20 due to the Acute providers not meeting the 78% target and this is impacting on patient flow.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Amy Grazier Senior Operational Resilience Manager Dan Merrison Senior Performance & Assurance Manager Jasbir Dosanjh	
06A	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position. **Delivery of 24/25 Financial Plan**	4	5	20	4	5	20	⇔	Guidance re the repayment of deficit funding is still awaited. Propose this risk remain at 20. The target risk of 6 is challenging.	Claire Finn, Interim Chief Financial Officer	David Hughes Director of Finance Derby and Derbyshire ICB Tamsin Hooton, Programme Director, Provider Collaborative	
06B	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position. **Delivery of 2-year Break Even**	4	5	20	4	5	20	⇔	Work has commenced re the ICS's underlying position and will be shared with the Committee on a continual basis. It is proposed the risk remains at 20.	Claire Finn, Interim Chief Financial Officer	David Hughes Director of Finance Derby and Derbyshire ICB Tamsin Hooton, Programme Director, Provider Collaborative	
09	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	4	4	16	4	4	16	⇔	UHDB have agreed a recovery plan for the back log of harm reviews which will be overseen by the UHDB.	Prof Dean Howells Chief Nursing Officer	Letitia Harris Assistant Director of Clinical Quality	
11	If the ICB does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	3	3	9	3	3	9	⇔	There have been further delays to the publication of the Green Plan refresh guidance which is now expected in the new year.	Helen Dillistone Chief of Staff	Katy Dunne Head of Corporate Programmes	
13	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.	2	3	6	2	3	6	⇔	NHS 10-Year Plan public engagement programme being developed, drawing additional capacity across the team.	Helen Dillistone Chief of Staff	Sean Thornton - Director of Communications and Engagement	

Risk Reference	Risk Description	Previous Rating (Nov)			Residual/ Current Risk Rating (Dec)			Movement - December	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
15	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	2	2	**4**	2	2	**4**	⇔	No change to the risk score as the next stage is still awaited.	Helen Dillistone Chief of Staff	Chrissy Tucker - Director of Corporate Governance and Assurance	
17	Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.	4	3	**12**	4	3	**12**	⇔	Local engagement approach launched for NHS 10 Year Plan, seeking to provide feedback on existing insight gleaned.	Helen Dillistone Chief of Staff	Sean Thornton - Director of Communications and Engagement	
19A	Failure to deliver a timely response to patients due to excessive handover delays. Leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential levels of harm.	5	4	**20**	5	4	**20**	⇔	CRH had significantly more delays during October than for the previous year, RDH had significantly higher delays during October, relative to the previous year.	Dr Chris Weiner Chief Medical Officer	Andrew Longbotham	
19B	The risk of delayed or inadequate patient discharge is heightened by factors including, unsuitable home environments, limited availability of community and home care services, and delays in providing necessary equipment. Poor coordination among healthcare providers, insufficient rehabilitation and long-term care options, rigid discharge policies, and ineffective communication and data management is further exacerbated by seasonal increases in patient volumes and inadequate transport services. The result is that the system struggles to effectively manage and support patient transitions from hospital to home or long-term care, leading to potential harm and unmet patient needs.	3	4	**12**	3	4	**12**	⇔	The risk score remains at 12, Strategic Discharge Group recommended decrease to 8 however System Quality Group did not agree and therefore discussions continue.	Strategic Discharge Group	Jodi Thomas Discharge Improvement Lead JUCD	
19C	Lack of digital interoperability across information platforms leads to inadequate visibility of discharge information and communication between providers. There are a lack of effective performance indicators to monitor and manage discharge processes. Inadequate data collection and analysis to identify bottlenecks in discharge pathways. Lack of system data intelligence to inform decision making to manage risks when in system escalation.	5	3	**15**	5	3	**15**	⇔	Initial digital specification drafted. Interim digital solutions scoped ready to support a pilot.	Strategic Discharge Group	Jodi Thomas Discharge Improvement Lead JUCD	
20	Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.	3	3	**9**	3	3	**9**	**RISK RECOMMENDED FOR CLOSURE**	As an ICB we will work with our Primary care team in the community, our partners and health providers and Home office should any issues arise.	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children	**RISK RECOMMENDED FOR CLOSURE**

Risk Reference	Risk Description	Previous Rating (Nov)			Residual/ Current Risk Rating (Dec)			Movement - December	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
21	There is a risk that contractors may not be able to fulfil their obligations in the current financial climate. The ICB may then have to find alternative providers, in some cases at short notice, which may have significant financial impact.	3	4	12	3	4	12	⇔	NHSE issued guidance on revised cost uplift factor to take into account the pay award changes, the net CUF has increased from 0.6% to 3.9% to be applied to those NHS and non-NHS providers covered by the NHS Payment System.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Craig Cook Director of Acute Commissioning, Performance and Contracting & Clive Newman Director of Primary Care	
22	National funding for pay awards and the application to staff who are not necessarily on NHS payrolls. Consequently there is a an increasing risk of legal challenge as well as real, emerging loss of morale for over 4,500 staff across the Derbyshire system which could affect recruitment and retention of critical frontline colleagues.	3	4	12	3	4	12	**RISK RECOMMENDED FOR CLOSURE**	National pay award funding has been received. Following review, it is considered funding is sufficient.	Claire Finn, Interim Chief Financial Officer	David Hughes Director of Finance	**RISK RECOMMENDED FOR CLOSURE**
23	There is an ongoing risk to performance against RTT and the cancer standards due to an increase in referrals into UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.	4	4	16	4	4	16	⇔	Due to the risk being long term, the risk score remains the same, waiting lists have doubled in the last four years.	Prof Dean Howells Chief Nursing Officer	Monica McAllindon Associate Director of Planned Care	
25	There is a risk of significant waiting times for moderate to severe stroke patients for community rehabilitation. This means, patients may have discharges from acute delayed, be seen by non-stroke specialist therapists and require more robust social care intervention.	4	4	16	4	4	16	⇔	There will be no reduction in score until the Stroke Rehab service review is completed and new model is implemented.	Dr Chris Weiner Chief Medical Officer	Scott Webster Head of Programme Management, Design, Quality & Assurance	
27	As a result of the introduction of the new provider selection regime, existing processes to connect PPI governance into change programmes may weaken. This may result in services not meeting needs of patients, reduced PPI compliance, risk of legal challenge and damage to NHS and ICB reputation.	3	3	9	3	3	9	⇔	This risk has not materialised and is mitigated to the extent that this risk may now be closed. PPC agreed this in principle at its meeting on 26/11/24 and will discuss again at the next PPC business meeting.	Helen Dillistone - Chief of Staff	Sean Thornton - Director of Communications and Engagement	
32	Risk of the Derbyshire health system being unable to deliver it's capital programme requirements due to capacity and funding availability.	3	4	12	3	4	12	⇔	Capital is at risk over overspending to the value of £4m	Claire Finn, Interim Chief Financial Officer	Jennifer Leah Director of Finance	
NEW RISK 33	There is a risk that the current contractual dispute with Midlands and Lancashire CSU (MLCSU) may result in a failure to deliver against national statutory performance and financial targets leading to a reputational risk for the ICB.	4	4	16	4	4	16	**NEW RISK**	**NEW RISK**	Prof Dean Howells Chief Nursing Officer	Jo Hunter Deputy Chief Nurse	**NEW RISK**

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th January 2025

Item: 114

Report Title	Audit & Governance Committee Assurance Report – December 2024							
Author	Sue Sunderland, Non-Executive Member							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Sue Sunderland, Non-Executive Member							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Sue Sunderland, Chair of Audit & Governance Committee							
Which committee has the subject matter been through?	Audit & Governance Committee, 12th December 2024							

Recommendations		
The ICB Board are recommended to **NOTE** the Audit & Governance Assurance Report.		
Board Assurance		
Level of Assurance	**The report demonstrates that:**	***Please select***
Full	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required by the Board.	☐
Adequate	• Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required by the Board.	☒

Partial	• Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or • Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required by the Board.	☐
Limited	• Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required by the Board.	☐

Items to escalate to the ICB Board

No matters of concern or key risks to escalate.

Purpose

This report provides the Board with a brief summary of the items transacted at the meeting of the Audit & Governance Committee on the 12th December 2024.

Background

The Audit & Governance Committee ensures that the ICB effectively delivers the statutory functions of the ICB.

Report Summary

The Audit & Governance Committee's Assurance Report (Appendix 1) highlights to the ICB Board any:

- matters of concern or key risks to escalate;
- decisions made;
- major actions commissioned or work underway;
- positive assurances received; and
- comments on the effectiveness of the meeting.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

	to achieve long term strategic objectives including reducing health inequalities and improve outcomes.				

Any risks highlighted and assigned to the Committee will be linked to the ICB's Board Assurance Framework and Risk Register.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

No interests were declared at the meeting.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

Not applicable to this report.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable to this report.

Appendix 1

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Audit & Governance Committee on 12th December 2024

Overall Board Assurance Level			
Full ☐	**Adequate** ☒	**Partial** ☐	**Limited** ☐

Matters of concern or key risks to escalate	Decisions made
None.	Approved the replacement of the maternity governance internal audit review with an advisory review to support the ICB as it works through the implementation of actions that emerged from risk workshop with the Board on 17 October. Approved the following policies: • Ethical framework for decision making – minor changes • Mobile phone policy – first consideration as previously using old CCG policy • Disability & long term conditions policy – expanded to provide more guidance • Temporary agency staff policy – first consideration as previously using old CCG policy – updated to reflect current guidance • Travel & expenses policy – minor changes • Retirement policy – minor update
Major actions commissioned or work underway	**Positive assurances received**
The procurement highlight report and associated discussion highlighted a couple of issues that need further work: • Ensuring timely contract sign off processes/delegation arrangements for multi-partner contracts • 2025/26 will see a lot of contracts coming to an end, early work has started to develop a procurement plan and evaluate the cost/benefit of contracts to avoid just rolling	Took reasonable assurance from Internal Audit's Progress report which summarised the current position. However, the Committee noted the drop in first follow up rate from 100% to 64% implementation of recommendations. Whilst noting that the small number of recommendations can skew the overall percentages we were reassured that this has already been flagged with Executives along with a reminder to ensure that in agreeing recommendations the timescales should be realistic. Took reasonable assurance from the procurement highlight report that due process is being followed in all procurement projects that are compliant under the regulations and meet the required dates.

forward existing contracts that may not be providing value for money.	Took positive assurance from the ICB Board Assurance Framework and the risks responsible to the Audit and Governance Committee which confirmed that risks are being monitored and managed on an ongoing basis and that all committees are in the process of reviewing the underlying threats and associated actions. We did note that the BAF had already been reported to Board when it would normally come to Audit Committee first – the forward plan will be reviewed to ensure this doesn't recur. Took reasonable assurance from the Corporate Resilience and Assurance Group report and the EPRR Core standards review around the processes for health, safety and fire, EPRR and business continuity. Took reasonable assurance from the policy management framework review that the majority of policies are up to date, for the few exceptions updates are in progress although it is not clear what the revised target date is. Took reasonable assurance from the statutory and mandatory training compliance report, noting the significant improvement in compliance with the new managing conflicts of interest training. The only areas of low compliance are where there is a known issue with accessing the training which is not on ESR and also recording completed training. Took reasonable assurance on the Month 7 financial position review which was in line with the position agreed by the system. We note the challenges to delivery that underpin this year's financial plan and will keep this under review. Took reasonable assurance on the ICB's controls through the regular reports on: • single tender waivers • losses and special payments.
Comments on the effectiveness of the meeting	
The meeting was well attended and effective contributions were made by all.	

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th January 2025

Item: 115

Report Title	Finance Estates and Digital Committee Assurance Report – November and December 2024							
Author	Jen Leah, Director of Finance and Jill Dentith, Non-Executive Member							
Sponsor (Executive Director)	Claire Finn, Chief Finance Officer							
Presenter	Jill Dentith, Non-Executive Member							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 and 2 – Committee Assurance Reports							
Assurance Report agreed by:	Jill Dentith, Non-Executive Member							
Which committee has the subject matter been through?	Finance, Estates and Digital Committee November and December 2024							

Recommendations		
The ICB Board are recommended to **NOTE** the Finance, Estates and Digital Committee Assurance Report.		
Board Assurance		
Level of Assurance	**The report demonstrates that:**	***Please select***
Full	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required by the Board.	☐

Adequate	• Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required by the Board.	☒
Partial	• Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or • Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required by the Board.	☐
Limited	• Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required by the Board.	☐

Items to escalate to the ICB Board

Please see the report at Appendix 1 and 2 for information.

Purpose

This report provides the Board with a brief summary of the items transacted at the meeting of the Finance, Estates and Digital Committee for November and December 2024.

Background

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

Report Summary

The Finance, Estates and Digital Committee's Assurance Report (Appendix 1 and 2) highlights to the ICB Board any:

- matters of concern or key risks to escalate;
- decisions made;
- major actions commissioned or work underway;
- positive assurances received; and
- comments on the effectiveness of the meeting.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the	☒

	development of services, leading to inequitable access to care and poorer health outcomes.			ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

Any risks highlighted and assigned to the Committee will be linked to the ICB's Board Assurance Framework and Risk Register.

Financial impact on the ICB or wider Integrated Care System

Yes ☒	No☐	N/A☐

Details/Findings	**Has this been signed off by a finance team member?**
Underlying deficit prevents the ICB from investing in out of hospital serves with the aim of reducing health inequalities and improving population health.	Jen Leah, Director of Finance

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

Not applicable.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable.

Appendix 1

NHS
Derby and Derbyshire
Integrated Care Board

Board Assurance Report

System Finance, Estates and Digital Committee – November 2024

Overall Board Assurance Level			
Full	**Adequate**	**Partial**	**Limited**
☐	☒	☐	☐

Matters of concern or key risks to escalate	Decisions made
Financial position 2024/5- As of 31 October 2024, the system is reporting a deficit of £24.2m the JUCD position is £3.8m away from its planned position of a £20.4m deficit. The Derbyshire system has a plan to breakeven and is committed to delivering this plan. However, there are ongoing risks to delivery. Based on current run rates there is a worst case risk of £41m however significant work has taken place to enact mitigations which will improve the run rate. **System Efficiency** – At M7 there was a year-to-date shortfall of £3.6m. The system continues to progress delivery of schemes with a risk to full year delivery of £20-30m. **Capital Board Assurance –** At M7 the YTD position was £11.6m under plan (should be noted the plan included an overprogramming allowance of 5%). It was noted there is a requirement for the ICB Board to sign off on assurance that as a System we would deliver our FOT on behalf of the whole System at M8. Providers confirmed that they were forecasting to be in line with allocation for M8, however there was a significant risk around the Eradication of Dormitories. There was a question as to how the extra costs had arisen and what the Trust was doing to mitigate.	**Capital Board Assurance –** The committee noted the proposal for managing the sign off of the M8 Board Assurance Statement required for the system capital position and recommended circulation to Board.

Financial Planning 2025/26 - The committee received an update on the work to prepare for 2025/26 financial planning. The committee noted the level of work undertaken to date jointly by all system finance teams. There were several key themes emerging from the underlying position with further actions being taken to mitigate. The committee discussed the scale of the underlying deficit and gave consideration as to level of transformation required and what we might have to stop doing as a system to achieve financial balance.	
Major actions commissioned or work underway	**Positive assurances received**
M7 Finance position - The M7 finance report included actions contained within it; all organisations were asked to provide timely updates ahead of the December meeting to address progress in those actions. Actions referred to the route to outturn and delivery of the 2024/25 breakeven plan. **Eradication of Dormitory Spending** – Committee asked for ongoing oversight of the programme delivery and financial outturns. **Elective Recovery** – The committee asked for a review of ERF to be presented to a future committee for assurance on delivery.	Formal presentations were received from each organisation on risks and mitigations to ensure delivery of agreed 24/25 plans. A report on the System transformation programmes and efficiency delivery was noted. Financial Planning - The System Finance, Estates and Digital Committee NOTED the JUCD 2025/26 financial plan update and actions being taken to ensure the plan was understood, realistic, deliverable and in line with our obligation to achieve medium term financial balance.
Comments on the effectiveness of the meeting	
There was good representation from System partners at the meeting. The Committee noted the work required and being done within the system to deliver the revised 2024-25 plan and the triangulation required across committees re finance, operations (inc. transformation) and workforce. Committee members contributed to the confirm and challenge discussions.	

Appendix 2

Derby and Derbyshire Integrated Care Board

Board Assurance Report

System Finance, Estates and Digital Committee – December 2024

Overall Board Assurance Level			
Full ☐	**Adequate** ☒	**Partial** ☐	**Limited** ☐

Matters of concern or key risks to escalate	Decisions made
Following on from the budget announcement key national messages were provided. • Welcome increase in funding announced £22bn for 2024/25 and 2025/26 which will support increases in pay awards, inflationary pressures and elective recovery. • Expectation for all systems to deliver the plans they have committed to for 2024/25 and for systems to focus on productivity to deliver improvement in activity levels into 2025/26. **Financial position 2024/25** • At M8 we had a £4.3m YTD adverse variance. • Derbyshire system has a plan to breakeven at year end and is committed to delivering this plan. • Continued ongoing risks to delivery. Based on current run rates there is a worst-case risk of £35m, this has reduced since M7. • The route to deliver a break even position is being developed by all system partners however this is dependent on a number of assumptions. These will need to be finalised as part of the M9 reporting process.	
Major actions commissioned or work underway	**Positive assurances received**
• A number of systems have entered a national **Intervention and investigation (I&I)** review. Learning and feedback from these reviews has been issued by NHSE. All systems expected to assess where they are against the findings and	• It was recognised as part of the regional review meeting the positive work carried out in relation to workforce numbers.

recommendations. **Action – All organisations to assess against the recommendations and take through internal governance. Overall collated System position against recommendations to be brought into Jan SFEC** • **National productivity packs** will be issued to support 2025/26 planning process. These are expected by the end of w/c 6th Jan. **Action – Productivity pack and actions to be brought into future SFEC. Date to be determined once packs received.** • Assumptions which underpin the M8 route to delivery to be confirmed as part of the M9.	

Comments on the effectiveness of the meeting
The Committee did not meet formally in December but had various updates via email and MS Teams meetings which kept them updated on the month 8 position.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th January 2025

Item: 116

Report Title	Population Health and Strategic Commissioning Committee Assurance Report – November 2024							
Author	Margaret Gildea, Non-Executive Member							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Margaret Gildea, Non-Executive Member							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Margaret Gildea, Non-Executive Member							
Which committee has the subject matter been through?	Population Health and Strategic Commissioning Committee, 12th December 2024							

Recommendations		
The ICB Board are recommended to **NOTE** the Population Health and Strategic Commissioning Committee Assurance Report.		
Board Assurance		
Level of Assurance	**The report demonstrates that:**	***Please select***
Full	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required by the Board.	☐
Adequate	• Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required by the Board.	☒

Partial	• Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or • Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required by the Board.	☐
Limited	• Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required by the Board.	☐

Items to escalate to the ICB Board

No matters of concern or key risks to escalate.

Purpose

This report provides the Board with a brief summary of the items transacted at the meeting of the Population Health and Strategic Commissioning Committee on the 14th November 2024.

Background

The Population Health and Strategic Commissioning Committee ensures that the ICB effectively delivers the statutory functions of the ICB. It is a requirement for Committees of the ICB to produce an assurance report as set out in the Committee's Terms of Reference.

Report Summary

The Population Health and Strategic Commissioning Committee's Assurance Report (Appendix 1) highlights to the ICB Board any:

- matters of concern or key risks to escalate;
- decisions made;
- major actions commissioned or work underway;
- positive assurances received; and
- comments on the effectiveness of the meeting.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource	☐

	immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.			digital transformation in order to improve outcomes and enhance efficiency.	

Any risks highlighted and assigned to the Committee will be linked to the ICB's Board Assurance Framework and Risk Register.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

No interests were declared at the meeting.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

Not applicable to this report.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable to this report.

Appendix 1

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Public Board Meeting

Population Health & Strategic Commissioning Committee – 14th November 2024

Overall Board Assurance Level			
Full ☐	**Adequate** ☒	**Partial** ☐	**Limited** ☐

Matters of concern or key risks to escalate	**Decisions made**
None to report.	14th November meeting: **Commissioning Decisions** The committee reviewed a confidential procurement process and agreed for it to move to board approval as per process. **Board Assurance Framework (BAF)** See below **Risk Register** See below
Major actions commissioned or work underway	**Positive assurances received**
14th November meeting: The Population Health and Strategic Commissioning Committee discussed the PSR regime for contracting, the impact of its now know complexity, and the impact on integration. A paper was commissioned from the ICB contracting team to focus on what is permissible under national regulations and how best to achieve integration and transformation. The Population Health and Strategic Commissioning Committee discussed the Primary Care Access Recovery Plan and noted that the ICB has continued to make good progress against the Primary Care Access Recovery plan in year 2 and has robust plans to deliver	14th November meeting: **Commissioning Decisions** The committee received the confidential Primary Care Subgroup Report **Risk Register** The corporate risks were not discussed at this meeting. **Board Assurance Framework (BAF)** The BAF strategic risks owned by the committee were not discussed at this meeting.

to target by the end date of 31/03/25. The Committee commend the work that's been carried out, recognise it as a partial - necessary but not complete - solution. The Committee recognises that the issues facing primary care network are multifactorial and exacerbated by the in higher National Insurance and increase in Minimum wage unless there's a solution proposed. This committee is really interested in a strategic approach and therefore having more input from the GP Provider Board as they look at the next phase of the work on the delivery model. <u>Matters arising</u> The committee briefly discussed the challenges emerging from the Living Wage and National Insurance Changes. The committee briefly discussed the potential impact of Derbyshire County Council cabinet decision and impact on NHS services and wider Residential Care, VCSE provision, befriending services etc. Post meeting note – the council cabinet decisions and impact on health are discussed at the ICS executive meeting and ICB executive meeting as appropriate.	**The following items were received for information:** • CPAG updates • Derbyshire Prescribing Group report/minutes • JAPC Bulletin • CPLG minutes • GP Strategy Update
Comments on the effectiveness of the meeting	
Nothing of note in terms of concerns. It was noted to be a productive meeting with good items received and good input and participation from committee members.	

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th January 2025

Item: 117

Report Title	Public Partnership Committee Assurance Report – November 2024							
Author	Sean Thornton, Director of Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, ICB Chief of Staff							
Presenter	Sue Sunderland, Vice Chair – Public Partnership Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Sue Sunderland, Vice Chair – Public Partnership Committee							
Which committee has the subject matter been through?	Public Partnership Committee, 26th November 2024							

Recommendations		
The ICB Board are recommended to **NOTE** the Public Partnership Committee Assurance Report.		
Board Assurance		
Level of Assurance	**The report demonstrates that:**	***Please select***
Full	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required by the Board.	☐
Adequate	• Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required by the Board.	☒

Partial	• Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or • Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required by the Board.	☐
Limited	• Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required by the Board.	☐

Items to escalate to the ICB Board

No matters of concern or key risks to escalate.

Purpose

This report provides the ICB Board with highlights from the meeting of the Public Partnership Committee on the 26th November 2024. The committee alternates its monthly meetings between business, through which project and programme schemes are reviewed for assurance, and development, where the committee discusses structural and process issues in greater depth to support committee establishment and role; the November meeting was a business meeting. This report provides a summary of the items transacted for assurance.

Background

The Public Partnership Committee ensures that the ICB effectively delivers the statutory functions of the ICB in relation to patient and public involvement. The committee also seeks, through its terms of reference, to drive citizen engagement in all aspects of the ICB's work to ensure that local people are central to planning and decision-making processes.

Report Summary

The Derbyshire Public Partnership Committee Assurance Report (Appendix 1) highlights to the ICB Board any:

- matters of concern or key risks to escalate;
- decisions made;
- major actions commissioned or work underway;
- positive assurances received; and
- comments on the effectiveness of the meeting.

Identification of Key Risks

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐

SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Any risks highlighted and assigned to the Public Partnership Committee will be linked to the ICB's Board Assurance Framework and Risk Register.

Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☐	No☐	N/A☒

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

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

No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

None raised as a result of the items reviewed at these meetings.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable to this report.

Appendix 1

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Public Partnership Committee on 26th November 2024

Overall Board Assurance Level			
Full ☐	**Adequate** ☒	**Partial** ☐	**Limited** ☐

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	<u>Board Assurance Framework (BAF)</u> The risk relating to population engagement in the design and development of services was reviewed, with the risk score remaining at 12. The Committee felt more assured through the actions being undertaken and asked when the score would decrease. They were informed that the score remained at 12 due to the complexity of the work underway and the high workload capacity which was being monitored. <u>Corporate Risks</u> The ratings for the Committee's corporate risks relating to communications and engagement team capacity (risk score of 6), stakeholder engagement (risk score of 12) remained the same due to ongoing work. The recently-adopted risk relating to the introduction of the new provider selection regime, ensuring that processes to connect PPI governance into change programmes are retained, remained at a risk rating of 3x3=9 but given that the risk hadn't materialised in practice, the committee may consider closing it at it's next meeting.
Major actions commissioned or work underway	**Positive assurances received**

• Board Assurance Framework action plan – ongoing delivery of mitigating actions
• East Midlands Fertility Policy Review
• Learning Disability Short Breaks pre-engagement
• Review of approach to committee/sub-group diversity.
• Establishment of Lay Reference Group.
• Ongoing development of engagement frameworks
  ○ Insight Framework
  ○ Governance Framework
  ○ Evaluation Framework
	<u>Patient and Public Involvement Log</u>
	This log records the outcomes of all assessments of legal duty triggers where service changes are identified. The log is presented to PPC at each meeting, with the open opportunity for members to request deep dives on any schemes listed. There had been eleven new assessments completed since the last meeting, and items noted by the Committee included:
	• The Women's Pelvic Health Service in Ashbourne: An additional clinic had been offered which was over and above what the majority of patients were offered, so equity was being sought. There were two other clinics close by that patients could be signposted to so no impact on patients.

○ Co-production Framework ○ Engagement Framework	• The Imperial Road Surgery, Ashover, medical centre practice merger: this was a merger of patient lists, not a takeover and would help patients due to better choice. Patients could now use either practice. <u>Women's Health Hub Engagement</u> The national health strategy for women aims to improve health outcomes for women and girls across England reducing inequalities but more importantly it is how we engage and listen to women and girls to make sure our services are fit for purpose. Funding was provided for two years and ends 2025. In Derby and Derbyshire, the approach taken was to improve what we have whilst better linking up to improve experiences and reduce waits. This is non recurrent funding, so it is being used to invest in upfront costs of developing training and investment in local women's health leaders, health champions and inclusive training for schools. from the project commencement our communities have been fully engaged. Two community events had been hosted, patients and public partners had been invited to join a steering group and workstream groups along with partnering with voluntary and community sector and enterprises reaching out further into more diverse and underserved groups. The committee was advised that the ICB had been working in co-production with Community Action Derby in the City and Link CVS in the County. A Patient and Public Partner for the Women's Health Hub Workstream attended committee to provide information around co production and how barriers had been highlighted that may have been overlooked by including women in the design process. Following engagement, which will end January 2025, reports will be produced whilst looking to developing a communications campaign. <u>Strategic Review of Community and Same Day Urgent Care</u> A strategic review of urgent treatment centres has begun, to include consideration of all community urgent and same day emergency care services, including out of hours and GP services. Data gathered around demographics, demand and transport shows that services are not equally distributed across the county. Currently the UTCs are located in Buxton, Whitworth, Ilkeston and Ripley.

	A period of pre-engagement will commence in early 2025, to seek the views of local people on access and other issues. Depending on conversations with public and geographical areas it is proposed that likely transformation and integration programmes will be required, and this position will be fed back to the committee. <u>Fertility Policy Review</u> The Committee has received previous updates on this work. The latest presentation marked the formal launch of pre-engagement, and outlined the programme that is underway across the East Midlands. There has been a fertility policy for many years, but boundary changes following formation of ICB Boards where Nottinghamshire are bringing Bassetlaw into their boundaries and Derbyshire have brought in Glossop have prompted a review given the differences in the policies. Currently there are three public engagement sessions planned in Derbyshire, along with a virtual session. Whilst working with the whole of the East Midlands, one survey has been developed that each ICB could use, assisted by an expert panel which included experts by experience and Fertility UK. Specific focus groups have been included for Glossop given the existing difference to policy position.
Comments on the effectiveness of the meeting	
The committee reviewed a series of assurance questions and agreed that the meeting had been effective.	

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

PUBLIC SESSION

16th January 2025

Item: 118

Report Title	Quality and Performance Committee Assurance Report – November 2024							
Author	Philip Sugden, Assistant Director of Quality							
Sponsor (Executive Director)	Prof Dean Howells, Chief Nurse Officer							
Presenter	Dr Adedeji Okubadejo, Clinical Non-Executive Member							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report Signed off by Chair	Dr Adedeji Okubadejo, Chair of Quality and Performance Committee							
Which committee has the subject matter been through?	Quality and Performance Committee – 28th November 2024							

Recommendations		
The ICB Board are recommended to **NOTE** the Quality & Performance Committee Assurance Report.		
Board Assurance		
Level of Assurance	**The report demonstrates that:**	***Please select***
Full	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required by the Board.	☐
Adequate	• Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required by the Board.	☒
Partial	• Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or	☐

	• Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required by the Board.	
Limited	• Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required by the Board.	☐

Items to escalate to the ICB Board

No matters of concern or key risks to escalate.

Purpose

This report provides the Board with a brief summary of the items transacted at the Quality and Performance Committee on 28th November 2024. Please note there was no Quality and Performance Committee in December 2024. As reported in previous reports the ICB is currently not compliant with any statutory operational targets relating to the urgent care and planned care and cancer programme. The 2024/25 NHS Operational Plan developed by the Derby and Derbyshire System addresses these issues of underperformance.

Background

The Quality & Performance Committee ensures that the ICB effectively delivers the statutory functions of the ICB.

Report Summary

The Quality and Performance Committee Assurance Report (Appendix 1) highlights to the ICB Board any:

- matters of concern or key risks to escalate.
- decisions made.
- major actions commissioned or work underway.
- positive assurances received; and
- comments on the effectiveness of the meeting.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital	☐

	achieve long term strategic objectives including reducing health inequalities and improve outcomes.			transformation in order to improve outcomes and enhance efficiency.	

ICB Risk Register risks 01, 03, 09, 19, 20.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

Not applicable.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable.

Appendix 1

Derby and Derbyshire Integrated Care Board

ICB Board Assurance Report

ICB Quality and Performance Committee – 28th November 2024

Overall Board Assurance Level			
Full ☐	**Adequate** ☒	**Partial** ☐	**Limited** ☐

Matters of concern or key risks to escalate	Decisions made
There were no items for escalation.	The following paper was discussed and approved: • **Learning from lives and deaths of people with a learning disability and autistic people (LeDeR): Presentation** Outline of current performance/outcomes from LeDeR reviews. A full report will be presented to the MH, LD&A Board with clear evidence of quality improvement work across Derbyshire.
Major actions commissioned or work underway	**Positive assurances received**
• **Update Operation Periscope:** High confidence that this will be fully operational by April 2025.	The following papers were presented for assurance: • **Derby and Derbyshire LMNS Quality and Safety Update Quarter 2, 24/25:** Paper outlining progress made and current position for Chesterfield Royal Hospital (CRH) and University Hospitals of Derby and Burton (UHDB) against maternity and neonatal service priorities. Members approved the report. • **Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust, from a Derbyshire perspective:** ongoing actions underway to seek assurance across Derbyshire providers against recommendations from the CQC Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust (Part 1 and 2). Members were assured of the self-assessment review. • **Integrated Performance Report:** members noted the pressures that the UEC System were under, and the winter plan had been presented to the DDICB Board.

	• **System Quality Group Assurance Report – 5th November 2024:** There were no identified items/concerns for escalation. • **AoB – SEND Inspection:** Following the inspection in September 2024 the report was published in November 2025. Outcome was an assessment of three. Improvement group established with independent chair commissioned by DDICB and Local Authority. **Ratified Minutes from:** • **Derbyshire Prescribing Group - 3 October 2024** • **System Quality Group Meeting - 1st OCTOBER 2024**
Comments on the effectiveness of the meeting	
Those present agreed that the meeting had been effective, with sufficient opportunity for discussion and that the papers presented were appropriate.	

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th January 2025

Item: 119

Report Title	Mental Health, Learning Disability and Autism Specialised Services host ICB commissioner and contract model							
Author	Chrissy Tucker, Director of Corporate Governance & Assurance							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1 – NHSE Commissioning Development Team Briefing Paper							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Not applicable							

Recommendations
The ICB Board are recommended to **NOTE** the appended briefing paper.
Purpose
The purpose of the paper is to update the Board on the plans for the management of Mental Health, Learning Disability and Autism services as part of the delegation of the specialised services functions from NHSE to ICBs.
Background
ICBs will be the responsible commissioners for a number of specialised services from 1 April 2025. However, the National NHSE will remain accountable for all specialised MHLDA services regardless of whether services have been delegated to ICBs or retained services that NHSE regions continue to be responsible commissioners for. There are 8 NHS Led Provider Collaboratives who own the operational and day to day delivery responsibility of the delegated services on behalf of NHSE and who are bound by a Partnership Agreement.
Report Summary
Post delegation, all 11 Midlands ICBs will assume commissioning responsibility for a number of MHLDA services, which align to the services co-ordinated by the Provider Collaboratives, and managed by the Commissioning Team that will transfer to the host ICB (Birmingham & Solihull for the East Midlands ICBs). The Commissioning Team will be expected to step in where appropriate and if required in the unlikely event that any of the functions of the Provider Collaboratives become unavailable.

Contracting options are being worked through and will be incorporated in the Delegation Agreements for ICB board approval before the end of March 2025.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain an affordable and sustainable workforce supply pipeline and to retain staff through a positive staff experience.	☐	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable.
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings Not applicable.

Appendix 1

BRIEFING PAPER

DATE: December 2024

PAPER TITLE: Mental Health, Learning Disability and Autism specialised services host ICB commissioner and contract model

PURPOSE: INFORMATION ☒

EXECUTIVE SUMMARY: This paper provides a summary of the considerations for contracting models for Specialised Mental Health, Learning Disability and Autism (MHLDA) services Provider Collaborative contracts which will be taken to the East and West Midlands Joint Committees.

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1. INTRODUCTION AND PURPOSE OF THE PAPER

1.1 The purpose of this paper is to update Boards on Specialised Mental Health Learning Disability and Autism Provider Collaborative Contracts prior to a decision that will be taken at the East and West Midlands Joint Committees on the ICB host contract leads once the Provider Collaborative Contracts are delegated to ICB in April 2025.

1.2 NHSE Midlands will cease to have commissioner responsibility for the services delegated to ICBs in the Midlands subject to final Board agreements. ICBs will be the responsible commissioners from 1 April 2025. However, the National NHSE will remain accountable for all specialised MHLDA services regardless of whether services have been delegated to ICBs or retained services that NHSE regions continue to be responsible commissioners for.

1.3 ` (ICBs post delegation).

1.4 There are 8 NHS Led Provider Collaboratives in the Midlands. There is a Lead Provider Contract (LPC) in place with each NHS trust who coordinate a set of mental health provider organisations (NHS and Independent sector) working together as a provider collaborative bound by a legal Partnership Agreement and a risk and gain share agreement (in some case). Pre and post delegation, each PC will continue to:

- Coordinate planning/ service transformation activities.
- Coordinate and lead annual contract negotiations with sub-contractors (NHS and ISP) within their PC footprint (circa 18 subcontractors that cover 39 different sub-contracts).
- Hold quarterly contract meetings with sub-contractors.
- coordinate and submit quarterly LPC contract review reports to NHSE Midlands (ICBs post delegation).
- Coordinate and identify population needs, gaps e.g. capacity and bed planning, Natural Clinical Flow with the LPC footprint/ services lines (NB: beds cannot be ring fenced just for East/ West or Midlands patients)
- Have financial oversight and management (payments, investments, expenditure) on a sub-population basis with sub-contractors.
- Ensure quality engagement and involvement of EbE in all activities.
- Undertake procurement activities/ PSR regime 2015 where required e.g. sub-contracting arrangements, new market entrants.

- Have quality and patient safety oversight of providers including annual quality service site reviews, quality improvement oversight.
- Coordinate and submit national/regional returns as requested related to LPC service lines.
- Be part of national LPC network and take part on national/regional working groups e.g. service transformation work, interface with other LPCs in other regions re cross border patient flows/ clinical pathway interdependencies.

1.5 The new 2-year LPCs have been issued and signed from 1 April 2024 with an option to extend for one additional year from 1 April 2026. The decision to extend the additional one year will be via ICBs post delegation as the new responsible commissioner from 1 April 2025.

2.Post Delegation

2.1 All 11 Midlands ICBs will have commissioning responsibility for the following specialised MHLDA delegated services:

- Adult secure services (incudes low secure, medium secure)
- Adult eating disorder services
- Perinatal (Mother Baby Units)
- Tier 4 CYPMH services (includes General Adolescent Unit, Eating Disorder, Low Secure, Psychiatric Intensive Care Units and community forensic CAMHS)

2.2 These delegated services align to the 8 Midlands NHS Led Provider Collaborative operating model/ arrangements (across 40 subcontracts) on a sub-regional footprint (East/West Midlands).

Table 1 – Midlands LPCs.

Specialised MHLDA services	**Live as at**	**East Midlands NHS Lead Provider and no: of subcontracts within footprint**	**Live as at**	**West Midlands NHS Lead Provider and no: of subcontracts within footprint**
Adult Low & Medium Secure (includes MI, PD and LDA)	1 Oct 2020 (Fast Track)	Nottinghamshire Healthcare NHS Foundation Trust 8 subcontracts	1 Oct 2021	Birmingham and Solihull Mental Health NHS Foundation Trust 7 subcontracts
Tier 4 CYMHS services (GAU, PICU, ED, LSU)	1 April 2021	Northamptonshire Healthcare NHS Foundation Trust 6 subcontracts	1 Oct 2022	Birmingham Women's and Children NHS Foundation Trust 7 subcontracts

Appendix 1

Specialised MHLDA services	Live as at	East Midlands NHS Lead Provider and no: of subcontracts within footprint	Live as at	West Midlands NHS Lead Provider and no: of subcontracts within footprint
Adult Eating Disorders (AED)	1 April 2021	Leicester Partnership NHS Trust 5 subcontracts	1 April 2021	Midland Partnership NHS Foundation Trust 5 subcontracts
Perinatal (Inpatient MBU)	1 Oct 2023	Derbyshire healthcare NSH Trust 1 subcontract	1 Oct 2023	Midland Partnership NHS Foundation Trust 1 subcontract

A small number of acute and MHLDA specialised services will remain commissioned through NHSE.

2.3 From 1 April 2025, NHSE Midlands will cease to have commissioner responsibility.

2.4 The Commissioning Team that will transfer to the host ICB will continue to provide the commissioning expertise to include the following

- Leadership/ coordination and assurance role re retain Midland's view across the 8 LPCs e.g. service transformation across LPC in the Midlands.
- Provide expertise and support to NHS Led Provider Collaboratives (LPC) to achieve strategic ambitions.
- Support LPCs to develop and deliver their transformation programme across specialised MHLDA delegated service lines.
- Coordinate learning, risks, and issues within the local systems and LPCs to inform learning and action at a national, regional and system level.
- Ensure LPCs complete consolidated annual PAMs for all delegated specialised MHDLA service lines by provider.
- Hold quarterly LPC contract review meetings with the respective 8 Midlands Lead Provider Collaboratives.
- Director level representation to each LPC programme boards.
- Interface with national NHSE and networks that include all LPCs across the country and NHSE regions (retained NHSE service lines).
- Coordinate, facilitate, de-escalate matters raised by LPCs and other regions/ ICBs.
- Coordinate/respond to FOI, complaints, and legal proceedings with respective LPCs and relevant partners.

2.5 The ICB host holding the contract would be expected to be:

- 3-way signatory to all NHS Led Provider Collaborative Direct Agreements with subcontractors to enable 'step in rights' should a LPC declare they no

longer wish to be a Lead Provider or ICB decision to disband the NHS Led Provider Collaborative operating model.

- Step in rights mean, the responsible commissioner is required to take back direct operational responsibility for these services and to directly manage the subcontracts and all the associate actions that the LPC would have undertaken.

2.6 The management capacity and leadership of all processes will be provided by the expertise in the specialised commissioning team (who will be hosted by BSOL) but working on behalf of the East And West Midlands joint committees.

2.7 In the unlikely evet of any requirement to take back direct operational responsibility the specialised commissioning team would undertake this function working closely with the host ICB holding the contract. This would be articulated in the delegation agreement.

3. NEXT STEPS

3.1 Options are being developed through November and December 24 through the working groups to develop a consensus view of the most appropriate model for hosting the contracts which manages risk effectively and whilst maximising the opportunities.

3.2 These options will need support from the ICB host designate before going to the East Midlands Joint Committees and West Midlands Joint committees in January 25.

3.3 The agreed position will then be incorporated in the delegation agreements for ICB board approval before the end of March 2025.

NHS
Derby and Derbyshire
Integrated Care Board

Derby and Derbyshire ICB

Meeting in Public Forward Planner 2024/25 - Summary

Please Note: All reporting timeframes are currently indicative and subject to review and confirmation.

ICB Key Areas	16 May	18 Jul	19 Sept	21 Nov	16 Jan	20 Mar
Leadership						
Chair's Report	X	X	X	X	X	X
Chief Executive Officer's Report	X	X	X	X	X	X
Citizen's Story		X	X	X	X	X
Annual Report and Accounts (AGM to follow Sept Board)			X			
Strategy, Commissioning and Partnerships						
Joint Forward Plan		X		X		
Strategic Update from Place			X			
Strategic Update from Provider Collaborative				X		
Estates Plan/ Infrastructure Strategy			X			
Opportunities for Delegated Services			X			
Research Strategy		X				
Primary Care GP Strategy and Primary Care Access Recovery Plan / GP Strategy Update	X			X		
Empowering General Practice Programme Update					X	
Digital Strategy – Progress and Priorities for 2025/26					X	
Green NHS Strategy and Progress						
Cyber Security Strategy						X
Final delegation papers for the Delegation of Specialised Commissioning, Host ICB Commissioner and Contract Model				X	X	X
Delivery and Performance						
Performance Report • Quality • Performance		X		X	X	X

ICB Key Areas	16 May	18 Jul	19 Sept	21 Nov	16 Jan	20 Mar
• Workforce • Finance			X			
Primary Care Access Recovery Plan	X					
NHS Impact	X					
Operational Plan and Financial Plans 24/25 and 25/26		X				X
2025/26 Operating Plan – Improvement objectives					X	
H1 & H2 Review and Reset				X		
Winter Plan			X	X		
Review on Intensive & Assertive Community Mental Health Care				X		
People and Culture						
ICB Staff Survey		X				
NHS Long Term Workforce Plan/ System Strategy						
One Workforce System Strategy, Approach and Ethos					X	
Governance and Risk						
Board Assurance Framework		X		X		X
ICB Risk Register	X	X	X	X	X	X
Assurance Reports from Committees	X	X	X	X	X	X
ICB Committee Review Proposal				X		
Committee Terms of Reference						X