NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC AGENDA

Thursday 18th July 2024 at 9.15am to 11:00am

Joseph Wright Room, First Floor
Derby City Council House, Derby, DE1 2FS

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

Time	Reference	Item	Presenter	Delivery
09:15	**Introductory Items**			
	ICBP/2425/027	Welcome, introductions and apologies: Dr Deji Okubadejo, Dr Chris Weiner, Ellie Houlston	Dr Kathy McLean	Verbal
	ICBP/2425/028	Confirmation of quoracy	Dr Kathy McLean	Verbal
	ICBP/2425/029	Declarations of Interest • Register of Interests • Summary register for recording interests during the meeting	Dr Kathy McLean	Paper
09:20	**Minutes and Matters Arising**			
	ICBP/2425/030	Minutes from the meeting held on 16.5.2024	Dr Kathy McLean	Paper
	ICBP/2425/031	Action Log – May 2024	Dr Kathy McLean	Paper
09.25	**Leadership**			
	ICBP/2425/032	Citizen's story	Steve Hulme	Paper/ Discussion
	ICBP/2425/033	Chairs Report – June 2024	Dr Chris Clayton	Paper
	ICBP/2425/034	Chief Executive Officer's Report – June 2024	Dr Chris Clayton	Paper
09.50	**Strategy, Commissioning and Partnerships**			
	ICBP/2425/035	Joint Forward Plan – Progress Report	Dr Chris Clayton	Paper

Time	Reference	Item	Presenter	Delivery
	ICBP/2425/036	Derby and Derbyshire Health and Care Research Strategy	Steve Hulme	Paper
10.10	**Delivery and Performance**			
	ICBP/2425/037	Final Operational Plan 2024/25	Michelle Arrowsmith	Paper
	ICBP/2425/038	Performance Report (including relevant Committee Assurance Reports) • Quality – Including Quality and Performance Committee Report • Performance – Including Population Health and Strategic Commissioning Committee Report • Finance – Including Finance, Estates and Digital Committee Report • Workforce Performance	Jill Dentith, Prof Dean Howells Richard Wright, Michelle Arrowsmith Jill Dentith, Keith Griffiths Margaret Gildea, Linda Garnett	Paper
10:30	**People and Culture**			
	ICBP/2425/039	People and Culture Committee Assurance Report – June 2024	Margaret Gildea	Paper
	ICBP/2425/040	ICB Staff Survey and Action Plan	Helen Dillistone	Paper
10:40	**Governance and Risk**			
	ICBP/2425/041	Audit and Governance Committee Assurance Report – June 2024	Sue Sunderland	Paper
	ICBP/2425/042	Public Partnership Committee Assurance Report – June 2024	Richard Wright	Paper
	ICBP/2425/043	Corporate Committees' Annual Reports 2023/24	Helen Dillistone	Paper
	ICBP/2425/044	ICB Board Assurance Framework – Quarter 1 2024/25	Helen Dillistone	Paper
	ICBP/2425/045	Risk Register Report – June 2024	Helen Dillistone	Paper

Time	Reference	Item	Presenter	Delivery
10.50	**For information**			
	The following items are for information and will not be individually presented			
	ICBP/2425/046	Forward Planner	Dr Kathy McLean	To note
	ICBP/2425/047	Glossary	Dr Kathy McLean	To note
10.55	**Closing Items**			
	ICBP/2425/048	Any Other Business	Dr Kathy McLean	Verbal
	ICBP/2425/049	Any risks identified during the course of the meeting	Dr Kathy McLean	Verbal
	ICBP/2425/050	Questions received from members of the public	Dr Kathy McLean	Verbal
Date and time of next meeting in public: **Date:** Thursday, 19th September 2024 **Time:** 9.15am to 11am **Venue:** Joseph Wright Room, Council House, Derby			Dr Kathy McLean	Verbal

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

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Allen	Tracy	Participant to the Board for Place	Primary & Community Care Delivery Board Chair of Digital and Data Delivery Board Integrated Place Executive Meeting	CEO of Derbyshire Community Health Services NHS Foundation Trust	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if 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	Ongoing	
				Sister-in-law is Business Development Director of Race Cottam Associates (who bid for, and undertake projects for the Derbyshire system estates teams)				✓	01/07/22	Ongoing	
Arrowsmith	Michelle	Chief Strategy and Delivery Officer/ Deputy Chief Executive Officer	Finance, Estates & Digital Committee Population Health & Strategic Commissioning Committee Quality & Performance Committee	Director of husband's company - Woodford Woodworking Tooling Ltd				✓	01/11/14	Ongoing	No action required as not relevant to any ICB business
Austin	Jim	Chief Digital & Technology Officer	Finance, Estates & Digital Committee Primary Care Digital Steering Group	Employed jointly between NHS Derby and Derbyshire Integrated Care Board and Derbyshire Community Health Services NHS Foundation Trust	✓				01/11/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Spouse is a locum GP and the Local Place Alliance lead for High Peak (8 hours per week)				✓	01/11/22	Ongoing	
Bhatia	Avi	Participant to the Board for the Clinical & Professional Leadership Group	Chair - Clinical and Professional Leadership Group, Derbyshire ICS Population Health & Strategic Commissioning Committee	GP partner at Moir Medical Centre	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if 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	Ongoing	
				Spouse works for Nottingham University Hospitals				✓	01/07/22	Ongoing	
Clayton	Chris	Chief Executive Officer	ICS Executive Team Meeting	Spouse is a partner in PWC				✓	01/07/22	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Corner*	Julian	ICB Non-Executive Member	Public Partnership Committee Population Health & Strategic Commissioning Committee Remuneration Committee	As the CEO of Lankelly Chase Foundation, I may have an interest in organisations being commissioned by the JUCD if that would support a grant funding relationship that Lankelly Chase has with them.		✓			01/03/22	30/06/25	Not aware of any grant relationships between Lankelly Chase and Derbyshire based organisations, or organisations that might stand to benefit from JUCD commissioning decisions. If that were to happen I would alert the JUCD chair and excuse myself from decisions both at Lankelly Chase and JUCD.
Dentith	Jill	Non-Executive Member - Finance, Estates & Digital	Audit & Governance Committee Finance, Estates & Digital Committee People & Culture Committee Quality & Performance Committee	Self-employed through own management consultancy business trading as Jill Dentith Consulting	✓				2012	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Director of Jon Carr Structural Design Ltd	✓				06/04/21	Ongoing	
				Providing part-time management consultancy services to Conexus Healthcare Community Interest Company	✓				01/06/23	30/06/24	
Dillistone	Helen	Chief of Staff	Audit & Governance Committee Public Partnership Committee	Nil							No action required
Garnett	Linda	Interim Chief People Officer	People & Culture Committee Population Health & Strategic Commissioning Committee Finance, Estates & Digital Committee ICS Executive Team Meeting Clinical & Professional Leadership Group	My husband is an independent consultant and is currently working in the ICS via a commission with Amber valley CVS				✓	01/07/22	Ongoing	None required currently
Gildea	Margaret	Non-Executive Member / Senior Independent Director	Audit & Governance Committee People and Culture Committee Remuneration Committee Derby City Health & Wellbeing Board	Director of Organisation Change Solutions 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	Nil							No action required
Houlston	Ellie	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)	System Quality Group Integrated Care Partnership Health and Wellbeing Board - Derbyshire County Council	Director of Public Health, Derbyshire County Council	✓				01/09/22	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair. Sheffield based - unlikely to bid in work in Derbyshire
				Director and Trustee of SOAR Community			✓		01/09/22	Ongoing	

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Howells	Dean	Chief Nurse Officer	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee Local Maternity and Neonatal System Board Clinical and Professional Leadership Group Information Governance Assurance Forum ICS Executive Team Meeting	Honorary Professor, University of Wolverhampton	✓				13/09/23	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair.
McLean	Kathy	ICB Chair	Remuneration Committee	Non Executive Director Barking Havering and Redbridge NHS Trust		✓			20/06/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				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	Ongoing	
				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	
				Senior Clinical Advisor for Public Sector Consultancy	✓				Ongoing	Ongoing	
				Chair of ICS Network, NHS Confederation		✓			01/04/24	Ongoing	
				Chair of East Midlands Specialised & Joint Committees		✓			01/04/24	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 Primary Care Network Delivery & Assurance Group End of Life Programme Board Children's Urgent Care Group Urgent Treatment Centres Delivery Group Amber Valley Place Alliance Group Virtual Wards Delivery 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	
Posey	Stephen	Chief Executive Officer, UHDBFT (NHS Trust & FT Partner Member)	UEC Delivery Board (Chair) 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	Ongoing	
				Executive Well-Led Reviewer for the Care Quality Commission		✓			01/06/18	Ongoing	
				Chief Executive Member of the National Organ Utilisation Group		✓			02/07/21	Ongoing	
				Partner is Chief Executive Officer of the Royal College of Obstetricians and Gynaecologists				✓	01/08/23	Ongoing	
				Partner is a Non-Executive Director for the Kent, Surrey & Sussex (KSS) AHSN				✓	01/08/23	Ongoing	
				Partner is a Non-Executive Director for Manx Care				✓	17/05/23	Ongoing	

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Powell	Mark	Chief Executive Officer, DHcFT (NHS Trust & FT Partner Member)	People & Culture Committee Population Health & Strategic Commissioning Committee	CEO of Derbyshire Healthcare NHS Foundation Trust Treasurer of Derby Athletic Club	✓		 ✓		01/04/23 01/03/22	Ongoing Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
Radford	Lee	Chief People Officer	People & Culture Committee Population Health & Strategic Commissioning Committee Finance, Estates & Digital Committee ICS Executive Team Meeting Clinical & Professional Leadership Group	Nil							No action required
Sadiq	Perveez	Service Director - Adult Social Care, Derby City Council		Nil							No action required
Smith*	Andy	Strategic Director of People Services - Derbyshire County Council (Local Authority Partner Member)	Clinical and Professional Leadership Group	Director of Adult Social Care and Director of Children's Services, Derby City Council Member of Regional ADASS and ADCS Groups	✓	 ✓			01/07/22 01/07/22	Ongoing Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
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 Independent Audit Chair of Joint Audit, Risk & Assurance Committee for Derbyshire Office of the Police & Crime Commissioner and Chief Constable Husband is an independent person sitting on Derby City Council's Audit Committee	✓ ✓			 ✓	01/07/22 01/07/22 01/07/22	Ongoing Ongoing Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
Weiner	Chris	Chief Medical Officer	Population Health & Strategic Commissioning Committee Quality & Performance Committee System Quality Group EMAS 999 Clinical Quality Review Group Local Maternity & Neonatal System Board Clinical and Professional Leadership Group ICS Executive Team Meeting	Nil							No action required
Wright	Richard	Non-Executive Member	Population Health & Strategic Commissioning Committee Public Partnerships Committee	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

ITEM 030

MINUTES OF NHS DERBY AND DERBYSHIRE ICB BOARD MEETING IN PUBLIC

Held on Thursday, 16th May 2024

via Microsoft Teams

Unconfirmed Minutes

Present:		
Dr Kathy McLean	KM	ICB Chair (Meeting Chair)
Tracy Allen	TA	Chief Executive DCHSFT / Participant to the Board for Place
Michelle Arrowsmith	MA	ICB Chief Strategy and Delivery Officer / Deputy CEO
Jim Austin	JA	ICB Chief Digital and Information Officer
Dr Avi Bhatia	AB	Participant to the Board for the Clinical & Professional Leadership Group
Dr Chris Clayton	CC	ICB Chief Executive Officer
Jill Dentith	JED	ICB Non-Executive Member
Helen Dillistone	HD	ICB Chief of Staff
Linda Garnett	LG	ICB Interim Chief People Officer
Margaret Gildea	MG	ICB Non-Executive Member / Senior Independent Director
Keith Griffiths	KG	ICB Chief Finance Officer
Ellie Houlston	EH	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)
Prof Dean Howells	DH	ICB Chief Nurse
Dr Andrew Mott	AM	GP Amber Valley (Partner Member for Primary Care Services) / Medical Director of GP Provider Board
Dr Deji Okubadejo	DO	ICB Board Clinical Other Member
Stephen Posey	SPo	Chief Executive UHDBFT / Chair of the Provider Collaborative Leadership Board (NHS Trust and FT Partner Member)
Mark Powell	MP	Chief Executive DHcFT (NHS Trust and FT Partner Member)
Perveez Sadiq	PS	Service Director, People Services, Adult Social Care Services – Derby City Council (Local Authority Partner Member)
Sue Sunderland	SS	ICB Non-Executive Member
Dr Chris Weiner	CW	ICB Chief Medical Officer
Richard Wright	RW	ICB Non-Executive Member
In Attendance:		
Sam Waters	SW	BSL Interpreter
Helen Blunden	HB	BSL Interpreter
Clive Newman	CN	Director of Primary Care
Dr Duncan Gooch	DG	Place Lead for General Practice / Board Member for GP Provider Board / Chair of Primary Community Care Delivery Group
Kathryn Durrant	KD	ICB Board Secretary
Suzanne Pickering	SP	ICB Head of Governance
Apologies:		

Item No.	Item	Action
ICBP/2425/001	**Welcome, introductions and apologies:** Dr Kathy McLean (KM) welcomed all Board Members and attendees to the meeting.	

	No apologies for absence were received.	
ICBP/2425/002	**Confirmation of quoracy** It was confirmed that the meeting was quorate.	
ICBP/2425/003	**Declarations of Interest** The Chair reminded Committee Members of their obligation to declare any interests they may have on issues arising at Committee meetings which might conflict with the business of the ICB. Declarations made by members of the Board are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the ICB Board Secretary or the ICB website, using the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/integrated-care-board-meetings/ No declarations of interest were made with regards to this agenda.	
ICBP/2425/004	**Minutes of the meeting held on 21st March 2024** The Board were advised that an action relating to Holistic Discharge Review was stated as assigned to Sue Sunderland (SS) but was being taken forward by Dr Chris Clayton (CC). It was agreed to amend this detail in the minutes and in the action log. **Subject to the amendment as stated above, the Board APPROVED the minutes of the above meeting as a true and accurate record of the discussions held.**	
ICBP/2425/005	**Action Log – March 2024** All open actions and matters arising from the meeting on 21st March 2024 were closed. **The Board NOTED the action log, which will be updated accordingly.**	
ICBP/2425/006	**Chair's Report – April 2024** KM presented the Chair's report, which was taken as read and the following points of note made: • Thanks were given to RW for his hard work during his tenure as ICB Chair and for ensuring that there has been a smooth transition for the new Chair. RW's ongoing work within the ICB will be very valuable. • KM provided a broad overview of her background and other areas of responsibility, including as Chair of the NHS Network Confederation Board and the Confederation ICS Network, which will allow the Derbyshire system to share learning and influence across the country. • 2024/25 will be very challenging; the system will need to focus on current issues, such as improving outcomes and reducing health inequalities, while also ensuring that plans are put in place in a timely manner. Wider system sessions throughout the year will address this.	

	• The importance of the Board supporting the changes happening in local work and in the four Derbyshire Trust Boards was emphasised. Value will be added by the ICB convening the wider focus, for example on healthcare inequality and changing pathways, and working with Local Authority partners. • Claire Ward has been elected as Mayor of the East Midlands Combined County Authority; Mrs Ward was formally Chair of Sherwood Forest Hospitals NHS Foundation Trust and will likely have a keen focus on healthcare. **The Board NOTED the Chair's report.**	
ICBP/2425/007	**Chief Executive's Report – April 2024** CC presented his report, which was taken as read and the following points of note made: • A formal welcome to KM as the new Chair of the ICB and thanks to RW on behalf of the Executive Team for his hard work as Chair; • National changes in terms of access, including GP appointment data, MMR vaccine uptake and cancer Faster Diagnosis Standard. The Board receive equivalent figures for Derbyshire through regular reporting which show improvements to these areas; • The value of a recent meeting with Professor Claire Fuller, Medical Director of Primary Care at NHSE, to discuss changes and transformation of General Practice policy and implementation at national and local level; and • Changes within the system, including KM as the new ICB Chair, Prem Singh as the new Chair of UHDB and Dr Gisela Robinson as new Executive Chief Medical Officer at UHDB. **The Board NOTED the Chief Executive's report.**	
ICBP/2324/008	**Primary Care Model Update** Dr Andy Mott (AM) and Dr Duncan Gooch (DG) gave an overview of the model, which was initially presented to the Board in Autumn 2023 and has been updated following input and support from Prof. Claire Fuller. The following points were made: • the Board will be asked to decide how often updates on progress should be provided; • the Primary Community Care Delivery Group will take a key role in the coordination and delivery of the model, linking into Integrated Place Executive and the Provider Collaborative space. Learning from organisations such as Team Up will be helpful in delivery of the transformation; • engagement work with general practice and the local population has taken place and will continue; • a particular challenge is sourcing consistent data to inform regular access to services and stratification of patients into the three cohorts detailed within the paper; and • the model is a several-year programme that links in closely to the Joint Forward Plan. Management support is being provided by ICB Director of Primary Care Clive Newman's (CN) Team. The following points were made in discussion:	

	• the model is very important and a key driver in terms of the work taking place within primary care. Governance and well-established connectivity are vital. The system has been looking into efficiencies in terms of the links with Estates and Digital and how to make best use of assets; • strategic communication with staff and the local population is key to ensuring that those providing and using the service are aware of and supportive of the changes taking place; • there are considerable local geographical differences in communities around Derbyshire, so it will be vital that staff use local skills, adeptness and knowledge to reach the same outcomes. There must be a culture of encouraging and sharing learning; Team Up have been very successful in doing this so far and their methodology for implementing change and transformation in communities should be shared, implemented and built on; • it was asked if the Public Partnership Committee may be able to assist with the engagement work that still needs to be undertaken. Some work has been taking place within the ICB, but it would be helpful to discuss with the Committee as they will have the skillset required to advise further; • the importance of a more detailed implementation plan and establishing equity of delivery which, in terms of governance, the system is in a strong position for; • a vibrant general practice is vital to the model of care and the work that has taken place to reach the strategic priority. There are now more united general practices in Derbyshire contributing to the influence across the NHS and the broader ICS development space. Significant developments and cohesion of view are being seen in the General Practice Forward Plan. Colleagues in PCNs have been referencing the work taking place strategically; • alignment is being seen between general practice, PCNs and Place. The developing connections and bonds between them will start to be shown in future Board meetings; • in terms of cultural organisational development, the People and Culture Committee has been focussing on systemic, broad transformations, rather than at individual organisation-level, as this transformation will affect the whole system and the relationship between its component parts. Assurance was sought that the Committee are doing enough to support and provide assurance for this work; • from the perspective of DCHSFT and Place, the GP model and primary care transformation has been developed closely with Place partners via the Integrated Place Executive. The Derbyshire NHS system and Local Authorities are supportive of the model, with primary care transformation at the centre. DCHSFT have considered changes to structures, cultures and ways of working that must be made to align with the new transformation taking place, and to give staff the freedom and confidence to work differently. DCHSFT and CRHFT held a Board-to-Board recently, and discussed how the Trusts are changing to be part of the local Place transformations; • from the perspective of DHcFT, work is taking place to meet the imperative around integration and opportunities include the Living Well programme. There is also a focus on addressing healthcare inequalities, which are inextricably linked to the primary care model; • from the perspective of the acute trusts, there are many opportunities for alignment to the transformation work; and	

	• it is necessary to firmly establish oversight of the work, governance and the engagement process for the primary care model. **Action: KM to review all governance processes as part of the new Chair role.** In the next phase, the work should consider how the measures link to and impact on population health and prevention, and how this data can be collated and measured. There is support for the work that has been done so far on the model and that is still underway. More work will need to be done, particularly with the acute sector and in the public engagement space. It would be helpful for the Board to see some case studies of where and how changes have been made effectively. The culture aspect of the model will be strengthened, and good links with Place have already been established. KM advised that a governance review should be able to streamline some of the processes currently taking place. KM will look at the forward plan with Helen Dillistone (HD) and it will then be decided when this work will need to be brought back to the Board. **The Board:** • **NOTED the update and progress made implementing the primary care model and CONSIDERED it in the context of the current planning process;** • **AGREED to receive regular updates and assist unlocking strategic risks; and** • **SUPPORTED a greater system focus on enablers including workforce, data and digital which impact on implementation of the model.**	**KM**
ICBP/2425/009	**Performance Report** The Performance Report was taken as read; Chairs of the four relevant committees were invited to share their comments with regards to scrutiny, areas of limited assurance or any other areas of note. <u>Quality</u> Dr Adedeji Okubadejo (DO) and Prof Dean Howells (DH) provided the Board with assurance in relation to the following areas from the Quality report: • maternity performance is progressing across the whole system; • Quality and Performance Committee have received reports that progress is being made in Infection Prevention and Control (IPC) across the system, particularly in the management of sepsis; • assurance reports have been received for Personal Health Budgets and Neurodevelopment in Children and Young People, with no concerns expressed; • work is progressing in relation to stroke services; • future planning will be a focus for the Committee, with a view to predicting what will happen and guiding progress; • an oversight meeting with UHDBFT and CQC has taken place to discuss the Section 31 CQC maternity plans; UHDBFT are showing an appropriate level of intent and progress. Assurance is expected in September 2024; • an All-Party Parliamentary Group publication regarding birth trauma was published on 13th May 2024, which advocates for the creation	

	of a National Maternity Improvement Strategy and makes twelve strategic recommendations. The Local maternity and neo-natal system will discuss the publication and recommendations; and • DH thanked NHSE for their oversight and support with IPC issues. Comments were invited on the Quality and Performance Report. The Board were assured that the required mitigations and actions are in place, and that progress is being made. <u>Performance</u> Thanks were given to front-line staff for their hard work resulting in a significant performance improvement last year. RW and Michelle Arrowsmith (MA) highlighted the following areas from the Performance report: • there are certain areas where good progress is not reflected in improvements elsewhere; for example, although acute turnaround times have dropped, this has not resulted in expected improvement to Category 2 response times. Improvements have been seen in handover delays and in meeting the 4-hour target. Correlations between improvements in separate areas are nuanced and complex, and work is taking place with EMAS and urgent and emergency care colleagues to understand how the metrics connect and influence each other; • there are considerable challenges in out of area work, which may be mitigated by mental health investment; • how activity can be balanced to ensure best allocation of resources to areas for a positive, sustained effect on performance levels; and • the importance of embedding continuous improvement and entrenching the systems and processes that keep the metrics improving. It is important to recognise that 20% of overall health outcomes are generated from health access and improvements in performance have a direct effect on population health. The next Board Meeting in Public will include discussion of the Joint Forward Plan; through this plan the system will be able to crystallise how to deliver the integrated care strategy, specific performance requirements and actions that promote health access. The ICB played an important role last year in convening the system and ensuring all partners were signed up to focus on a safe and efficient emergency care pathway. The Board recognised the system-wide improvement in discharge work; the target of 15% was met due to all the NHS and Local Authorities working together towards an overarching priority of a safe and effective emergency non-elective care system during the winter. It would be helpful to pull together a brief narrative to describe the improvement that the work has had on the system, and how the positive impact can be continued. **Action: HD to include the Joint Forward Plan refresh for July on the Forward planner.**	**HD**

Workforce

Margaret Gildea (MG) highlighted the following areas from the Workforce report:

- there has been a huge concentration at year-end on workforce numbers and reconciling them with the financial position:
  - concern was raised on how to reconcile the necessary growth in vital areas, such as mental health and maternity, with the challenging resources available to the system and in the face of industrial action. This resulted in the wording of the Board Assurance Framework for Risk 5 being changed to reflect the system's need to successfully provide services within the financial constraints that are in place; and
  - the difference that the Committee can make is in changes that are systemic rather than at individual level.
- the Derbyshire Academy has been set up with a view to reducing duplication and saving costs through working together;
- the system is in a better place in terms of outturn than last year; currently the system is above the target by 600 WTE. A steering group will review agency spend where the system is over capacity, particularly in the admin and infrastructure agency;
- there is a high level of scrutiny in general for the Committee's work at Board-level and national-level. The focus is on making small changes that can have a big impact;
- the Derbyshire-wide Leadership Development programme has been launched, which is of no cost to staff in healthcare, social care or voluntary sector. This programme has been very well received and there has already been a large take-up of the offer; and
- the importance of the future workforce plan, which will cover pathways through the workforce, changing the working culture of the system and ensuring that resources are available at the right level when needed.

Linda Garnett (LG) made the following comments:

- the focus in 2023/24 was on sourcing and triangulating workforce data, ensuring accuracy in the workforce numbers as correctly aligned with financial figures. At the end of 2023/24 this focus is reflected, for example in the control of growth and reduction of agency usage; and
- the Committee's focus will now need to be on the future health and care workforce, for individual organisations and the system.

From the perspective of the Provider Collaborative, it is important to take a fresh approach and establish if there are opportunities to work differently, rather than simply replacing staff. This has been part of the Collaborative's planning but it is now looking at how services can be transformed.

There were issues triangulating accurate workforce numbers with finance over 2023/24, therefore in 2024/25 triangulation across quality, safety and performance agendas is important to ensure the workforce in Place can be remodelled in the most appropriate way to deliver high quality care.

DCHSFT have made progress in preparing for the future and working together as a system. The NHSE Enhance Programme, in which DCHSFT have been a national trailblazer, develops skills in doctors. The

	Newly Qualified Nurse Rotation Programme develops nurses' leadership skills and ensures that they have worked in placements across acute, primary care, mental health and community services. The socio-economic importance of training local staff locally is vital and the Board was reminded of the importance and contribution of university and college colleagues. It is hoped that the work around data and figures will be carried out at executive level, then reported to Board, allowing the Board to take up a strategic, guidance role. <u>Finance</u> Jill Dentith (JED) and Keith Griffiths (KG) highlighted the following areas from the Finance report: • the report presents the triangulation between finance, workforce and efficiency, focussing on the statistical aspect and not duplicating the work of the People and Culture Committee; • the system has ended the year with £43.2m deficit, including the deviations agreed from the 'break even' position; the actual final position was £59.8m incorporating technical adjustments; • 99% of the required efficiencies have been delivered; the Finance, Estates and Digital Committee focuses on the split between recurrent and non-recurrent efficiency and ensures the balance is maintained. There is still concern that the system is not delivering efficiently in terms of the current resource; • in terms of the capital position, the Committee are looking at the mental health dormitories programme and ensuring that their work does not overlap with that of the provider organisations; • the Committee are considering how the Estates and Digital Strategies fit in with the overall capital allocation to ensure the balance of the recurrent and non-recurrent split in the cash position is maintained, and to protect the system against difficulty later in 2024/25; and • thanks to managerial and clinical leadership colleagues across the system who have been coordinating issues of quality, performance and workforce to deliver the efficiencies, which is a significant achievement. The commitment to deliver the H2 reset; the operational challenge to maintain elective and non-elective activity through surge and super surge over Quarter 4 was delivered within the financial forecast. This success may not have been possible without system connectivity in the planning process. **The Board NOTED the Performance Report.**	
ICBP/2425/010	**Operational Plan Update 2024/25** CC gave an overview of key points in the updated plan: • it is broadly compliant with the national requirement from NHSE. Where the plan is not compliant, improvement plans are in place; • it is not yet affordable within the constraints of the financial resources that Derbyshire is allocated, as the current position is a £68m deficit position. Work continues with NHSE to balance system finance against the service that it wishes to deliver; • in terms of workforce, there is growth in some areas and efficiency in other areas. Excluding EMAS, across the system the position is flat, including specific growth in diagnostic centres, targeted workforce and introduction from Local Authorities into DCHSFT; and	

	• strategic aims for this year are to maintain the stabilisation of emergency care and focus on improving the position of elective care, with the ambition to reduce overall waiting times by 2%. Comments and discussion were invited on the updated plan: • thanks were expressed to all colleagues for their hard work in preparing the plan; a very complex and detailed process. There remains a considerable amount of improvement and productivity work that will need to be delivered, however an improvement has taken place in the triangulation of activity, performance, finance and workforce compared to previous years; • it will be necessary to focus this year on what the system can achieve together to address the financial imbalance, to provide all the services that are required by the population with a high level of quality and safety, and to reach a sustainable position; • Audit and Governance Committee have received internal audits and a review of operational planning for 2023/24; the audits were reviewed and compared to the planning process for 2024/25 with a view to learning lessons and informing the process for future planning. The Committee found that the current year's process has involved more mature discussions between providers and has improved transparency and triangulation; • at a recent meeting of provider Chairs, the consensus was that the focus should be on supporting medium term clinical and financial sustainability. The Provider Collaborative is focussing on what can be achieved together; it is acknowledged by every provider that the way the system has operated in the past will no longer work moving forwards; and • by the next Board meeting it is likely that the finalised Operational Plan and the Joint Forward Plan will be ready for completion. **The Board NOTED the report on the Operational Plan 2024/25.**	
ICBP/2425/011	**Primary Care Access Recovery Plan** The Board were reminded that the primary concern of the population is being able to make a face-to-face appointment with a GP when required. There are over 1 million interactions with primary care every day and a minor shift in this area can have tremendous impact elsewhere. MA gave an overview of the Recovery Plan, noting the following: • the Recovery Plan is a national initiative and is focused on improving access to primary care for patients and managing the rush that patients face in the early morning to make an appointment with a GP or other primary care health professional; • there are a number of areas of national requirement where the Derbyshire system is responding locally; and • it covers two years and is currently at around the halfway stage. Clive Newman (CN), Director of Primary Care, highlighted the following: • general practice is the biggest provider of contact with the community, with over 500k appointments each month and over an 11% increase in appointments since 2019. Demand is higher than capacity and supply; this is an ongoing problem for patients and practices and there are considerable challenges still in terms of workforce demand and rising acuity;	

- there has been significant investment in general practice through the Additional Roles Reimbursement Scheme; there has been an increase of 686 WTE since 2019, representing investment of £25m;
- telephone systems have been upgraded this year and are now all digital cloud-based systems;
- the Pharmacy First scheme was introduced in January 2024;
- over half of Derbyshire GP practices have completed the GP Improvement Programme;
- this piece of work needs to be linked to broader strategic work; and
- In general, good progress has been made towards the targets of the two-year plan, but more structural and strategic work needs to be done to change the model of general practice.

Clarification was sought on two points:

- in terms of reporting progress to the regional oversight Quarterly system Review Meeting, the target for increasing available appointments since the pandemic has been met. There is additional work needed to address the target for two-week-waits as the target for patients being seen within two weeks is 85% and the system is at 82%; Derbyshire are not an outlier in this. The target for installing digital telephony has been met; and
- in terms of qualitative feedback from patients, the National Patient Survey is implemented locally; results of this survey are mixed.

Comments and discussion were invited regarding the plan:

- patients contacting a practice may be reluctant to be seen by a professional that is not a GP, even if this would be the most appropriate course of action. If a patient is not able to source an appointment that they feel is right for them, with the right professional and at the right time, they may instead present at emergency care or another provider, increasing the pressure elsewhere in the system;
- there is considerable disparity between practices. For example, some employ training GPs and so have greater capacity;
- initial triage when a patient makes first contact with a practice, and ensuring that the patient gets to the right person at the right time in the right place, are crucial;
- in April 2024 there were 655,047 patients logged into the NHS App in Derbyshire, and 4,474 appointments managed via the App. The number of appointments represents a fraction of the total number of interactions; however the number has grown by around 14% each month for the last six months and is currently at its highest level in three years. Tracking and understanding the use of the NHS App will be helpful, although there may be issues in terms of equity of access to healthcare, which will need to be addressed in future. All NHS App data is available at ICB, PCN and practice level here: NHS App dashboard - NHS England Digital; and
- although the number of appointments offered in Derbyshire each year is significantly higher than at any time before, access and public perception of access to general practice is worse, and the prime issue is capacity.

The Board NOTED that the ICB has made good progress against the Primary Care Access Recovery plan in year one and has robust plans to deliver to target by the end date of the 31st March 2025.

ICBP/2425/012	**NHS Impact Programme** Dr Chris Weiner (CW) gave an overview of the NHS Impact Programme, highlighting that: • the programme is focussed on continuous quality improvement within the NHS and outlines the next steps needed; and • the majority of the continuous quality work currently taking place is undertaken in provider settings; the programme seeks to develop a more system-based quality improvement approach, which is an opportunity for the system to align the quality improvement agenda with the Five-Year Plan, with delivery of improved health equity to communities and with the primary and secondary care prevention agendas. This work is a positive development and should be considered by the whole system, not just at Board-level. Providers have started to look at the wider approach across the system; currently DHCFT, CRHFT and DCHSFT all use the quality, service improvement and redesign methodology that the Impact Programme is promoting, and accredited trainers are now training colleagues. There will be a meeting to discuss providing a quality improvement intervention for integrated Place-based teams to support the implementation of the GP programme. This is a key ambition within the GP model and it would be helpful to have a common framework and set of tools to bring these community-based teams together to work on the priorities in the Five Year Plan. **Action: KM to consider what the system should do to push forwards and build on this work.** **The Board DISCUSSED and NOTED:** • **the NHS Impact Programme; and** • **how the NHS Impact Programme could assist in the delivery of the strategic priorities for the Derby City and Derbyshire Integrated Care system.**	**KM**
ICBP/2425/013	**Audit and Governance Committee Assurance Report – May 2024** SS presented the report which was taken as read, and highlighted the following: • the Committee were impressed with the draft Annual Report and Accounts and recognised the hard work that has gone into preparing them to such a high standard of quality and completeness. This was echoed by the external auditors; and • there is currently an issue around finalisation of internal audit reports where it has not yet been possible to receive an overall Head of Internal Audit opinion; this is an unusual position and will be rectified promptly. **Action: Final publication of internal audit reports to be chased.** **The Board RECEIVED and NOTED the report for assurance purposes.**	**HD**
ICBP/2425/014	**Finance, Estates and Digital Committee Assurance Report – March and April 2024** These reports were taken as read. No questions were raised.	

	The Board RECEIVED and NOTED the report for assurance purposes.	
ICBP/2425/015	**Quality and Performance Committee Assurance Report – December 2023 and January 2024** This report was taken as read. No questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes.**	
ICBP/2425/016	**Population Health and Strategic Commissioning Committee Assurance Report – April 2024** This report was taken as read. No questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes.**	
ICBP/2425/017	**People and Culture Committee Assurance Report – February 2024** This report was taken as read. No questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes.**	
ICBP/2425/018	**Public Partnership Committee Assurance Report – February 2024** This report was taken as read. No questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes.**	
ICBP/2425/019	**ICB Board Assurance Framework (BAF) – Quarter 4 2023/24 and Opening 2024/25 position** The item was taken as read and it was noted that the BAF will be reviewed at a future Development Session. HD highlighted three areas of the report: • in terms of the changes to scores, considerable work has been undertaken this quarter to scrutinise and review the controls, mitigations and actions to ascertain if they are making a difference in the scores; • it will be necessary to review and refine the risk descriptions during quarter 1; and • controls and mitigations will be reviewed to ensure that they are driving the actions to implement the changes that are required. **The Board:** • **RECEIVED the Quarter 4 23/24 closing BAF strategic risks 1 to 10 and opening Quarter 1 24/25 BAF strategic risks;** • **NOTED the decrease in risk score for Strategic Risk 1 from a very high score of 16 to a high score of 12;** • **NOTED the decrease in risk score for Strategic Risk 3 from a very high score of 16 to a high score of 12;**	

	• **NOTED the revised risk description for Strategic Risk 5;** • **NOTED the new threat assigned to Strategic Risk 5 owned by the People and Culture Committee; and** • **NOTED the closure of Strategic Risk 6 owned by People and Culture Committee.**	
ICBP/2425/020	**ICB Risk Register Report – April 2024** This report was taken as read. No questions were raised. **The Board:** • **RECEIVED and NOTED:** ○ **the Risk Register Report at Appendix 1;** ○ **Appendix 2, as a reflection of the risks facing the organisation as at 30th April 2024;** ○ **Appendix 3, which summarises the movement of all risks in April 2024; and** • **APPROVED the CLOSURE of risk 05 relating to Emergency Preparedness, Resilience and Response (EPRR).**	
ICBP/2425/ 021	**Ratified Minutes of ICB Corporate Committees** • Audit and Governance – 14.03.2024 • Finance, Estates and Digital –26.03.2024 • People and Culture – 22.02.2024 • Population Health and Strategic Commissioning – 14.03.2024 • Public Partnerships – 27.02.2024 • Quality and Performance – 28.03.2024 Available online at the following link: Ratified Minutes of ICB Committee Meetings » Joined Up Care Derbyshire **The Board RECEIVED and NOTED the above minutes for information.**	
ICBP/2425/022	**Forward Planner** The forward planner was taken as read and will be reviewed and updated. **The Board NOTED the forward planner for information.**	
ICBP/2425/024	**Any Other Business** • Future meetings of the Board will be held in person, rather than via MS Teams. Meeting invitations will be updated and circulated as appropriate. • Comments, requests or suggestions from the Board were invited with regards to the revised format of this Board meeting.	
ICBP/2425/025	No risks were identified during the course of the meeting.	
ICBP/2425/026	**Questions received from members of the public** No questions were received from members of the public.	
Date and Time of Next Meetings		
Date: Thursday, 18th July 2024 **Time**: 9:15am to 11.15am **Venue:** Joseph Wright Room, Council House, Derby		

ITEM 031

ICB BOARD MEETING IN PUBLIC

ACTION LOG – MAY 2024

Item No.	Item Title	Lead	Action Required	Action Implemented	Due Date
ICBP/2324/050 20.7.2023	NHS Long Term Workforce Plan	Linda Garnett	It was agreed that the Plan would return to a future Board for further discussion.		**September 2024**
ICBP/2324/051 20.7.2023	Integrated Assurance and Performance Report	Richard Wright	Support was sought for the Board to have a conversation on how to get this report right, to ensure it has oversight of the important matters and understands the position against plan. The sub-committees need to be used to their full effect to gain assurance, whilst ensuring that governance processes are adhered to.	RW considered that today's report, compared to the one produced a year ago, has changed markedly, now better reflecting system working. Although improvements have been made, there is still more work to do to rationalise what is presented to the Board and to better reflect the strategic nature of the whole system.	**CLOSED**
ICBP/2324/075 21.9.2023	Integrated Assurance and Performance Report	Keith Griffiths	UHDBFT provides services for Staffordshire residents; it must be ensured that Staffordshire ICB receives funding based on its population, some of which will support the pressures UHDBFT incur. It is a material boundary issue that will have implications on income flows this year, and baselines for future years.	A briefing note was circulated around the system after the last Finance, Estates and Digital Committee. This is an ongoing theme in conversations with regional and national colleagues. 18/1 RW has raised this with NHSE to support	**CLOSED**

				conversations regarding the 2024/25 planning round.	
ICBP/2324/101 16.11.2023	System Level Primary Care Access Improvement Plan	Michelle Arrowsmith / Clive Newman	It was requested that a year-end report will be presented to a future Board in May 2024.	18/1 MA to present a paper in May 2024. **Update:** Item 011 on the May Public agenda	**May 2024 CLOSED**
ICBP/2324/124 18.1.2024-1	ICB Risk Register Report – December 2023	Prof Dean Howells	Quality and Performance Committee to conduct a forensic review on Risk 9.	The Quality and Performance Committee is to conduct a forensic review on Risk 9 at its March meeting and feedback will be provided accordingly. **Update:** Item 45 on the agenda. further evidence to support the reduction in score to be discussed at June Q&P.	**July 2024**
ICBP/2324/151-2 21.3.2024	Delegation of Specialised Services from NHS England (NHSE)	Dr Chris Clayton	Although this was supported, there are a lot of risks involved namely capacity, complexity and working collaboratively; TA made a plea for feedback in early 2024/25 on a small number of key areas where the ICB wants to make a difference for the Derby and Derbyshire population through the changes implemented.	**Update:** June 2024 Board Development session focus on stocktake of NHSE Delegated Services	**June 2024 CLOSED**
ICBP/2324/154	Holistic Discharge Review	Dr Chris Clayton	RW requested SS to look at this as a holistic issue, as there are a lot of people in hospital beds not being discharged; there needs to be system wide approach on this therefore consideration by the ICS Executive Team was requested.	**Update:** The ICS executive has discussed ongoing discharge matters, including the use of the adult social care discharge fund and will continue to oversee the partnership work in addition to oversight via the ICP. Action closed.	**May 2024 CLOSED**

ICBP/2425/001 16.05.2024	Performance Report	Helen Dillistone	HD to include the Joint Forward Plan refresh for July on the Forward planner.	**COMPLETED** Included on July Board	**July 2024 CLOSED**
ICBP/2425/002 16.05.2024	Audit and Governance Committee Assurance Report	Helen Dillistone	Final publication of internal audit reports to be chased.	**COMPLETED** All ICB Internal Reports finalised and Final Head of Internal Audit Opinion and Annual Report presented to Audit and Governance Committee 19th June 2024	**July 2024 CLOSED**

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th July 2024

Item: 032

Report Title	Citizen's Story							
Author	Beth Fletcher, Engagement Manager							
Sponsor (Executive Director)	Steve Hulme, Chief Pharmacy Officer							
Presenter	Ejaz Sarwar, Deputy CEO – Community Action Derby /Derby Health Inequalities Partnership Beth Fletcher, Engagement Manager Jas Kaur, Head of Medicines Management – Medicines Outcomes and Contracts							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1 – Hypertension Case Finding, Going Further and Faster (Presentation)							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	CVD Delivery Group monthly updates January 2023 – March 2024 CLPG June 2023 and February 2024 ICB Executive Committee January 2023 – January 2024 Population Health & Strategic Commissioning Committee – January 2024 Public Partnership Committee – April 2024 Derby Health Inequalities Partnership – May 2024 Derby City Place Partnership – December 2023							

Recommendations

The ICB Board are recommended to **NOTE** for information the presentation for Hypertension Case Finding – Going Further and Faster.

Purpose

The summary below and attached presentation describes the models tested to go further and faster in the identification of hypertension in the Derby City area and level of success of each model, particularly public engagement which was used to inform the communications campaign and learning across the system. To highlight the significant partnership working between agencies and the community in improving local health.

Background

The ICB was successful in securing NHSE funding (non-recurrent) to go further and faster in the detection of hypertension. Hypertension case finding to reduce strokes, heart attacks, and other CVD complications will be a key priority for Derbyshire as part of the Integrated Care Strategy.

Derby Health Inequalities Partnership
The Derby Health Inequalities Partnership (DHIP) was established in response to the COVID-19 pandemic, which shone a light on inequalities in the city and on the good work and potential of communities to respond to this challenge.

DHIP is a co-led, joint initiative between Derby City Council (Public Health) and Community Action Derby, working together with community organisations and leaders to help achieve better health outcomes in the city. DHIP have made a short video that captures the voices of the community of Derby City. DHIP - Voices of the Community (youtube.com)

Report Summary

Derby and Derbyshire Integrated Care Board (DD ICB) were awarded £155,990 to test models to reduce the number of undiagnosed people with hypertension in Derby City. From the outset, it was identified that community engagement was a vital component to the potential success of the programme. The models included a communications campaign, public engagement, upskilling volunteers in various communities in Derby City to take blood pressure (BP) readings and increasing the number of healthcare professional led BP clinics.

Public Engagement Outcomes
Relationships were built with Derby Health Inequalities Partnership (DHIP) to utilise their expertise in local health inequalities and the most appropriate way to engage with the local public. The objectives of engagement were to; gauge the general public's understanding of hypertension, its risks, understand why people are less likely to have their BP monitored, whether people are aware where they can get their BP monitored, what the barriers to accessing BP checks at a community pharmacy are and how these barriers could be reduced. From this engagement a report was written and fed into the communication campaign. https://www.dhip.org.uk/community-consultations

Communications
A key part of the communications work was to provide volunteers with appropriate materials and resources to support them when doing blood pressure checks. The resources were tested with community connectors and feedback was acted on. Feedback from volunteers has demonstrated that these materials were really important when they were having conversations with people.

Throughout winter 2023/24, we ran a communications campaign to encourage people to get their blood pressure checked at a local pharmacy. Previous campaigns didn't feel relevant to some higher-risk groups as previous assets included images of elderly white males, and lifestyle advice was not culturally relevant. All of the social media adverts created higher than average engagement rates, one reached 5.4% where the average for previous campaigns is 2.2%.
Feedback from the whole communications campaign and comms support has been very positive. The project has also been recognised at the NHS Communicate Awards by winning the 'Working in Partnership' award.

Upskilling Community Action Derby (CAD) volunteers
Communities within Derby City were invited to express interest in receiving upskilling to enable individuals to monitor BP within their communities. The ICB Medicines Management Team worked with Community Action Derby to design and implement BP monitoring training.

The initiative gained much interest from a wide range of the city's communities, multiple upskilling events were set up and communities reported back outcomes on a weekly basis. Upskilling of Community Action Derby (CAD) volunteers was very successful, a target of 400 BP checks was far exceeded and in at the end of October 2023 stood at 909.

Feedback from this part of the initiative has been very positive, community representatives from within Derby City have embraced the challenge and the public have shown high levels of engagement. Communities are wanting and will be continuing with monitoring BPs beyond this project as they now feel empowered and have had such a positive response.

Healthcare professional BP checks

GP practices in Derby City were asked to design how they would identify, encourage, and monitor BP in those most at risk and/or less likely to present at a healthcare setting. They were able to use their search and risk stratification tools to identify higher risk patients, engage either virtually or face-to-face to monitor their BP and were required to go above and beyond what would normally be done for QOF to meet the criteria. There was a range of types of BP clinics offered to support access including evening and weekend clinics, virtual clinics, online booking offered and text links to book appointments. Clinics were tailored to target populations or those that did not usually visit healthcare settings such as including drop in clinics with translators at the automated BP kiosk with healthcare professional appointment if high, loaning of BP monitors the ability to text in BP measurements with follow up appointments and outreach to transient communities including the marina residents identified at high risk.

Overall

The project so far, has achieved a direct increase of 4113 BPs monitored, 1228 of which (30%) were identified as high or very high, although this would require further investigation to determine diagnosis. It is clear that a targeted community-led approach, prioritising those at higher risk or less likely to present at a healthcare setting results in greater rates of high or very high BP identification.

Next steps

The methodology used in this work was driven by a desire to work with communities on testing potential campaign messages and to use data and other insight to target patients at risk. The success of this approach will strengthen the case for seeking small amounts of investment to seek to target messaging in this way, which in turn produces a more significant and measurable health outcome.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☐	**SR6**	*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.	☐

No further risks identified.

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

Have any conflicts of interest been identified throughout the decision-making process?
No conflicts of interest have been identified.

Project Dependencies

Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☒	No☐	N/A☐	**Details/Findings**
				Positive due to level of engagement and opportunities/contacts to signpost
Equality Impact Assessment	Yes ☒	No☐	N/A☐	**Details/Findings**
				Positive due to level of engagement and opportunities/contacts to signpost

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:** Positive due to level of engagement and opportunities/contacts to signpost

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

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
The ICB's relationship with DHIP and its constituent connector groups will enrich the NHS knowledge of the impact of equality and diversity implications on the local communities. Longer term planning will see NHS leadership more visible in these groups and communities, supporting in part the ICB's role in fostering good relations between people who share and do not share a relevant protected characteristic.

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

Hypertension Case Finding – Going Further and Faster

ICB – Board

Ejaz Sarwar -Deputy CEO – Community Action Derby / Derby Health Inequalities Partnership

Beth Fletcher – Engagement Manager

Jas Kaur, Head of Medicines Management – Medicines Outcomes and Contracts

Ambition

To increase the number of Blood Pressure checks in Derby City in populations at higher risk of CVD

Upskilling and providing equipment for Community Action Derby (CAD) volunteers	Public Engagement	Communications campaign	Healthcare professional led BP checks

Derby and Derbyshire ICB worked in partnership with Derby Health Inequalities Partnership (DHIP), Community Action Derby (CAD) and Derby City Practices to achieve these ambitions

Outcomes

- Between September - December, Community Action Derby volunteers delivered **997 blood pressure checks** (and counting)
- In October, Primary Care delivered **3224 blood pressure checks**
- **105 extra irregular pulses detected**

A total of…

4221

Extra blood pressure checks

Why blood pressure checks in Derby City?

- Hypertension (high blood pressure) is the most determinant risk factor for stroke and is reported in **70%** of stroke patients.
- Hypertension is one of the most **prevalent** and **preventable** conditions
- Reducing blood pressure by a 10mmHG can reduce the risk of, stroke by 25% as well as significantly reducing the risk of other cardiovascular related conditions
- Derby Inner-City is a high-priority area that has been identified nationally via Core20Plus5 principles as being in the most deprived 20% of the national population and with a high South Asian population identified as high risk of CVD
- It has been estimated that there are 9,656 people with undiagnosed hypertension in Derby City.

How did we do it?

Upskilling and providing equipment for Community Action Derby Connectors

- Purchased approved Blood Pressure check meters
- Signposting pathway and patient information developed for volunteers
- Trained volunteers to take blood pressure readings using an external company
- Softer skills training provided by a trained community pharmacist.
- One-to-one follow up from Community Action Derby co-ordinator to confirm confidence of individual to begin
- Planned ad hoc quality control support to support connectors and ensure continuity

Community Connectors pathway

BLOOD PRESSURE FLOW CHART:

Community Action | dhip | NHS Derby and Derbyshire

BLOOD PRESSURE READING

Volunteers should emphasise that they are NOT CLINICALLY trained and are following the local BP Check pathway to signpost on.

LOW BP:	NORMAL BP:	HIGH BP:	VERY HIGH BP:
90/60mmHg or lower	**90/60mmHg to 140/90mmHg** • **If either systolic or diastolic reading is high, advise as high BP**	**140/90mmHg to 180/120mmHg** • **If either systolic or diastolic reading is high, treat as very high BP**	**180/120mmHg or higher.**
Advise on maintaining healthy behaviour. Signpost to local Community Pharmacy for a BP check. Details of pharmacies providing the BP check service can be found on the NHS Website: https://www.nhs.uk/service-search/pharmacy/find-a-pharmacy Provide individual with a written record of their BP results.	Advise on maintaining healthy behaviour. Provide individual with a written record of their BP results.	Advise on implementing healthy lifestyle changes. Signpost to local Community Pharmacy for a BP check. Details of pharmacies providing the BP check service can be found on the NHS Website: https://www.nhs.uk/service-search/pharmacy/find-a-pharmacy Provide individual with a written record of their BP results.	Advise on implementing healthy lifestyle changes. Signpost to Community Pharmacy for a BP check within 24 hours. Details of pharmacies providing the BP check service can be found on the NHS Website: https://www.nhs.uk/service-search/pharmacy/find-a-pharmacy Provide individual with a written record of their BP results.
Low BP can be caused by medication or another health condition. Low BP is often symptomless. **IN ADDITION** these individuals should be signposted to a local Community Pharmacy to arrange a formal BP Check. Signpost to GP if patient suffers from fainting and dizziness.	High BP can often be prevented or reduced by: 1. Eating healthily 2. Maintaining a healthy weight. 3. Regular exercise 4. Reducing alcohol intake/drinking in moderation 5. Not smoking Individuals should be provided with leaflets to support healthy behaviours – **See lifestyle advice information.** The individual can also be signposted to other providers to improve general health and wellbeing.	High BP can often be prevented or reduced by: 1. Eating healthily 2. Maintaining a healthy weight. 3. Regular exercise 4. Reducing alcohol intake/drinking in moderation 5. Not smoking Individuals should be provided with leaflets to support healthy behaviours – **See lifestyle advice information.** **IN ADDITION** these individuals should be signposted to a local Community Pharmacy to arrange a formal BP Check.	High BP can often be prevented or reduced by: 1. Eating healthily 2. Maintaining a healthy weight. 3. Regular exercise 4. Reducing alcohol intake/drinking in moderation 5. Not smoking Individuals should be provided with leaflets to support healthy behaviours. **IN ADDITION** these individuals should be urgently signposted to a local Community Pharmacy to arrange a formal BP Check **within 24 hours**.

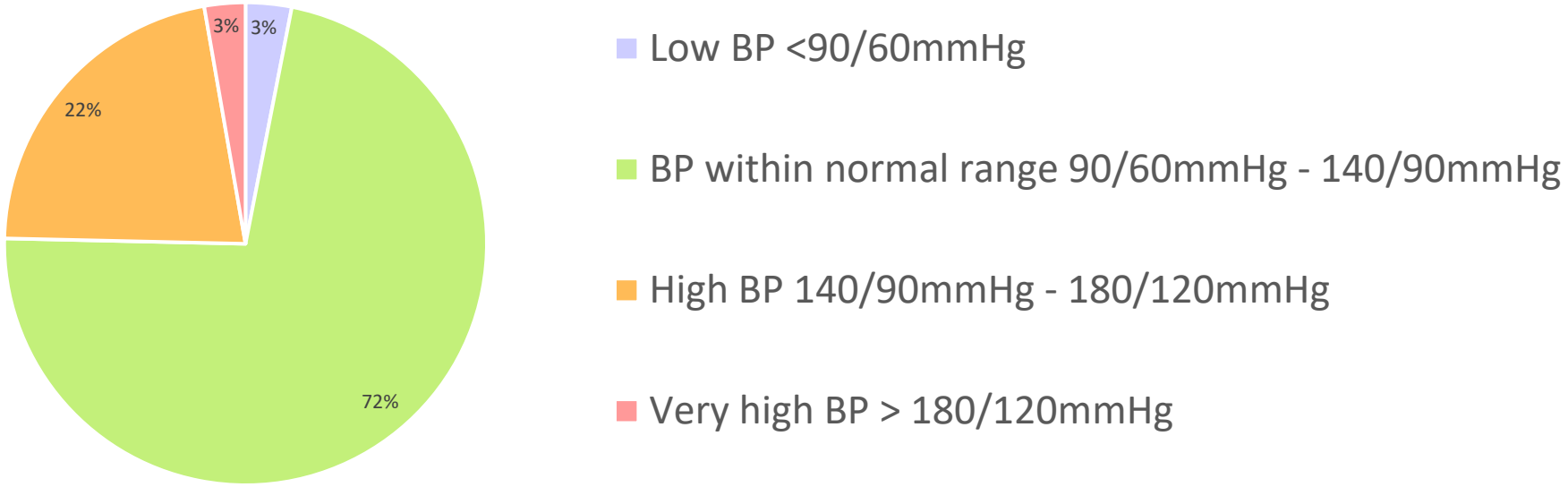
Communities involved in the project

Place/ organisation	Main demographic of group
Pakistan community centre/ community one	South Asian community both men and women
Community action derby	Mixed population
Dads and lads	Men from the south Asian community will be based in the mosque
Derby Asian Strategic Partnership	South Asian community
Islah Ul Muslimeen	Men from the south Asian community (based in the mosque)
Kashmir badminton club	South Asian community
Reflection path	South Asian community
Derby West Indian Community Association	Black Caribbean and African
Central education and training centre	Mixed population
Bosnia and Herzegovina Centre	Males from the Bosnian Community
Sahara Care Derby	Older people
Hadhari project	Afro Caribbean over 50 years of age
Shanti ladies group	Women - Based at the Hindu Temple
Prospects ABC	Boxing club
Derby Chinese welfare association	Chinese community
A Nisa event	Women
Deaf-inatly women	Deaf, deafblind and hard of hearing women

Community Action Derby Outcomes

- October data: 909 BP checks well exceeded target of 400 checks in 40 years+ at higher risk of CVD events or harder to reach populations.

Number of BP checks	Results			
	Low <90/60mmHg	Normal 90/60mmHg to 139/89mmHg	High 140/90mmHg to 179/119mmHg	Very High >180/120mmHg
909	28	657	199	25



Engagement Project – Aims and Objectives

Commissioning Derby Health Inequalities Partnership (DHIP) to run engagement activities with people living in Derby City to:

Assess people's knowledge and awareness of high blood pressure and its associated risks

Identify potential barriers around accessing community pharmacies to have blood pressure readings and why some people might not engagement with their blood pressure medication

Identify communication preferences

Methodology of engagement

Engagement was targeted across the city, working with grass root and community organisations.

1. **Survey:** A comprehensive survey was circulated to communities to collect individual responses on awareness, knowledge and experiences relating to high blood pressure.

2. Community-Led Workshops: Engagement workshops ran by community groups provided a platform for open discussions, idea sharing and gathering qualitative data.

3. Case Study: An in-depth case study allows us to explore a personalised viewpoint and experience of a local individual, shedding light on the human stories behind the statistics.

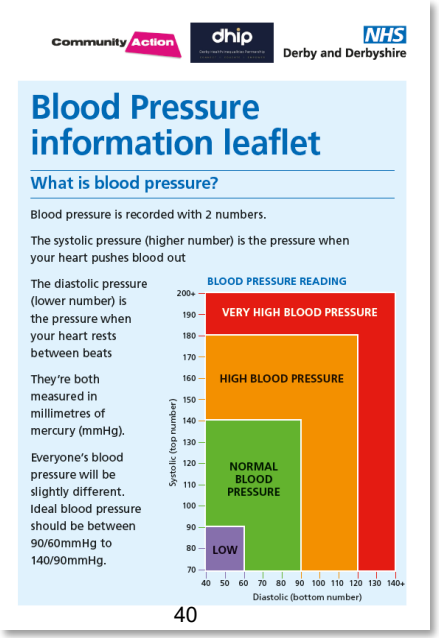
Engagement Outcomes

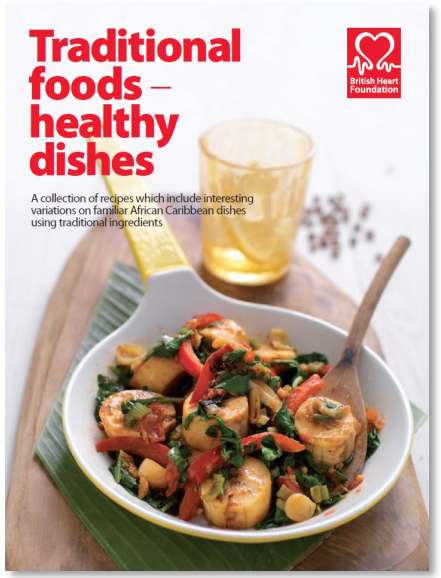
- 265 people completed the survey
- 409 people in 11 different community groups took part in the community led engagement workshops

- Key findings indicate a general awareness of hypertension and its risks among the population
- There is a gap in knowledge about the services available at community pharmacies
- There was a wide range of barriers raised around why people might not access community pharmacies for blood pressure readings and why people might not engage with their blood pressure medication
- Communication preferences are noticeably different between the 2 engagement methods, this shows the need to activity involve grass route organisations and communities in future communication designs and campaigns

Communications

- Development of assets and materials to support Community Connectors.
- The communications assets were tailored to our target audience and were produced with support from communities.
- Previous assets have not been culturally relevant or representative.





Communications

- Produced videos with Community Connectors encouraging people to get their blood pressure checked
- Filmed some clips with a Pharmacist explaining the process of getting a blood pressure check at a pharmacy.

Click here to watch the Hypertension video

Community Action dhip NHS Derby and Derbyshire

ब्लड प्रेशर से जुड़ी सूचना पत्रिका

ब्लड प्रेशर क्या है?

ब्लड प्रेशर को 2 संख्या में रिकॉर्ड किया जाता है।

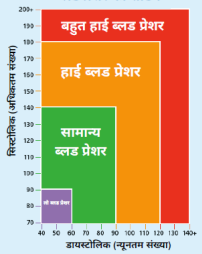
Tसिस्टोलिक प्रेशर (अधिक संख्या) वह प्रेशर है जब आपका दिल रक्त को बाहर धकेलता है

Tडायस्टोलिक प्रेशर (कम संख्या) वह प्रेशर है जब आपका दिल धड़कनों के बीच कुछ क्षण के लिए रेस्ट करता है

इन दोनों को पारा के मिलीमीटर (mmHg) में मापा जाता है।

हर किसी का ब्लड प्रेशर अन्य लोगों से थोड़ा अलग होता है। एक आदर्श ब्लड प्रेशर 90/60mmHg से 140/90mmHg के बीच होना चाहिए।

ब्लड प्रेशर की रीडिंग



Community Action dhip NHS Derby and Derbyshire

Get your blood pressure checked here for free

It could save your life

- Free blood pressure check
- Signposting advice
- Healthy living advice

At least half of all heart attacks and strokes are caused by high blood pressure

High blood pressure is also a risk factor for heart disease, kidney disease and vascular dementia

1 in 4 people have high blood pressure but most don't know it

High blood pressure often has no noticeable symptoms so the only way to know is to get it checked

It is easy to reduce your blood pressure through simple lifestyle changes or medication

If you are of Black African, Black Caribbean or South Asian descent you are more likely to have high blood pressure

Jakie są zagrożenia związane z wysokim ciśnieniem krwi?

Zbyt wysokie ciśnienie krwi powoduje dodatkowe obciążenie naczyń krwionośnych, serca i innych narządów, takich jak mózg, nerki i oczy.

Utrzymujące się wysokie ciśnienie krwi może zwiększać ryzyko wystąpienia wielu poważnych i potencjalnie zagrażających życiu schorzeń, takich jak:

- Choroby serca
- Udary mózgu
- Choroby nerek
- Ataki serca
- Niewydolność serca
- Demencja naczyniowa

British Heart Foundation szacuje, że wysokie ciśnienie krwi jest przyczyną ponad 50% zawałów serca i udarów mózgu.

Dlaczego należy kontrolować ciśnienie krwi?

Badanie ciśnienia krwi sprawdza, czy ciśnienie krwi jest odpowiednie, czy też zbyt wysokie lub niskie.

Wysokie ciśnienie krwi (nadciśnienie) może zwiększać ryzyko wystąpienia poważnych problemów, takich jak zawały serca i udary mózgu, jeśli nie jest leczone.

Ponad 1 na 4 osoby dorosłe w Wielkiej Brytanii ma nadciśnienie, ale wiele z nich o tym nie wie, ponieważ nie występują u nich żadne oczywiste objawy.

Jeśli okaże się, że masz wysokie ciśnienie krwi, możesz podjąć proste kroki w celu jego obniżenia, takie jak więcej ćwiczeń i zdrowsze odżywianie, lub lekarz może przepisać Ci leki obniżające ciśnienie krwi.

Badanie ciśnienia krwi jest jedynym sposobem, aby dowiedzieć się, jakie jest Twoje ciśnienie krwi – i może uratować Ci życie.

Community Action dhip NHS Derby and Derbyshire

میں اپنا بلڈ پریشر کہاں سے چیک کروا سکتا ہوں؟

اگر آپ کی عمر 40 سال یا اس سے زیادہ ہے تو ، آپ اکثر مقامی فارمیسیوں میں اپنا بلڈ پریشر چیک کروا سکتے ہیں۔ اپنے اس پاس فارمیسی تلاش کرنے کے لئے، "فارمیسی تلاش کریں" پر سرچ کریں اور اپنا پوسٹ کوڈ ٹائپ کریں۔

بلڈ پریشر کی چیکنگ کروانے کے لئے کسی فارماسسٹ یا فارمیسی ٹیکنیشن کے ساتھ فارمیسی کنسلٹیشن روم میں تقریبا 10-15 منٹ لگتے ہیں۔ اس کے بعد آپ کو ایک بلڈ پریشر مانیٹر گھر لے جانے کی ہدایت کی جاسکتی ہے جو آپ کی روزمرہ کی زندگی میں آپ کے بلڈ پریشر کیچیکنگ کرتا ہے۔

آپ کے بلڈ پریشرکی ریڈنگ کی بنیاد پر آپ کو اپنے جی پی کے پاس بھیجا جاسکتا ہے۔ فارماسسٹ آپ کے بلڈ پریشر کے نتائج کی بنیاد پر کسی بھی ضروری اقدامات کے ذریعے آپ کی رہنمائی کرے گا۔

ما الذي يمكن أن يزيد من خطر إصابتي بارتفاع ضغط الدم؟

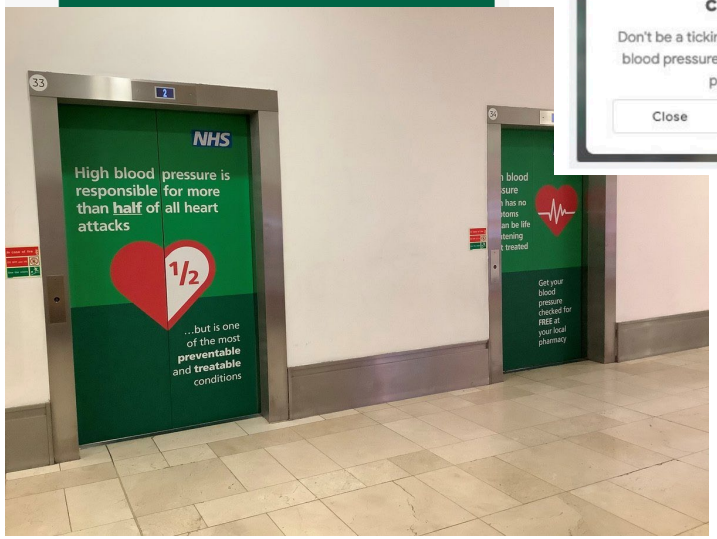
- زيادة الوزن
- تناول الكثير من الملح وعدم تناول ما يكفي من الفواكه والخضروات
- عدم ممارسة التمارين الرياضية بشكل كافي
- الإفراط في شرب الكحول أو القهوة (أو غيرها من المشروبات التي تحتوي على الكافيين)
- التدخين
- أن يكون عمرك أكبر من 65 عامًا
- وجود قريب يعاني من ارتفاع ضغط الدم
- أن يكون من أصل أفريقي أسود و/أو أسود من منطقة البحر الكاريبي.

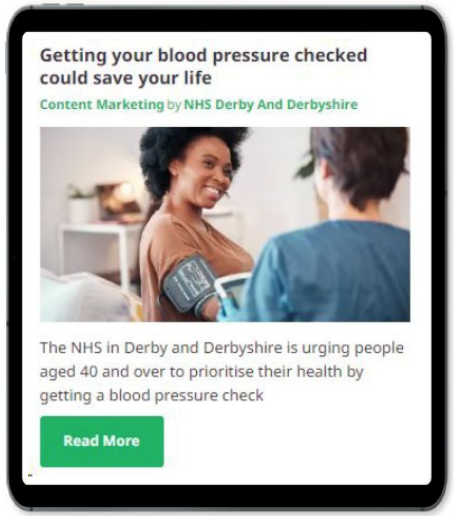
إن ممارسة المزيد من التمارين وتناول الطعام الصحي وتناول كميات أقل من الملح والتقليل من تناول الكحول وعدم التدخين يمكن أن تساعد جميعها في خفض ضغط الدم.

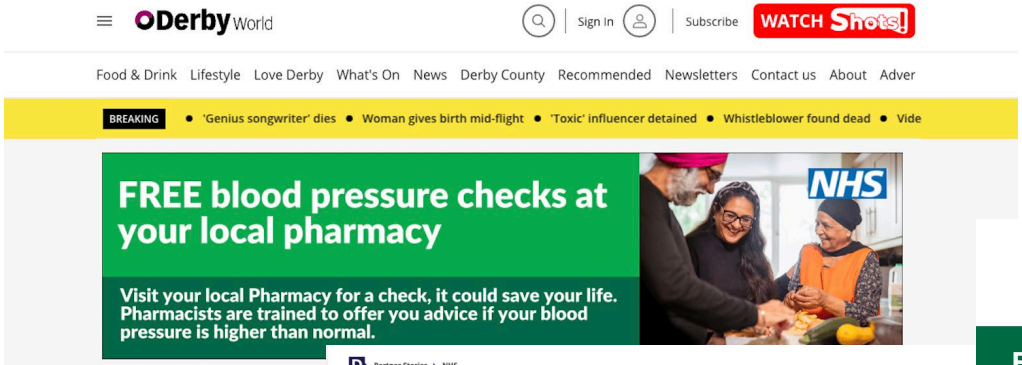
Communication campaign – advertising

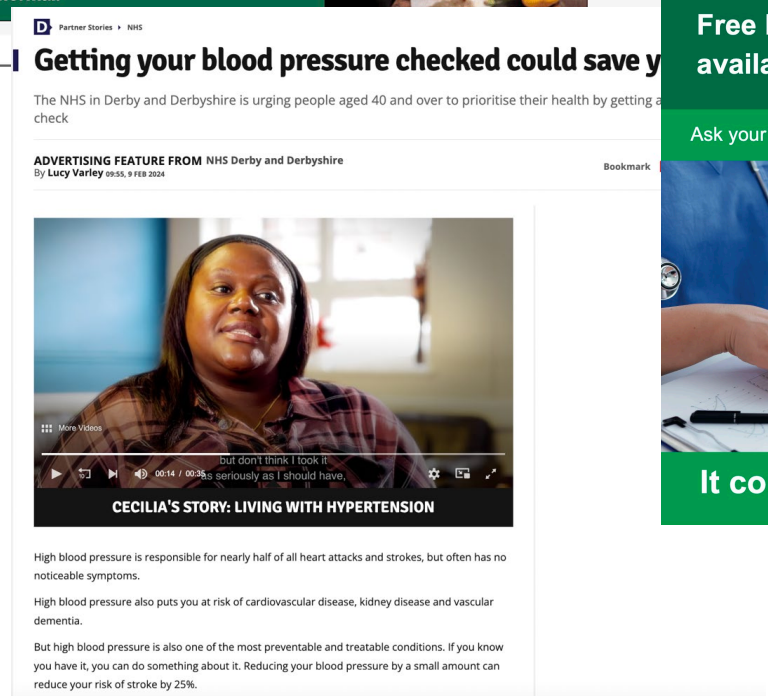
- The engagement survey stated that people would like to see more promotion of blood pressure checks
- Key messages were tailored following the engagement survey to address barriers people faced
- The delivery of the campaign crossed multiple formats and channels such as; leaflets, posters, videos, social media, web articles, digital, and outdoor advertising channels.
- The campaign gained approximately 7 million impressions.

Communication campaign – advertising









GP practice/PCN led BP checks

GP practices/PCNs were asked to:

- Identify at risk and/or harder to reach populations (additional to QOF).
- Identify people using system searches and/or risk stratification tools e.g. Eclipse Live or UCL partners search tool.
- Design sessions/methods to deliver and record BP readings and irregular pulses (optional) based on their identified populations.
- Expressions of interest were approved by ICB for payment
- Delivery of sessions throughout Oct 23.

GP practice/PCN outcomes

25 of 28 GP practices took part (some practices combined data, and some submitted as PCNs).

3224 additional BP checks recorded by GP practices. This is over 100 additional checks per day!

31% had high or very high BP. This indicated that practices targeted and prioritised patients most at risk.

1305 people were given healthy lifestyle advice.

105 abnormal pulses were detected.

843 people were offered a follow up appointment and work is still ongoing.

Feedback from practice staff

- ‘Staff have really liked to be involved in this as they can see it helps patients. It has really helped test the model and we will use this for future pieces of work.’
- ‘We have found the response rate to be higher than expected.’
- ‘The outreach work in our more deprived population really has made a positive impact for the patients and the staff who truly felt we could make a difference. We have taken the learning from our first event and hope to repeat it in our other hard to reach areas.’
- ‘Current 49% uptake which is highest achieved in this transient group of people at this practice. We will use this model moving forward.’

Best practice identified

Highest achieving practices for total numbers were often aligned to Flu clinics.

Follow up phone calls or letters in harder to reach cohorts showed success.

Promoting BP checks using reception staff, website, social media or waiting room screens supported higher uptake.

Higher uptake when variety of options offered e.g. waiting room BP machine, community pharmacy, home BP reading, face to face (out of traditional 9-5 hrs).

Supporting cohorts by involving interpreters and communities e.g. marina staff, Live Well Derby supported higher uptake.

Project impact

- 4113 BPs monitored, 1228 of which (30%) were identified as high or very high
- Community Action Derby connectors are continuing with the principles of the project to measure blood pressure in their communities
- The indication of the engagement and communications campaign reach has been very positive, although difficult to directly measure, there is likely an ongoing impact over time on awareness and prompting people to have their BP checked
- Practice/PCN fedback that they will be using the learning from the models and clinic design to reduce health inequalities
- Really positive feedback from NHS England

Project learnings

- The success of this project was driven by the relationships we made and the involvement of communities
- Involving communities is key for service development and messaging
- Public engagement building trusted relationships and links with the Derby communities
- Matrix working internally, externally, best mix of skills and developing approaches of how we (ICB) work with partners
- Giving autonomy to partners to deliver the project based on their populations
- Can model to Place level
- Blueprint for future projects

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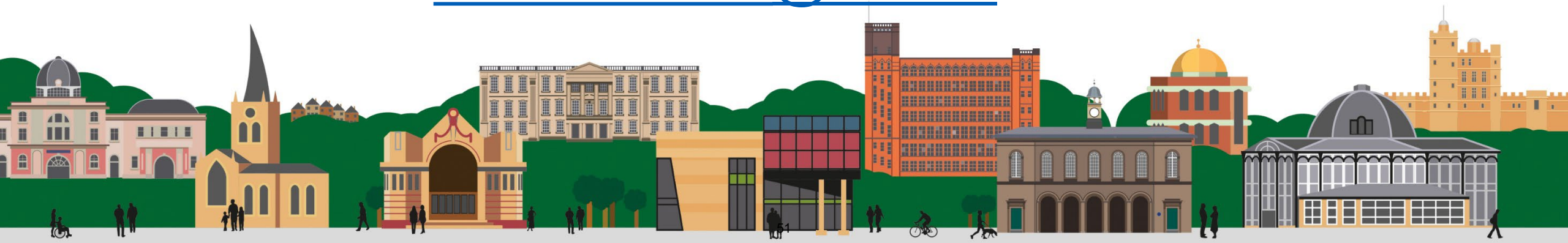


NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th July 2024

Item: 033

Report Title	Chair's Report – June 2024							
Author	Sean Thornton, Director of Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
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
It has been a busy two months since I took up post as ICB Chair. I have spent time getting to know colleagues across the system and increasing my understanding and view of how we need to focus our time and effort. I am pleased we have completed the submission of our update on the Derby and Derbyshire NHS 5-Year Plan, also known as the Joint Forward Plan, to NHS England. It is now important for us to refresh our plans in light of the current context and be clear about the specific areas of focus for the next year, and the measurements we will use to reflect on progress in June 2025. We will remain focused on delivering key operational activity today but maintain our focus, through place and neighbourhood, on the future, in particular prevention and health improvement for the long term. Alongside this, we are all now aware that the UK political landscape has changed following the General Election earlier in July. We look forward to working closely and collaboratively with our elected Members of Parliament in Derby and Derbyshire and to understand the new Government's proposals and approach for the NHS and social care. Health and care was debated prominently in the election campaign, particularly in relation to waiting times, and this, as well as General Practice and dental care, will be a priority focus in the coming weeks and months. The Chief Executive and I have written to all the MPs to establish communication and will look forward to meeting them in due course.

It has also been the two-year anniversary of the establishment of Integrated Care Boards and Integrated Care Systems. The Chief Executive and I wrote to all ICB staff on Monday 1st July to reflect briefly on the progress to date, and to set the scene for the next chapter. First and foremost, our message was one of thanks to everyone for their continued efforts on behalf of our population, and for their expertise, commitment and resilience in seeking to improve both our NHS and the lives of our citizens. The NHS itself also celebrated it's 76th birthday on Friday 5th July.

I am grateful to everyone who has taken time to speak with me and talk about their part of the health and care system since I took up post. My previous ICB and Trust experience, both as a clinician and Board member, has meant that I have a good understanding of the workings of the NHS, but every system and organisation has its own style and challenges, and Derby and Derbyshire is no different. Understanding these is important, to ensure that the progress we make is in keeping with the history of relationships and the unique culture that has been created in our system. As I have said before, I am a great believer in getting out and meeting colleagues to understand their work and I'm working with a range of colleagues to build a programme of visits to meet as many colleagues as possible across the patch during my tenure.

Integrated Care Partnership
I attended my second Derby and Derbyshire Integrated Care Partnership (ICP) meeting in June. An important item of discussion was an update report from the Voluntary, Community and Social Enterprise (VCSE) sector on the progress that has been made in forging their role and relationships in the system since the signing of the first VCSE memorandum of understanding a year ago. There have been many successes, and the engagement of the sector in decision-making forums reflects the importance placed upon the sector as a key partner in delivery of our plans.

There is still some way to go, and the sector's representatives outlined their concerns around the precarious nature of funding arrangements for voluntary services in the coming year, given the financial position of the NHS and the consultations already taking place regarding VCSE grant funding. It is important that we continue to recognise the importance of the sector in providing care to so many people within our communities, and reflect that once services which are delivered on small budgets and a large amount of goodwill are removed through short-term decisions, they are very challenging to re-establish in the long term and these services often underpin our efforts to improve health in our most vulnerable population groups.

Infected Blood Enquiry
The report of the Infected Blood Inquiry was published on the 20th May 2024. The report is the conclusion of the public inquiry after more than 30,000 people in the UK during the 1970s and 1980s were infected with HIV, hepatitis B, hepatitis C Creutzfeldt-Jakob disease (“vCJD”) infections after being given contaminated blood products. The report summarises the scale of the scandal and finds that, “that most infections could and should have been avoided” and that this was caused by a catalogue of failures.

The ICB acknowledges the publication of the Report and it's 12 recommendations, formally recognising this as, in the words of the report, “the worst treatment disaster in the history of the NHS”. The ICB commits, alongside the Integrated Care Partnership, to considering the implications of the recommendations within our partnership, specifically those that relate to local services including:

1. Learning from the Inquiry- including considering how lessons learnt are incorporated into clinical practice
2. Preventing future harm to patients: achieving a safety culture- including those relating to duty of candour and culture

3. Monitoring liver damage for people who were infected with Hepatitis C including ensuring the appropriate follow up is conducted and fibroscan technology utilised
4. Patient Safety: Blood transfusions- including the use of tranexamic acid and recording the outcomes of transfusion
5. Finding the undiagnosed- including asking about transfusion history
6. Protecting the safety of haemophilia care- including peer review
7. Giving patients a voice - including engagement with patient advocacy organisations

I would urge everyone to read the Report, and we commit to supporting the Integrated Care Partnership in reviewing actions in relation to these recommendations within 12 months.

Integration Index
As we know, some groups of the population have complex health and social care needs, and would benefit particularly from joined-up, holistic integrated care as described in last year's Proactive Care Framework. NHS England and seven ICSs, including Derby and Derbyshire, have launched the first phase of the national 'Integration Index' – a key commitment in the NHS Long Term Plan - which aims to measure within key population groups the impact of integrated, personalised and proactive care on experience, outcomes and local resources.

Ipsos UK are helping us to conduct a survey across patients who have been identified at risk of adverse outcomes through the electronic frailty index, as well as their carers. If a patient consents, the results can be linked anonymously to other data held by local NHS organisations so they can understand where to direct efforts to improve care and understand whether they're having the right impact. In time, this will support the spread and scale of innovative models of proactive integrated care making a positive impact on people's health and wellbeing.

NHS Confederation Activities
As the Board is aware, I am now Chair of the NHS Confederation ICS Network and as part of that I was delighted to speak to the Health and Social Care Journal and share my perspective on the role of ICBs in health and care systems. As set out in the resultant article, I am clear that the whole-population and holistic approach that ICBs can bring to the conversation is a critical one – if there was to be a "carve-up" of responsibilities, fragmenting that overall oversight of a population's health outcomes and the services required then that would, in my view, be detrimental.

I was pleased to chair last month a session at the annual ConfedExpo conference in Manchester. The session heard from colleagues leading a project developed between the Confederation, the Universities of Stirling and Southampton, and Newton, which has helped to better understand the barriers to delivering the shift towards preventative models of health and care that are being experienced at both a system and local level. Through focussing on this sort of activity and celebrating success where it occurs, we can make the incremental progress we need to achieve our strategy.

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

[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.

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

Not applicable to this report.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

Not applicable to this report.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Not applicable to this report.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th July 2024

Item: 034

Report Title	Chief Executive Officer's Report – June 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
The Derby and Derbyshire NHS 5 Year plan outlined our guiding policies in response to the health and care needs of local people. The JFP was the NHS' response to the Derby and Derbyshire Integrated Care Strategy and set out five guiding policies, which remain true: 1. Allocate greater resource to activities that will prevent, postpone, or lessen disease complications and reduce inequity of provision. 2. Give the teams working in our localities, the authority to determine the best ways to deliver improvements in health and care delivery for local people. 3. Give people more control over their care. 4. Identify and remove activities from the provision of care which result in time and cost being expended but do not materially improve patient outcomes. 5. Prioritise the improvement of the System's Intelligence Function and the capacity and capability of its research programme. We submitted an update on that plan to NHS England on 28 June, outlining the progress we have made in its first year. What is important to emphasise is our continued focus on balancing the progress we need to make on the NHS today and the increasing focus we wish to make on moving towards a more community-based, preventative NHS which by design seeks to take

pressure off secondary care acute services. Our Board development session in June heard from local pharmacists, opticians and dentists, the challenges they face in delivering high quality care to our population, and also the role they believe they can play in connecting with other parts of the NHS to support our prevention agenda. We continue to assess the steps we must make to prioritise programmes which will enable our teams to focus in key areas and have the greatest integrated impact on health and care. It is important that we move quickly from planning into delivery to make the progress we desire during 2024/25.

NHS England has written to all ICBs following the screening of the Channel 4 Dispatches documentary, filmed in the emergency department at the Royal Shrewsbury Hospital. However busy and pressurised health and care systems are, people in our care – as well as their families and carers – deserve at all times to be treated with kindness, dignity and respect. While Urgent and Emergency Care (UEC) is facing real pressures as a result of increasing demand, lack of flow and gaps in health and social care capacity, the documentary highlighted examples of how the service some patients are experiencing is not acceptable. NHS England is asking every Board across the NHS to assure themselves that they are working with system partners to do all they can to:

- provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence
- maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on

This matter has been discussed by the ICB's Executive Team; Dr Chris Weiner will lead on our response through the System Quality and Performance Committee, with further reflection at our Urgent and Emergency Care Delivery Board to ensure our current approach has strength. It is important that we fully work through and understand the risks across the pathway.

I have read with interest the annual reports from our local authority Directors of Public Health, as I'm sure others will have. Dr Robyn Dewis' report in the city has a detailed focus on the impacts of gambling on health and wellbeing, while Ellie Houlston in the county focuses on mental health. We will take due regard of the information set out as we develop our plans.

Director of Public Health Annual Report 2023 (derby.gov.uk)
Director of Public Health Annual Report 2023 (derbyshire.gov.uk)

The results from the General Election have seen significant change to the political landscape, both nationally and within Derby and Derbyshire. The election campaign period heard much debate about the NHS, not least our efforts to tackle elective care waiting lists. We will await the new Government's approach to NHS policy and of course deliver accordingly, and we expect that the focus we have placed on access, prevention and integration will remain at the cornerstone of our efforts to improve local health and to reduce health inequality. In Derby and Derbyshire, Toby Perkins MP remains from the previously elected MPs, with all other constituencies returning new MPs, and we have already made contact with them all to assist them in understanding the local NHS landscape and performance in more detail as they take on their elected positions.

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

NHS publishes data following junior doctors strike
Since strikes began, the cumulative total of acute inpatient and outpatient appointments rescheduled is now nearly 1.5 million (1,486,258). Junior doctors took industrial action from 7am on Thursday 27 June to 7am on Tuesday 2 July. The action saw 61,989 inpatient and outpatient appointments rescheduled, and 23,001 staff were absent from work due to strikes at the peak of the action.

NHS launches final call for people to get their covid jab
With just days left of this year's spring covid vaccine programme, the NHS is urging anyone eligible to get their jab by this Sunday [30 June 2024]. More than 4 million people have now received their spring booster jab since the campaign began in April.

More GP appointments in May than before pandemic
GP teams delivered more than 30 million appointments for patients last month (May 2024), up by more than a fifth on the same period before the pandemic.

NHS urges more women to take up cervical screening invitations
Millions of women are being urged to come forward for cervical screening as figures show a third of eligible under 50s didn't take up the potentially lifesaving offer.

NHS delivers 4 million spring covid vaccines
Over 4 million people have now received their spring covid booster from the NHS just 10 weeks after bookings officially opened as part of the latest vaccination campaign.

NHS staff among those recognised in 2024 King's Birthday Honours
NHS staff including paramedics, nurses and doctors are among dozens of frontline workers recognised in the 2024 King's Birthday Honours list, released today (Friday 14 June). Among the staff recognised for their hard work and dedication is David Dean, Senior Paramedic Mentor at East of England Ambulance Service, who has been awarded the King's Ambulance Service Medal for Distinguished Service.

NHS announces 143 hospitals to roll out 'Martha's Rule' in next step in major patient safety initiative
The NHS announced the 143 hospital sites that will test and roll out Martha's Rule in its first year.

NHS plan to cut avoidable admissions to further boost efforts to reduce waiting times
The NHS is set to increase virtual ward use as new analysis shows that 9,000 hospital admissions have been avoided in the South East in the past year thanks to the world-leading initiative.

NHS expands 'soup and shake' diets to thousands more patients with type 2 diabetes across England
Over 10,000 more people living with type 2 diabetes and excess weight or obesity in England are to be offered NHS soup and shake diets this year to help them lose weight and significantly improve their health.

NHS launches Dentist Recruitment Scheme
The NHS is encouraging local dental practices with the highest demand to hire new dentists using a new recruitment incentive scheme. Around 240 dentists will be offered bonus payments of up to £20,000 to work in under-served areas for up to three years, with NHS guidance issued to practices today to encourage them to advertise the "golden hello" scheme.

NHS brings down longest waits for cancer care alongside faster ambulance responses
The NHS has met the 28 day faster diagnosis target for cancer for the second month in a row, new figures show today (May 9), with ambulances responding to callouts faster than the month before. Almost 200,000 (77%) people referred or screened received a definitive diagnosis or the all clear within four weeks, exceeding the national ambition of 75%.

NHS App messaging saved NHS more than £1 million in last year
Messages sent to millions of patients via the NHS App have saved the NHS £1.1 million on the cost of previously sending the information via text message. During 2023/24, 22.5 million messages were sent through the NHS App, which would have previously been sent as a text message or letter.

Local developments

NHS announces eight hospitals in the East Midlands to roll out 'Martha's Rule' in next step in major patient safety initiative
The NHS has announced the 143 hospital sites that will test and roll out Martha's Rule in its first year. Eight of these sites are in the East Midlands.

Successful NHS Type 2 Diabetes Path to Remission Programme to be rolled out across the whole of England from April 2024 – East Midlands
The Type 2 Diabetes Path to Remission Programme was originally piloted across the Midlands back in 2020 and due to the programme's success from April 2024 the programme will be rolled out across all areas in England.

Improved year end budget position welcomed but challenges remain – Derbyshire County Council
We ended the last financial year in an improved position following a number of measures taken to tackle an overspend but we are warning that challenging times remain. A report to be considered by our Cabinet on 10 July details how we have reduced our forecast revenue overspend to less than half the original forecast overspend for 2023 to 2024 of £46.4 million which was first reported last September.

We appoint new Civic and Vice Civic Chairmen for year ahead – Derbyshire County Council
A retired NHS healthcare manager, consultant and businessman with 17 years' experience as a local councillor has been appointed as our new Civic Chairman. Councillor Tony Kemp, who is the county councillor for the Buxton West Division, accepted his new position at our AGM on Wednesday 22 May 2024, taking over the role from Councillor David Taylor.

Public consultation on care homes and day services launched – Derbyshire County Council
Derbyshire residents are being encouraged to have their say on proposals to redesign our residential care and day centres for older people. The public consultation will ask for people's views on 2 proposed options for modernising the service designed to increase support for people with dementia and their carers.

New medical diet portal supports children needing modified school meals – Derbyshire County Council
Parents of children who require a modified school meals menu will now find it easier thanks to a new medical diet portal our school catering service has introduced. If any child requires a medical diet due to food allergies, intolerances or auto immune conditions, their parent or carer can now complete the online application form and upload the required medical evidence from their GP or hospital consultant.

New Leader of Derby City Council appointed
Last night (18 June 2024) an extraordinary meeting of Council took place, to debate a vote of no confidence motion in the Leader of the Council, Councillor Baggy Shanker. Councillor Peatfield was appointed unopposed as the new Leader of Derby City Council, having previously served as the Deputy Leader since May 2023.

Volunteer spreads the word about tackling loneliness and social isolation
A volunteer is working with Derby City Council to help people get chatting to combat loneliness and social isolation.

Gambling with our health: Working to reduce gambling-related harm in Derby
Derby City Council is exploring how to reduce gambling-related harm in the city.

Shaping a stronger and healthier Derby: A year in review
Councillor Alison Martin, Cabinet Member for Integrated Health and Adult Care, looks back over the last twelve months in administration.

Trust appoints Executive Chief Operating Officer – UHDB
The Trust is pleased to announce today (12 June) that Andrew Hall has been appointed as substantive Executive Chief Operating Officer (COO).

New chief people officer for Joined Up Care Derbyshire system
Lee Radford has been appointed as the new chief people officer for NHS Derby and Derbyshire and for the Joined Up Care Derbyshire system.

BBC - Anaesthetist jailed after sexually assaulting child
Edward Finn, 36, who worked as a doctor across a number of hospitals in Derbyshire and Nottinghamshire was jailed for eight years.

Publications that may be of interest:

Joined Up Care Derbyshire – April 2024 Newsletter

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	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		
[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.
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

18th July 2024

Item: 035

Report Title	Joint Forward Plan - Progress Report							
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 - NHS Derby and Derbyshire Joint Forward Plan 2023/24 to 2027/28 - Progress on Delivery							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Population Health and Strategic Commissioning Committee							

Recommendations

The ICB Board are recommended to **DISCUSS** the Derby and Derbyshire NHS' Joint Forward Plan - Progress Report.

Purpose

In line with NHS England Guidance, the Derby and Derbyshire Integrated Care Board (NHS D&D ICB) has reviewed progress of delivery against the first year of the Derby and Derbyshire NHS' Joint Forward Plan. The purpose of the review was to provide information on the level of achievement against planned milestones to date, and signal where we might need to correct our course of action.

Background

In July 2023, the NHS D&D ICB published its *Joint Forward Plan* for the period 2023/24 to 2027/28, which set out the NHS' contribution to achieve the aims of the wider Integrated Care Partnership Strategy.

In doing so, the plan set out key *guiding policies of action* for the Derby and Derbyshire NHS to change its operating model over the next five years, becoming more (i) preventative in nature; (ii) personalised for the citizen; (iii) intelligence led and (iv) with services integrated by design.

Report Summary

Against the backdrop of a very difficult operating environment in 2023/24, we were able to advance some elements of our JFP aim to **enhance NHS "prevention focused" activity**, as follows:

- Over the course of 2023, we achieved a 5pp increase in the proportion of the people with pre-diabetes, who were offered access to the Diabetes Prevention Programme. In addition, more 3% more people took up the offer to attend the course.
- We enhanced access to NHS-funded tobacco treatment services.
- We increased the number of blood pressure checks, identifying a cohort of people identified as having high to very high blood pressure and directing them to an appropriate intervention.
- Over 2023/24, we exceeded our target dementia diagnosis rate, achieving 68.2%, representing a 2% improvement on the March 2023 position.
- We increased the number of women accessing specialist perinatal and maternal mental health services by 80% over the 2023/24 and ended the year in the top 10 of ICBs nationally for best access levels.

In addition to this we have designed and delivered 12 locally led multi-disciplinary neighbourhood teams to better support those with frailty and complexity in the place they call home – with the following achievements:

- Delivering 5000+ home visiting appointments monthly.
- Over 86% of GP practices reported freed-up GP appointments.
- 70% of urgent community response referrals were responded to within 2 hours, with only 2% of patients going to more advanced urgent care settings.

However, we acknowledge that our improvement effort needs to focus on achieving more *fundamental* change at a greater scale and pace and thus identify the following as immediate priorities in 2024/25:

1. Our approach to managing large scale change

The role of Derby and Derbyshire Integrated Care Board (DDICB) is to act as a steward on the delivery of large-scale change—to commission, coordinate, and provide assurance on delivery. Our review has identified that:

- We will need to create a common approach to change and change management to deliver the scale of complex change that is required.
- We will need to create a single view of our multiple work plans to ensure we create the support and oversight required.

We need to review our existing operational governance frameworks that currently provide assurance of both short-term immediate actions and medium to long-term, large-scale change to ensure each is supported effectively

- Our use of metrics to measure progress and impact is not yet universally consistent and therefore, our tracking of progress and managing interdependencies can be improved upon.
- Whilst Programme Management Office (PMO) capability exists to support the collaboration at scale initiatives, we do not yet have this capability universally at a system level.

In response to this, we will establish an integrated **Strategic Deployment and Portfolio Management Office** to align our system goals and change initiatives, engage and connect the stakeholders, support the development of the cases for change, measure the change, support the change, and prepare everybody to be the change.

The system PMO and the new large-scale change governance and assurance framework will enable us to carry out an independent review of our portfolio of complex programmes, identifying where we need to accelerate our plans, pause, or even stop initiatives that cannot demonstrate improved outcomes in quality, performance, and productivity. This will also enable us to map our existing change capability and where it is deployed.

2. The development of Place Alliances and Provider Collaboration

PLACE

We cannot lose the momentum we have built in our local place alliances. For this reason, we will enhance the connectivity between the Integrated Care Partnership (ICP) and the Integrated Care Board (ICB), with an Executive Member of the ICB joining the Integrated Place Executive (IPE). We will also strengthen the connection between the IPE and our Local Place Alliances regarding process and information flow. The differential operating frameworks within our Local Place Alliances are barriers to integrated care. We will work together to bring consistency to those frameworks.

Primary and Community Care is the “cornerstone” of our contribution to improving population health, and we have developed prevention and integration improvement strategies for both. Our goal is to enhance the interface between primary and community care. Therefore, the delivery of our *Primary Care Improvement strategy* will come under the umbrella of the Community Care Improvement programme. We believe all these actions will enhance how the teams in each locality determine the best ways to deliver improvements in health and care delivery for local people.

Provider Collaboration

We recognise the collaboration at scale work delivered by our provider colleagues, especially around fragile services (e.g., Ophthalmology and Haematology) and procurement. We are aware that large-scale change that cuts across our Local Place Alliance and hospital providers brings added complexity, especially in terms of interdependency management, and therefore, as an ICB, we are seeking to bring a greater level of transparency to this work and, in turn, help our provider colleagues to bring further momentum to discovering the opportunity for greater collaboration.

3. The ICB as a Strategic Commissioning Organisation

In transitioning from a Clinical Commissioning Group (CCG) to an Integrated Care Board (ICB), it is widely accepted that the DDICB's commissioning function needs to move from tactical focussed commissioning activity (i.e., based principally on care pathway development and interprovider/organisational facilitation) to a more strategic level, based principally on understanding the population's health and health needs and commissioning in line with these needs.

We are clear that the ICB is not yet fully fulfilling this role and will remain in a transition period, with 2025/26 seeing a further evolution towards this. However, with finite resources, this shift is constrained by all elements of the system being able to fulfil their new duties such as provider collaboration at Place and at Scale and the operational position of the health and care system.

Identification of Key Risks

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

SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	*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.	☒

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

Not applicable to this report.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
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 Joint Forward Plan 2023/24 to 2027/28

Joined Up Care Derbyshire

NHS Derby and Derbyshire Integrated Care Board

Progress on Delivery

Original Publication Date: 28th June 2024

Latest Publication Date: 28th June 2024

Version no. 1.1

Forward

The NHS in Derby and Derbyshire has real ambition to improve the overall health outcomes for the population it serves. Furthermore, that ambition is grounded in the knowledge that the NHS will need to work in full partnership with others to influence those improvements given the full and wide-ranging determinants of health that exist.

Therefore, this Joint Forward Plan (JFP) represents the contribution that the NHS will make into the broader Integrated Care System (ICS) strategy that is owned by the Integrated Care Partnership (ICP) between the NHS, Local Authority and Voluntary Sector partners. Lastly, The Integrated Care Strategy of the ICS is influenced by our two Health and Wellbeing Board strategies and the Joint Strategic Needs Assessments (JSNAs) that support them; thereby, creating the strategic links between the health needs of the population and the forward responses from the NHS and its partners.

We recognise that improvements of this nature will not be delivered overnight but will come from determined strategic effort over several years and through having clarity on priority areas of focus for the NHS itself and its intricate work with partners as referenced above.

Our Joint Forward Plan sets our ambition regarding increasing preventive approaches, moving care and control to local areas, developing better information and intelligence, and optimising daily operations while delivering large-scale complex change.

As this document summarises, working through 23/24 and now 24/25, we are gaining a greater sense of our roadmap to delivering the ambitions of the system over the coming years. We must remember that large-scale systems change is a complex and emergent process; the detail of our collective future as a system of care is often unknown at the beginning and is only now materialising through the discovery, design and delivery of new services. As a system leader, I recognise that we work in a dynamic environment, building from experience but also continually learning and developing as we move forward. Therefore, despite the inherent challenges, I am confident there is a navigable path to developing a sustainable health and care system and overall improved health outcomes for the population.

If I look back to when we published our Joint Forward Plan, I see that we have achieved much. Improvements in how we respond to those who need an urgent health and care response by both improving their outcomes and experience by being treated and cared for at the place they call home as evidenced by our "Team Up" model.

In terms of increasing the role of prevention in our care model, a total of 3400 people who have needed inpatient care (physical and mental health), as well as 590 maternity patients, have also accessed our Tobacco Dependency Treatment programme.

Our portfolio of large change initiatives signals our ongoing transition towards the destination set in our JFP and incrementally moves us towards a more sustainable health and care service. That said, we cannot afford to lose our focus on the priorities of today with improvements to the operational stability of NHS urgent and emergency care services and reducing our overall elective waiting list being clear current and interlinked priorities.

If we look to this year and our next contributions to delivering the JFP strategy, fully mobilising our Place approach will form a key priority. This will support our mission to build our primary and community care offer and take towards the ambition of increasing the quantity of care received closer to home. Improving the use and sharing of information will be a key enabling mechanism for doing this and support local population health management.

As detailed, this balance between managing today AND tomorrow remains our strategic intent. This JFP review illustrates both of these aspects giving further detail on our long-term plan but also reflecting against the progress that has been and will be made in each single year. Whilst this review has had a specific focus on delivery against the plan, we will also seek to refresh the JFP as a whole to make sure that our long term "guiding light" view remains relevant to our population's needs and remains aligned with the Integrated Care and Health and Wellbeing Boards strategies that inform it.

Chris Clayton,

Chief Executive

Contents

1. Introduction

The purpose of the publication is to provide an update on the delivery progress of the NHS Derby and Derbyshire Joint Forward Plan. As the NHS constituent of the Joined-Up Care Derbyshire Integrated Care System (ICS), DDICB acts as convenor and facilitator for the NHS family in the delivery of this plan. The plan's purpose, published on the 1st of April 2023, set the NHS in Derby and Derbyshire on a course over five years to develop how it operates.

In doing so, it informed a set of guiding policies for action, which were informed by a detailed analysis of the challenges and opportunities the NHS and care system faced. It articulated a set of high-level goals we wanted to achieve, the emergent large-scale changes required, and the choices to make. The Joint Forward Plan is the NHS's contribution to the Joined-Up Care Derbyshire Integrated Care Strategy. This sets out the broader Integrated Care Partnership (ICP) ambitions to ensure all citizens start their lives well, live well, and age well, and the strategies produced by our two Health and Wellbeing Boards.

In line with national guidance, the NHS Derby and Derbyshire Integrated Care Board has reviewed the progress of the delivery for the first year of the plan. This review informs us of the achievement of planned milestones and signals where we might need to correct our course. As we implement the proposals outlined in this review, we will have evidence-based information on any definitive changes required to the JFP that must be made before 31 March 2025. We will aim to achieve this as soon as possible. We have consistently recognised that our journey will be complex and emergent in achieving our goals.

The report is divided into the following sections:

- A summary of what we achieved in the year,
- A summary of what and why we need to change,
- What is the Derby & Derbyshire Integrated Care System,
- What we have learnt on our emergent journey.
- Progress on our work plans:
    - How we provide care,
    - How we enable that care,
    - How we work as an Integrated Care Board (ICB).

2. A summary of what we achieved in the year

While we recognise that we have a significant amount of work to do, we have made progress since the publication of our Plan, which provides a solid foundation for the future.

What follows is a summary of several of our achievements:

1. Leadership Development & Talent Management
    - We have co-designed and deployed a consistent core offer for leadership development and induction for all new leaders anywhere in the system. This supports a culture of improvement, encouraging learning and promoting system working. We are creating an inclusive talent approach as the driver for recruitment and development. This includes unified approaches to Leadership Development, Talent Management Development, and organisational development (OD).

2. Local Place Alliances - Team Up
    - We have designed and delivered 12 locally led multi-disciplinary neighbourhood teams to better support those with frailty and complexity in the place they call home. If we look at last year, the team delivered:
        i. 5000+ home visiting appointments monthly.
        ii. Over 86% of GP practices reported freed-up GP appointments.
        iii. 70% of urgent community response referrals were responded to within 2 hours, with only 2% of patients going to more advanced urgent care settings.
        iv. Slower growth in A&E attendance and non-elective admissions for over 65 with frailty compared to growth in this age category.

3. Hypertension - going Further & Faster
    - As part of our cardiovascular disease (CVD) prevention plan, we have increased the number of Blood Pressure checks being carried out across Derbyshire to increase the detection of those with undiagnosed Hypertension. The Hypertension case finding project has achieved an increase of 4113 BPs monitored, 1228 of which (30%) were identified as high or very high.

4. Tobacco Dependency Treatment Services
    - Patients who are admitted to the acute providers, mental health units and maternity patients and their partners are offered NHS-funded tobacco treatment services. Services are run at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB), Chesterfield Royal Hospital NHS Foundation Trust (CRH), and Derbyshire Healthcare NHS Foundation Trust (DHFT) for maternity and mental health inpatients. A total of 3400 inpatient and mental health patients, as well as 590 maternity patients, accessed the programme on 23/24.

5. Dementia Diagnosis
    - Over 2023/24, we exceeded our target dementia diagnosis rate, achieving 68.2%, representing a 2% improvement on the March 2023 position.

6. Access to Specialist perinatal and maternal mental health services
    - We have increased the number of women accessing specialist perinatal and maternal mental health services by 80% over the 2023/24 and ended the year in the top 10 of ICBs nationally for best access levels.

7. Access to care services for Children and Young People (CYP)
    - We increased the number of children and young people accessing services by a third over 2023/23.

3. The highlights for this year ahead (2024-2025)

What follows is a summary of several of our projected achievements for the end of this year:

a) Care Transfer Hub
   i) The hub triages strength-based referrals, asking, ‘Why not home? Why not today?’ prescribes and sources the most appropriate pathway for citizens, with full oversight of system capacity, demand and delays. Once operational, our hospitals will save between 336 and 346 monthly bed days.
b) Central Navigation Hub
   i) The hub's purpose is to simplify and make consistent internal care navigation so that staff can deliver the right care the first time. We are projecting an additional 5,935 patients will be deflected from conveyance and Emergency Department attendance compared to 2023-24.
c) Derbyshire Shared Care Record (DSCR)
   i) We have already achieved interoperability with partner organisations: View data: · Ashgate Hospice - Treetops - Blythe House - DHU - Primary Care Networks - Derbyshire County Council Adults - East Midlands Ambulance Service (EMAS). We are looking to expand this to a wider portfolio of our partner organisations, such as EMAS, to support improved support to emergency crews and expand the local authority data set to include children’s services.
d) Electronic Patient Record
   i) Having secured our EPR supplier via the procurement process, NerveCentre will commence implementation across our acute hospitals.
e) Adult Mental Health & Learning Disabilities
   i) Building works will be completed at Kingsway Hospital in Derby, and a new 14-bed psychiatric intensive care unit (PICU) will open. Derbyshire does not currently have a PICU, and people who need this level of support currently need to travel outside the county to access an appropriate bed.
f) Financial Balance
   i) To increase future investments in primary, community, and social care to reduce health inequalities, we need the overall NHS system to be at breakeven by the end of 2025/26. Currently, we have an underlying £50m deficit, so our goal is to eradicate this and create some financial headroom to strengthen out-of-hospital physical and mental health services. Clearly, the wider context is one of continued pressure on access to urgent and elective secondary care services, so we must be ambitious and establish new ways of collaborating across organisations and genuinely transforming models of care. This should also improve the patient's experience as well as the finances, so by working seamlessly on these two agendas, we will have the opportunity to stabilise our underlying financial position and make material steps towards improving population health.'

4. A summary of what and why we need to change

The Derby and Derbyshire NHS operates within a complex strategic context shaped by various factors over which we have varying degrees of control.

However, the NHS in Derby and Derbyshire has the opportunity and ability to improve the population's health – both in terms of resources, its reach into communities and the status the NHS has as an institution valued by the public. Overall, we want to keep people healthy and healthier through actions that the NHS has direct control over and through being a valued partner and contributor where the NHS has less direct control. The importance of partnership across our Integrated Care System (Joined up Care Derbyshire (JUCD)) is critical to this.

As set out in the Plan, the course will see the NHS change its operating model to become more preventative, integrated, personalised for the citizen, and more intelligence-led. The clinical sectors/organisations will be integrated by design in how they interact with patients and citizens. By all partners committing to this course and taking the necessary action, we will be able to improve the quality of provision, reduce cost and maximise the NHS' contribution to the broader agenda of improving population health.

Primary and Community Care is the “cornerstone” of the NHS’s contribution to improving population health, and we are committed to prioritising and strengthening this offer.

The three critical issues that we are addressing with our plan are:

1. Our Model of Care
    - Re-designing how clinical teams work across different care settings to combine the specialist's collective power with the generalist's expertise.
    - Developing the capability of clinical teams to proactively target limited clinical resources to those most at risk of their health deteriorating.
    - Providing people with the means to engage and influence decisions about their care.

2. Finance
    - We are changing our policy on distributing financial resources – focusing on incorporating specific “weights” for social deprivation and health inequity at the sub-population level – so that more financial resources are allocated to these areas to fund care.

3. Workforce
    - We will reverse the trend where “general medical” acute-based nursing and doctoring has increased faster than general practice doctoring and nursing.

Our plan was informed by local and national research and data highlighting social and health equality gaps. It also includes a variety of targets, aims, and ambitions designed to reduce health inequalities and improve health in specific areas. Sources include National Priorities: Core20PLUS5, Fuller Report, Turning the Curve, NHS 10-year plan, and the NHS Mandate 2023.

Within the JFP, five enabling approaches/principles/ambitions were described as follows and universally supported across the system:

- Allocate greater resources to activities that will prevent, postpone, or lessen disease complications and reduce inequity of provision

- Give the teams working in our localities the authority to determine the best ways to deliver improvements in health and care delivery for local people.
- Give people more control over their care.
- Identify and remove activities from the provision of care that result in expending time and cost but do not materially improve patient outcomes.
- Prioritise the improvement of the System's Intelligence Function and the capacity and capability of its research programme.

5. What is the Derby & Derbyshire Integrated Care System

Derby and Derbyshire Integrated Care System (ICS) is a local partnership that brings together the health and care organisations of Derby and Derbyshire to develop shared plans and joined-up services. It is formed by NHS organisations and upper-tier local councils. It also includes the voluntary sector, social care providers, and other partners who play a role in improving local health and wellbeing.

Our partnership constitutes.

- Chesterfield Royal Hospital NHS Foundation Trust (CRH)
- Derby and Derbyshire Integrated Care Board (DDICB)
- Derbyshire Community Health Services NHS Foundation Trust (DCHS)
- Derbyshire Healthcare NHS Foundation Trust (DHFT)
- East Midlands Ambulance Service NHS Trust (EMAS)
- University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)
- Derby City Council
- Derbyshire County Council
- 112 GP practices (reg. pop. ranges (2-25k) forming 15 Primary Care Networks, plus one Out of Hours provider
- Residential and care home providers
- Multiple voluntary and independent sector organisations

a) Derby and Derbyshire Integrated Care Board

The Derby and Derbyshire Integrated Care Board (DDICB) has numerous roles and function. Principally, it is a convenor for the NHS family in Derby & Derbyshire supporting the development of integrated care but also acts as a key partner in influencing the wider determinants of health. Furthermore, it has a role in supporting broader social and economic development in our area. It also has specific statutory duties and functions that it undertakes namely being a Strategic Commissioner of health and care services and also oversees and assures the NHS and its partners on the quality and performance of the services delivered.

DDICB's strategic commissioning role is focused on creating a systematic and proactive approach to planning, procuring, and delivering NHS services for all communities of the Derby and Derbyshire population. As a new organisation formed in 2022, the DDICB is evolving to achieve its ambition to be seen as a valued partner in the wider collective effort to improve population health and reduce inequity in healthcare provision.

As an NHS sovereign organisation, with staff seeking to understand healthcare needs, manage NHS finance and performance, ensure engagement with the local community in NHS care, and work with system partners to commission a sustainable healthcare landscape.

The board is responsible for delivering the Derby and Derbyshire Integrated Care Strategy and the contribution from the NHS through the Joint Forward Plan, which is currently deployed via the:

- Integrated Place Executive (IPE) & Local Place Alliances,
- Provider Collaborative,
- Several cross-cutting work programmes.

b) Integrated Place Executive (IPE)

The Integrated Place Executive (IPE) coordinates the agreed decisions and actions from two Place Partnership Boards (City & County), who draw priorities from and influence priorities in:

- Integrated Care Strategy
- Joint Health & Well-being Board Strategies
- NHS Integrated Care Board plan
- Joint Forward Plan

The IPE deploys its strategy and receives updates on place-based activities and change initiatives via the eight Local Place Alliances.

c) Local Place Alliances

Our eight place alliances, which are our city and county footprints, are coterminous with our local authority boundaries, and within these, our smaller alliance of partnerships at a local level.

The provider organisations/teams represented within each of our local places are as follows:

- Adult Social Care
- Children's Social Care
- Community Care (NHS)
- Community Mental Health Care (NHS)
- General Practice (NHS)
- Primary Care Network(s) (NHS)
- Public Health
- Voluntary care services

The purpose of our local place alliances is to understand the emergent care needs of our local community and join up to coordinate their services to meet these needs.

Illustration: 01

d) Provider Collaboration

The JUCD Provider Collaborative provides a single forum for all providers of NHS services to work together and take collective responsibility for delivering priorities within the NHS, enabling vertical and horizontal integration at scale. The collaborative includes the following organisations:

- Chesterfield Royal Hospital NHS Foundation Trust (CRH)
- Derbyshire Community Health Services NHS Foundation Trust (DCHS)
- Derbyshire Healthcare NHS Foundation Trust (DHFT)
- DHU Healthcare (DHU)
- East Midlands Ambulance Service NHS Foundation Trust (EMAS)
- University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)
- GP practices - represented by the GP Provider Board

e) DDICB cross-cutting work programmes.

These programmes aim to bring together and deliver system-wide large-scale changes, supporting our front-line care delivery teams. The following image illustrates how we deploy or work.

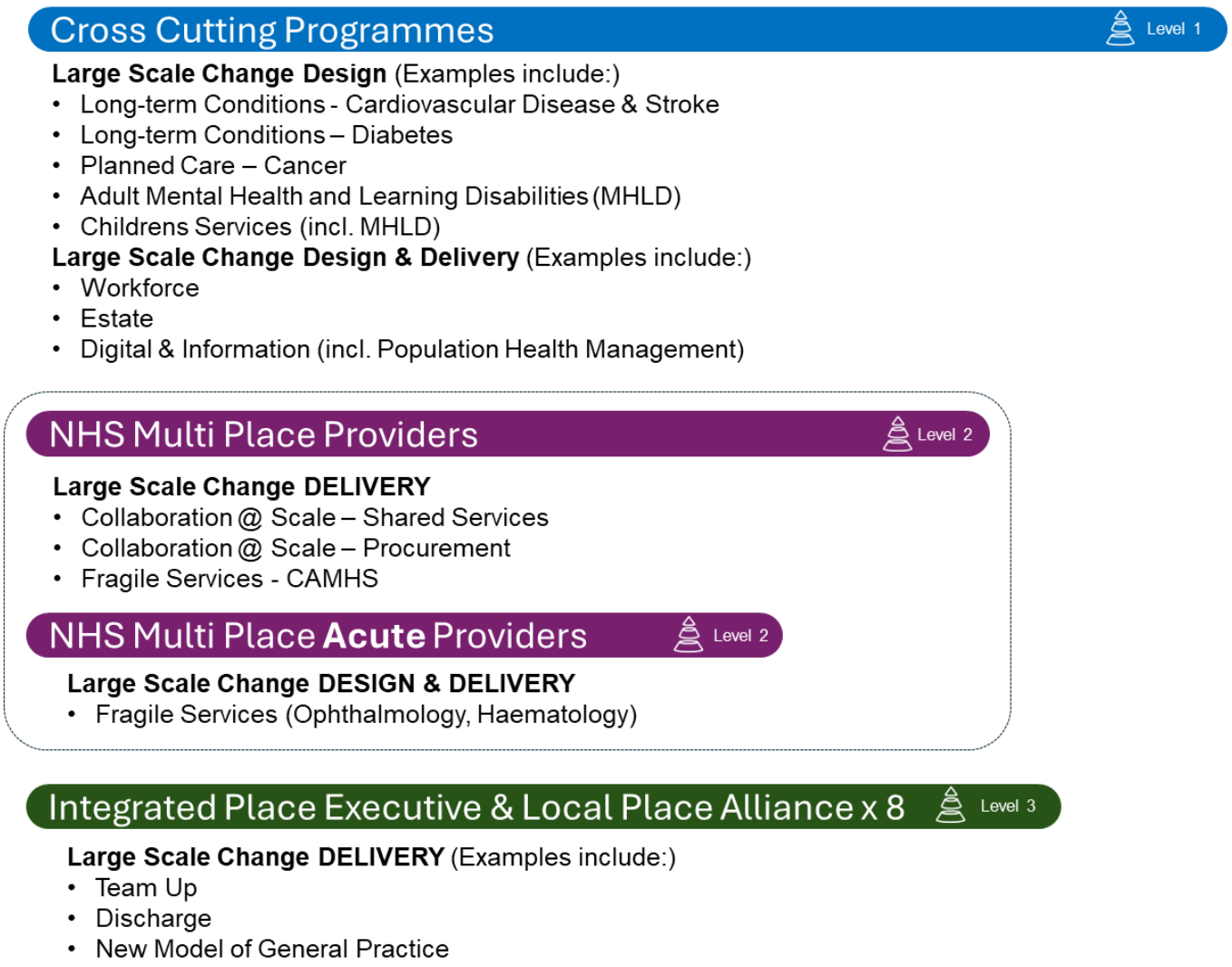


Illustration: 02

6. What we have learnt on our Emergent Journey

While we recognise there is much more to be done, we have improved the care we provide since the publication of the Joint Forward Plan in April 2023.

By working more closely together, we have better understood the services offered already, where gaps might be, what changes are needed to our models of care, how we spend the money entrusted to us, and our workforce. We want to become more preventative, integrated, personalised for the citizen, and be intelligence and information led.

This understanding, balanced alongside the commitments as described in the NHS long-term plan and progress on delivery of our five-year joint forward plan, has enabled us to challenge our assumptions about where we thought we were and recognise that some of our original goals and ways of working still need to evolve if we are to accelerate plans to deliver large-scale change.

While we have delivered real change, challenges emerge, and it is important that, as a system, we learn from these challenges and adapt as they will affect how we succeed in delivering our plan in the future. Critically, there are three areas of how we deliver large-scale change which require our immediate attention:

a) Our Approach to Large-Scale Change

The role of Derby and Derbyshire Integrated Care Board (DDICB) is to act as a steward on the delivery of large-scale change—to commission, coordinate, and provide assurance on delivery. We have a portfolio of large-scale, complex changes to deliver, and our current structure and processes mean we can't do that effectively. We don't have a common approach to change and change management. We have multiple work plans, and whilst they have oversight, we don't have a single view. We are using our existing operational governance frameworks to provide assurance of short-term immediate actions and medium to long-term, large-scale change; this is not working. The use of metrics to measure progress and impact is not consistent. Therefore, tracking progress and managing interdependencies is sub-optimal.

Whilst Programme Management Office (PMO) capability exists to support the collaboration at scale initiatives, we do not have this capability at a system level.

Therefore, we are setting up an integrated **Strategic Deployment and Portfolio Management Office** to align our system goals and change initiatives, engage and connect the stakeholders, support the development of the cases for change, measure the change, support the change, and prepare everybody to be the change. This office will provide a holistic view of all large-scale change progress across our geographical footprint. We will separate out the governance of our large-scale change but will actively manage the day-to-day operational management interdependencies. We will connect multidisciplinary teams, leveraging the ability of the tools, techniques, and methodologies from the professional practices of transformation and improvement, organisation development, programme

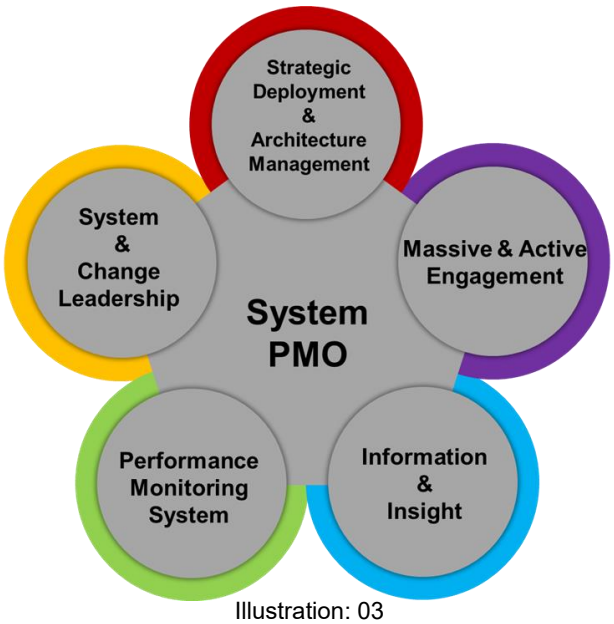


Illustration: 03

management, strategy & business planning, information & insight (incl. Finance) and communications to create a shared, collaborative and agile right-sized change function. The PMO will nurture a culture of collaboration, teamwork, and transparency to overcome inherent organisational and professional boundaries. It will facilitate the development of a sense of community and shared purpose and create communities by connecting the key people at all levels within the system.

The system PMO and the new large-scale change governance and assurance framework will enable us to carry out an independent review of our portfolio of complex programmes, identifying where we need to accelerate our plans, pause, or even stop initiatives that cannot demonstrate improved outcomes in quality, performance, and productivity. This will also enable us to map our existing change capability and where it is deployed.

b) Strategic Commissioning

Care is delivered along horizontal pathways that transcend different clinical and service intervention domains, often provided by multiple horizontal sovereign providers. An ideal intervention at the right time and place can, for example, stop hospital admission. The design and development work of our Integrated Partnership Executive and Local Place Alliances now means that horizontal independent community and primary care providers are working together and coordinating their services to prevent unwarranted hospital admissions.

To understand how this capability and our acute care need to evolve, we must start looking horizontally across our major condition pathways and understand how they need to change. This will inform our medium—to long-term workforce plan, as we will understand the skills and capacity required to deliver the emergent future models of care. These models can then be commissioned. The domains of prevent, detect, protect, treat & perfect can be used as a design guide to develop new models of care at the right stage in the patient's journey. The principles of the domains can be applied to any clinical specialities, as illustrated below:

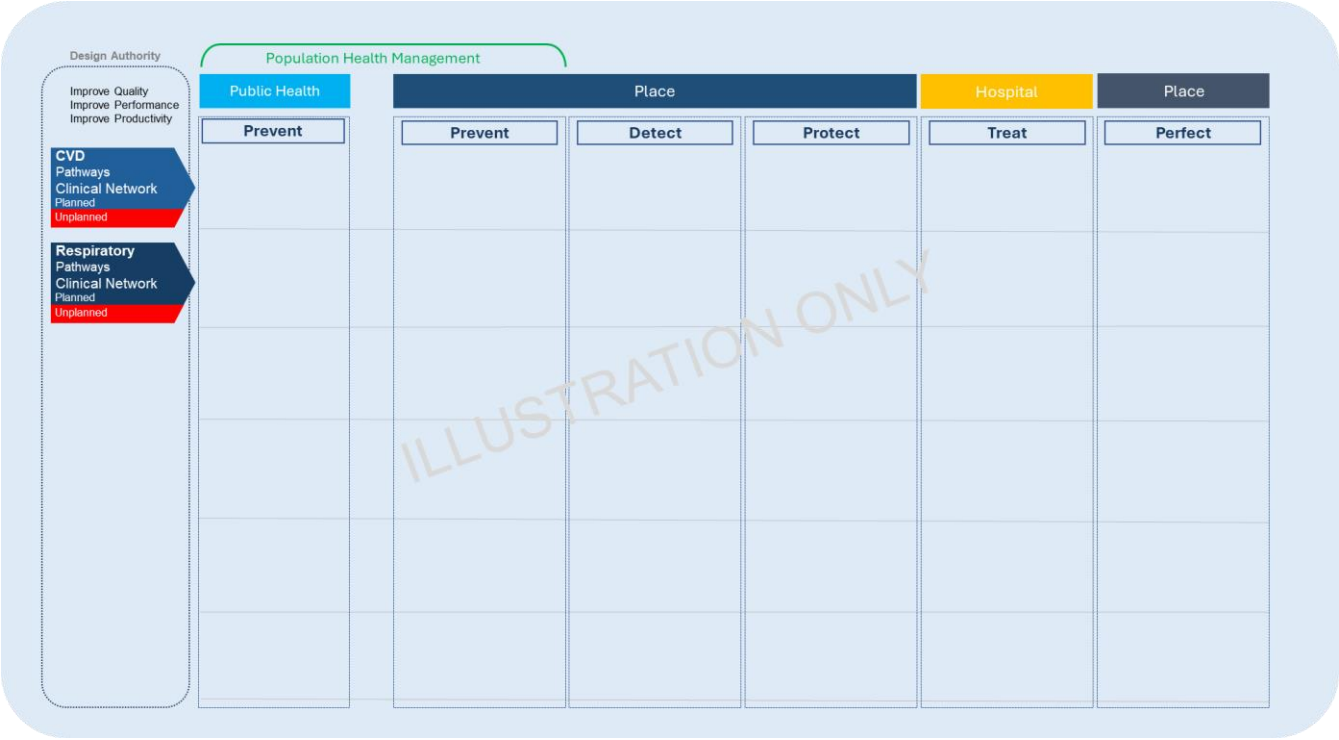


Illustration: 04

In the transition from CCG (Clinical Commissioning Groups) to ICB, it was widely accepted that the DDICB's commissioning function needed to transition from the tactical level of commissioning (based principally on care pathway development and inter-provider/organisational facilitation) to a strategic level (based principally on understanding the population's health and health needs and commissioning in line with these needs).

We are clear that the ICB is not yet fully fulfilling this role and remains in a transition period; next year will see a further evolution towards this. However, with finite resources, this shift is constrained by all elements of the system being able to fulfil their new duties (such as provider collaboration at Place and at Scale (see later)) and the operational position of the health and care system.

Image 04 is an illustration only; we will look to design and deploy a framework for Derbyshire Derby.

c) Integrated Place Executive and our Place Alliances

i) Integrated Place Executive

We cannot lose the momentum we have built in our local place alliances, the cornerstone of population health improvement. For this reason, we will enhance the connectivity between the Integrated Care Partnership (ICP) and the Integrated Care Board (ICB), with an Executive Member of the ICB joining the Integrated Place Executive (IPE). We will also strengthen the connection between the IPE and our Local Place Alliances regarding process and information flow. The differential operating frameworks within our Local Place Alliances are barriers to integrated care. We will work together to bring consistency to those frameworks.

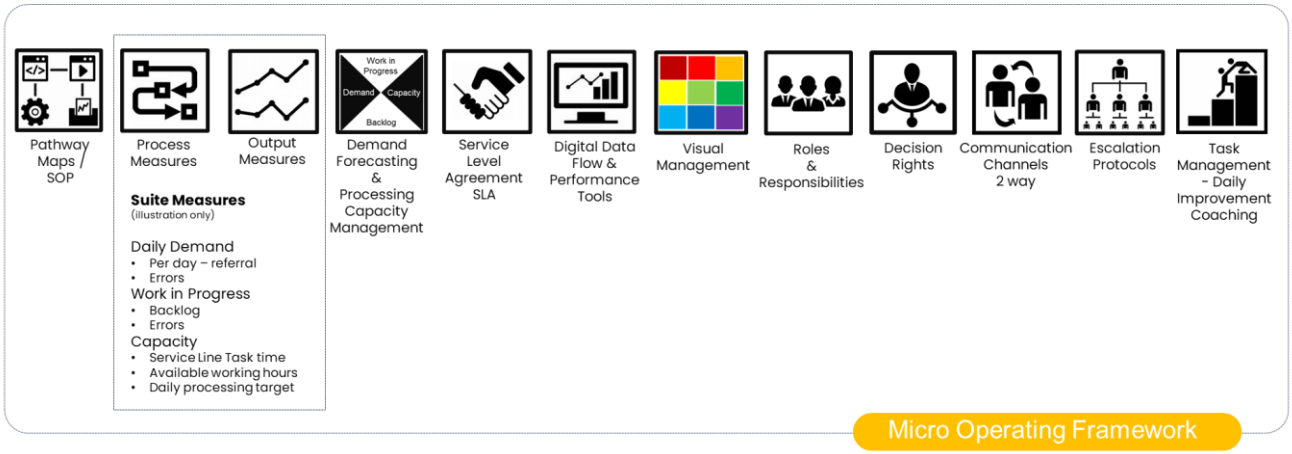


Illustration: 05

Primary and Community Care is the “cornerstone” of our contribution to improving population health, and we have developed prevention and integration improvement strategies for both. Our goal is to enhance the interface between primary and community care. Therefore, the delivery of our Primary Care Improvement strategy will come under the umbrella of the Community Care Improvement programme. We believe all these actions will enhance how the teams in each locality determine the best ways to deliver improvements in health and care delivery for local people.

ii) Collaboration at Scale

We recognise the collaboration at scale work delivered by our provider colleagues, especially around fragile services (e.g., Ophthalmology and Haematology) and procurement. We are aware that large-scale change that cuts across our Local Place Alliance and hospital providers brings added complexity, especially in terms of interdependency management, and therefore, as an ICB, we are seeking to bring a greater level of transparency to this work and, in turn, help our provider colleagues to bring further momentum to discovering the opportunity for greater collaboration.

In addition to the three areas of how we deliver large-scale change, we recognise that it can be difficult for our teams to find the line of sight from their contribution to our goals as an organisation.

d) Strategic Deployment – Line of Sight

Even the NHS family of organisations within Joined Up Care Derby has developed various goals, aims, objectives, and priorities. This is partly because we are a partnership of sovereign organisations and because of the multiple drivers for improvement and change that our regulatory frameworks require us to deliver. These frameworks are not all yet aligned.

All our teams must see how their contribution relates to our shared purpose and long-term goals. The more complicated we make this, the less relatable it becomes. People can struggle to make sense of their work and contribution, so their connection to the organisation is lessened.

We will work with our partners over the summer to simplify our various goals, aims & objectives.

However, we cannot lose the various priorities, associate targets, and measures we are asked to deliver. Our new Strategic Deployment and Portfolio Management Office will map, monitor, and maintain a register with our Informatics and Corporate Affairs Teams.

We will also look to integrate these goals, aims, objectives, and priorities into our decision-making and strategic commissioning service design frameworks (see image 06 for an illustration). We mustn't default to creating new and often siloed change initiatives for every new priority; design principles and decision frameworks can depend upon the ask, be just as effective, and be powerful tools for mainstreaming and sustaining change. The team leading our green and sustainability agenda is developing a Net Zero / Green Quality.

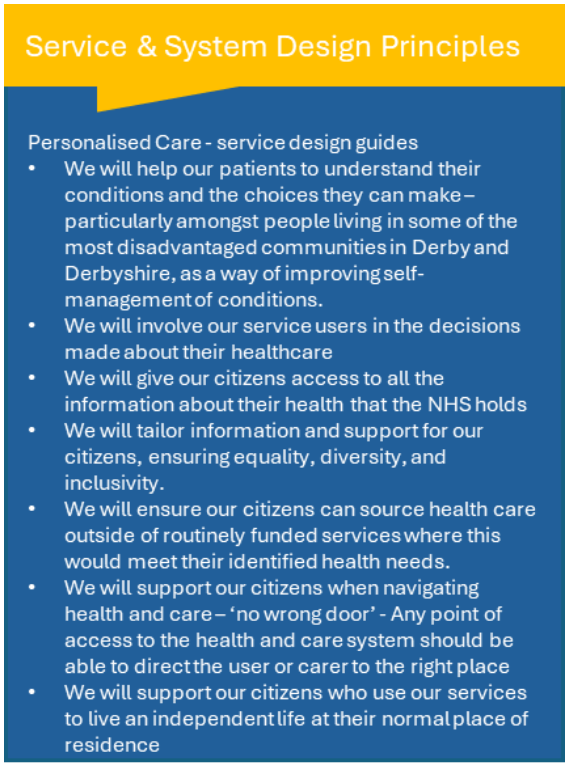


Illustration: 06

7. Next steps

Our collective focus over the next three months and beyond is to enhance our functionality to deliver large-scale change and strategic commissioning. We aim to accelerate our plans while ensuring we don't lose momentum on the progress we have made. Our work plan, coorindated by ICB, is as follows:

1. Setting up an integrated Strategic Deployment and Portfolio Management Office to align our system goals and change initiatives.
2. Transition to a new large-scale change governance and assurance framework, which may result in existing projects and programmes being absorbed into others.
3. The Strategic Deployment and Portfolio Management Office will conduct a deep-dive review of our portfolio of complex programmes, identifying where we need to accelerate our plans, pause, or recommend the stopping of initiatives that cannot demonstrate improved outcomes in quality, performance, and productivity.
4. Map our existing change capability and where it is deployed.
5. Continue our evolution towards being a strategic commissioner.
6. Enhance the connectivity between the Integrated Care Partnership (ICP) and the Integrated Care Board (ICB) and more directly with the Integrated Place Executive (IPE).
7. Strengthen the connection between the IPE and our Local Place Alliances regarding process and information flow.
8. Co-design harmonising the differential operating frameworks within our Local Place Alliances.
9. The delivery of our Primary Care Improvement strategy will be part of the Community Care Improvement programme.
10. Bring greater transparency and momentum to the programmes and projects that constitute Collaboration at Scale.
11. We will work with our partners over the summer to simplify our various goals, aims & objectives.
12. Our new Strategic Deployment and Portfolio Management Office and our Informatics and Corporate Affairs Teams will map, monitor, and maintain a register of priorities, associate targets, and measures.
13. Integrate goals, aims, objectives, and priorities into our decision-making and strategic commissioning service design frameworks.

Our Work Plans

Progress on Delivery

8. Our Work Plans - Progress on Delivery

This section of the document summarises the delivery work plan of the Joint Forward Plan. It is divided into 16 sections reflecting the following themes:

1. Prevention
2. Health Inequalities
3. Primary Care Programme
4. Community Transformation Programme
5. Urgent and Emergency Improvement Programme
6. Long-term conditions
7. Planned Care
8. Children's & Young Peoples Services
9. Adult Mental Health and Learning Disabilities
10. Fragile Services (Collaboration at scale) (C@S)
11. Estate Programme (Collaboration at scale) (C@S)
12. Procurement Programme (Collaboration at scale) (C@S)
13. Shared Services (Collaboration at scale) (C@S)
14. Integrated Pharmacy & Medicines Optimisation (IPMO)
15. Workforce
16. Digital
17. Population Health Management
18. Green Agenda & Net Zero
19. Estates
20. ICB

The themes are represented via a simple table; for the purposes of this report, the change initiatives are categorised as projects. The project's purpose, 2023-24 summary of the impact to date and 2024-25 forecast impact are described. If the cluster of projects forms a programme, then this is described. A summary of the national and/or local drivers for change is described. For the purposes of this document, we have limited this list to three. Where a cell is light grey, the designates that no further explanatory information is available or required at publication.

Productivity
The project title box's light blue background indicates where a project or theme contributes to or has been designated as driving productivity improvements.

Prevention			Driving our work	
			• Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • Prevention and health inequalities - Achieve 80% of those with hypertension to be treated by March 2025.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
1	Tobacco Dependency Treatment Services (Prevention)	Patients who are admitted to the acute providers, mental health units and maternity patients and their partners are offered NHS-funded tobacco treatment services.	• Services are running at UHDB, CRH and DHFT for maternity and mental health inpatients. A total of 3400 inpatient and MH patients, as well as 590 maternity patients, accessed the programme on 23/24.	• Increase access to services for maternity and mental health patients.
2	Cardiovascular disease (CVD) prevention plan	To identify and optimise treatment for undiagnosed hypertension, Arterial Fibrillation (AF) and Elevated Cholesterol in adults living in most deprived areas through a Place-based model of delivery.	• Designed a five-year phased CVD prevention plan.	• Awaiting decision as part of the 24/25 planning round related to the funding allocation to support delivery.
3	Obesity Digital Weight Management	To provide targeted support and access to weight management services for people living with obesity plus either diabetes, hypertension, or both.	• On 23/24, 44% of 112 General Practices referred to the programme. 378 eligible referrals have been made against a target of 1000 per annum (38%). Derbyshire is an outlier. A refreshed communications plan was implemented to include targeted practices not referred to.	• The target for Derby and Derbyshire ICB is 750 eligible referrals. The national target is to reach at least 90% eligible referral rate.

Health Inequalities

The Five (plus) Priorities for Healthcare Inequality Improvements

#	Driving our Work	2024-25 Summary of Progress
4	Restoring NHS services inclusively: Performance reports will be broken down by patient ethnicity and IMD quintile, focusing on unwarranted variation in referral rates and waiting lists for assessment, diagnostic and treatment pathways, immunisation, screening, and late cancer presentations.	• Our portfolio of providers is in various stages of discovery, design and delivery of changes to data collection, data monitoring, and performance reporting to inform action.
5	Mitigating against 'digital exclusion': ensuring providers offer face-to-face care to patients who cannot use remote services and complete data collection to identify who is accessing face-to-face/telephone/video consultations is broken down by patient age, ethnicity, IMD, disability status, etc.	• Our goal will be to introduce these requirements into our decision-making and strategic commissioning, large-scale change and service design frameworks.
6	Ensuring datasets are complete and timely: Continue to improve data collection on ethnicity across primary care/outpatients/A&E/mental health/community services, specialised commissioning and secondary care Waiting List Minimum Dataset (WLMDS).	• Our portfolio of providers is in various stages of discovery, design and delivery of changes to data collection, data monitoring, and performance reporting to inform action.
7	Accelerating preventative programmes: • Covering flu. • Covid-19 vaccinations. • Annual health checks for people with severe mental illness (SMI) and people with a learning disability. • Supporting the midwifery continuity of maternity carers targeting long-term condition diagnosis and management.	• No update was available at the point of publication. • No update was available at the point of publication. • SMI – please refer to section – Adult Mental Health & Learning Disabilities. • Our providers have plans to focus care on those most in need of continuity of carer in 24/25 and develop teams to support those in place to provide enhanced care in identified areas of deprivation.
8	Strengthening leadership and accountability: Supporting PCN, ICS, and Provider health inequalities SROs in accessing training and a wider support offer. • Increase the capacity and capability of the workforce to understand their role in reducing healthcare and wider inequalities. • Ensure that governance, accountability, and assurance mechanisms facilitate a clear focus on reducing health inequalities.	We have established a Prevention & Health Equalities board. • We have trained 8 Core Plus 2- Ambassadors. • Our goal will be to introduce these requirements into our decision-making and strategic commissioning, large-scale change and service design frameworks.
9	Inclusive recovery plans are in place to implement the inclusion health framework.	• No update was available at the point of publication.
10	Ensuring all A&E departments have access to an intense user service.	• Please refer to the Urgent and Emergency Improvement Programme.

Primary Care Programme			Driving our work	
A new Primary Care Model and delivery strategy will facilitate (1) streamlining access to care, (2) providing more personalised, proactive care, and (3) ensuring a far more ambitious and joined-up approach to prevention.			• Support primary care practices to ensure appointments within 2 weeks and urgent assessment the same or the next day. • Improve access to NHS dental services. • Ensure the ongoing sustainability and integration of other Primary Care Providers (Pharmacy, Optometrists and Dentists).	
#	**Projects**	**Purpose**	**2023-24 Impact to date**	**2024-25 Forecast Impact**
11	Strategy Development	Development of a new Primary Care Model and delivery strategy.	• The GP Provider Board set out its clinical model for General Practice, incorporating the GP response to Fuller, which was signed off by the ICB board. • GP estates strategy implementation continued. • PCNs continue to recruit additional roles. • The PCN development programme is ongoing and supported by the GP Provider Board. Place team overseeing the development of integrated neighbourhood teams – supporting Team up.	• Clear approach and plan for implementing the model. • Stratified population enabling tailored services to meet population needs, improve patient experience and maximise value for money. • Consistent approach to digital triage across primary care. • PCNs and Local Place Alliances begin implementing changes to the primary/ community care model on a local place alliance footprint.
12	Population stratification	Use population stratification tools to identify cohorts of patients and then tailor GP services for those cohorts at scale.		
13	Digital triage	Triage and direct patients to the appropriate cohort using a consistent and nationally recognised triage tool to get the right services.		
14		Work with PCNs/ Local Place Alliances to reorganise how General Practice works around cohorts of patients.		
15	PCN development in line with national priorities	Commission the PCN Directed Enhanced Services and develop Primary Care Networks. (Commissioning)	• Access to General Practice improved. • Primary Care Access Recovery Plan delivered. • PCN Directed Enhanced Services provided. • PCN development to mature, integrated system partners.	• ARRS roles are in place; PCNs are delivering directed enhanced services (enhanced access, care home support, etc.); PCNs are maturing and integrating. • Year 1 targets completed. Plan on target. •
16	Improved GP access through the delivery of the Primary Care Access Recovery Plan	Deliver the national Primary Care Access Recovery Plan to improve GP access.\ (Commissioning plan)		
17	Delivery of Dental Recovery Plan	Improve access to NHS dentistry and deliver the national dental recovery plan. (Commissioning plan)	• Commenced national dental recovery plan delivery and developed additional local dental plans to improve access.	• Delivery of year 1 of the national dental recovery plan and local work to improve dental access.
18	Pharmacy, Optometry and Dental (POD) Commissioning	Commission PODS to integrate and expand their role and ensure their sustainability (Commissioning plan)	• ICB has commissioning responsibility for pharmacy, optometry, and dental (POD) contractors, has established appropriate governance and oversight, and has launched Pharmacy First.	• POD commissioning plans in development.

Community Transformation Programme			Driving our work	
A comprehensive system diagnostic undertaken in 2023 identified three priority areas for system transformation and sustainability: • Home-based pathways • Complex discharges and bedded care • Population health management			• National requirements of Urgent Community Response - providing urgent care to people in their homes, helping avoid admission and enabling people to live independently for longer. • National mandate of Enhanced Health in Care Homes programme - aiming to improve care for Care Home residents. • Supporting more proactive, personalised care from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions. [Fuller Stocktake Report – 2022].	
#	**Projects**	**Purpose**	**2023-24 Impact to date**	**2024-25 Forecast Impact**
19	Team Up	To build and integrate multi-disciplinary neighbourhood teams to better support those with frailty and complexity in the place they call home. Delivered via the following workstreams: • Urgent community response • Home Visiting • Enhanced health in care homes • Navigating our system of care • Enhanced fall response at home • Improving management of falls in care homes	• 12 locally led integrated teams delivering 5000+ home visiting appointments a month. • Over 86% of GP practices reported freed-up GP appointments. • 70% of urgent community response referrals were responded to within 2 hours, with only 2% of patients going onto more advanced urgent care settings. • Slower growth in A&E attendances and non-elective admissions for over 65's with frailty compared to growth in these age categories. • A step change in how the ICB benchmarks nationally for A&E attendance for 65 years +, which coincides with the launch of this programme.	• Reduction of 900 A&E attends for those with moderate/severe frailty. • Reduction of non-elective admissions NELs for those with moderate/severe frailty.
20	Care Transfer Hub	The hub triages strength-based referrals, asking, 'Why not home? Why not today?' prescribes and sources the most appropriate pathway for citizens, with full oversight of system capacity, demand and delays.	• 15% reduction in number of people in P1 delay (patients with 7+ days LOS). • County relaunch of re-enablement service with increased capacity started in Jan 2024	• Care transfer hub to be developed with the potential to save between 336- 346 bed days per month. • Potential to save 333-660 bed days per month from 1–2-day reduction in P1 delay • Review of the P2/3 bedded offer has the potential to save 512 bed days per month through a 2-day reduction in P2 sourcing. • Dementia palliative care service will support 54 patients per month – earlier discharge from acute care.
21	Pathway 1 redesign	A multidisciplinary team is responsible for all Derbyshire Pathway 1-3 referrals, including step-up, step-down, and out-of-area referrals. Improve the hospital discharge arrangements across JUCD for individuals who cannot immediately return to the place they call home and who will benefit from accessing Pathway 2 or 3.		
22	Pathway 2 redesign			
23	Discharge database	To provide system-level oversight of capacity, demand and flow and support operational decision-making with real-time data.		

Urgent and Emergency Improvement Programme			Driving our work	
			• Urgent and emergency care - Improve A&E wait times with a minimum of 78% of patients seen within 4 hours in March 2025. • Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25. • Reduce High-Intensity Users (where safe and appropriate).	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
24	Central Navigation Hub	To design, implement and deliver an SPoA ICC to improve care navigation. Simplify and make consistent internal care navigation so that staff can deliver the right care the first time.	• 22,488 patients (83.9%) found appropriate alternative pathways to A&E. Including an increase in Hear, Treat and Discharge to over 13%, 10% received care through community services including UCR, 9% seen by primary care, 58% booked into or referred to UTCs. • CAT3&4 Telephone ambulance deflection has significantly increased to 73%, and CAT3 & 4 online has increased to more than 94% deflected from 999/111 to alternative pathways. • More than 1000 patients per month consistently continue to be found alternative pathways than conveyance to A&E across Derby and Derbyshire.	• An additional 5,935 patients deflected from conveyance and Emergency Department attendance compared to 2023-24.
25	Urgent Treatment Centre (UTC) Model Review	To review and implement change to the Derby and Derbyshire Community UTC model in the context of same-day urgent care offers to prevent inappropriate attendances at ED and see, hear and treat patients closer to home.	• Across the system, Community UTCs combined have seen an average of 11,455 patients per month or 373 per day. All sites remain above the 85% waiting target set for A&Es.	• Increase in patients attending all UTC settings - impact of new integrated UTC model yet to be modelled.
26	Virtual Ward	To implement change to maximise the capacity of virtual wards to support both step-up and step-down care and provide care in a home setting.	• Virtual Ward onboarded over 1,000 patients onto the digital platform. Successfully monitored 10,000 active patient days using the DOCCLA platform. CRH Cardiology increased daily capacity to 15 beds per day • April – monthly average 64 patients (40%), highest day 81 patients (51%).	• Work continues increasing utilisation
27	High-Intensity Users	Discover high-intensity users' demand patterns and capacity impact on our care system. To co-design the right care for the first time to reduce touchpoints and admissions where safe and appropriate.		• Discovery work commenced.

Long-term Conditions – cardiovascular disease (1)			Driving our work	
			• Prevention and health inequalities - Achieve 80% of those with hypertension to be treated by March 2025. • The percentage of patients aged 18 or over with GP recorded hypertension who had a blood pressure reading in the preceding 12 months – Derby and Derbyshire at 87.86, above the national average.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
28	Cardiovascular disease (CVD) prevention plan	To identify and optimise treatment for undiagnosed hypertension, Arterial Fibrillation (AF) and Elevated Cholesterol in adults living in most deprived areas through a Place-based model of delivery.	• Designed a five-year phased CVD prevention plan.	• Awaiting decision as part of the 24/25 planning round related to the funding allocation to support delivery.
29	Stroke Rehabilitation Services review (Fragile Service)	Review of Stroke Rehabilitation services to develop a service model to comply with the National Integrated Community Stroke Specification model.	• Stroke service benchmarked against the NHSE Integrated Community Stroke Service specification has been undertaken to identify gaps in provision	• Completed Case for Change to identify key challenges and public/patient engagement to commence in the summer of 2024.
30	Stroke - Critical Service Review (HASU) (Fragile Service)	Medical workforce recruitment and retainment risk impacts the sustainability of hyperacute and Acute Stroke Units across the region. A service review and options appraisal across Derbyshire, Nottinghamshire and South Yorkshire has been approved to identify cross-border service improvements.	• Identified key workforce risks across all trusts in the Critical Service Review.	• Derbyshire trusts to agree on workforce and recruitment strategy in partnership with tertiary centres.

Long-term Conditions – respiratory disease (2)			Driving our work	
			• Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • NHS Major Conditions Strategy.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
31	Respiratory Pathway Review	Variance in services across the county leads to health inequalities. Utilising an evidence-based approach, deliver a gap analysis to understand pathway improvement opportunities.	• Service review of UHDB Impact+ Specialist Community Respiratory service. Agreed on a new contract, KPIS, and implementation of service improvements in targeted areas (Smoking Cessation, Emergency Department case finding).	• Awaiting approval to commence countywide service review.

Long-term Conditions – diabetes (3)			Driving our work	
			• Reduce health inequalities and improve outcomes for young people with early onset type 2 Diabetes. • Improve patient care and reduce hospital admissions and length of stays.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
32	T2Day	Type 2 Diabetes in the Young programme – an initiative for people with Early Onset Type 2 Diabetes. An incentive scheme in General Practice to improve outcomes for people with Early Onset Diabetes (18-39) and reduce health inequalities downstream activity and healthcare costs. To increase 8 care process delivery.	• 71 practices signed up, and 63% increased the number of people receiving 8 Care process reviews within the 18 - 39 age group.	• If funding is agreed upon, expect an increase in the baseline of 8 care processes compared to 23/24.
33	Diabetes-Specific Health Psychology Pilot	Establish a system-wide clinical lead role to develop and deliver psychological interventions for people living with diabetes to improve patient care and reduce hospital admissions and length of stay. The service will also upskill clinicians at all levels, including NHS Talking Therapies, to better support category 1 - 3 patients. To develop a diabetes-specific pathway with NHS Talking Therapies to enable patients to access higher-level psychological services.	• Pathway design completed and recruitment undertaken.	• Reduce non-elective admissions by 10%. • Reduce LoS by 10% • Improved quality of life for 70% of patients. • Improved treatment and medication compliance by 80% • (patients seen by service) • 8 NHS Talking Therapies practitioners upskilled (2 per organisation).
34	Continuous Glucose Monitoring	• To give CGM access to patients with type 1 Diabetes who are not accessing secondary care. • To give CGM access to patients with type 2 Diabetes in line with NICE Guidance	• Business case created and approved.	• Quantitative forecast impact – ongoing development.

Long-term Conditions – Long Covid			Driving our work
			• Prevention & LTC Bundling 2024/25
#	**Projects**	**Purpose**	**2024-25 Progress & Impact**
	CVD-R – Long Covid	• Children and young people service funding into targeted SDF bundle. • Adult Service Funding into the core baseline.	• The service was reviewed on 23/24 and included an option appraisal process and public engagement. The review recommended continuing the service into 24/25 in line with national guidance but with the reduced resources (staffing and funding) aligned to current demand.

Planned Care (1)			**Driving our work**	
			• Eliminate 65-week waits by September 2024 at the latest. • Cancer - Improve performance against 28-day Faster Diagnosis Standards to 77% by March 2025. • Cancer - Increase stage 1 and 2 cancer diagnosis to achieve 75% early diagnosis ambition by 2028.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
35	Elective Care Community productivity	Increase efficiency of pathways into acute trusts.		• Further referral optimisation schemes, e.g. tele, dermatology, advice and guidance, offer the potential to reduce referrals to secondary care –reducing reliance on insourcing/outsourcing to manage waiting times. • Better patient experience / reduced waits.
36	Elective Care Cancer Primary Care Pathways	Increase efficiency of pathways into acute trusts • LGI Pathway. • Headache Pathway. • Non-Site-Specific Pathway (NSS). • Gyna DA Ultrasound.	• FIT pathway agreed 2023. Partially in place at UHDB (with LGI triage). • Headache/Brain MRI pathway clinically agreed. • NSS pathway in place across DDICB practices. • DA TV Pathway in place. Monitoring to confirm impact and further opportunities.	• Information was not available at the point of publication. • Pathway agreed. • Roll out across Joined up Care Derby. Limited uptake. • Pathway implemented.
37	Elective Care Outpatients Optimisation	Acute internal outpatient workstreams are connected to internal 24/25 planning. To increase productivity via A&G, RAS/CAS, Virtual consultation, PIFU, and VWA.		• Plan to bring under revised governance structure to include ICB oversight of system opportunities and GIRFT/FF Agenda. • Provider impact not currently quantified.

Planned Care (2)			**Driving our work**	
			• Eliminate 65-week waits by September 2024 at the latest. • Cancer – Increase stage 1 and 2 cancer diagnosis to achieve 75% early diagnosis ambition by 2028. • Cancer - Improve performance against 28-day Faster Diagnosis Standards to 77% by March 2025.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
38	Elective Care Optimise theatres/estate	Maximise Acute theatre capacity across our hospital providers (Delivered via Acute Provider Productivity programmes).	• Theatre utilisation improved CRH by 78% and UHDB by 82% • High volume, low complexity Ophthalmology lists in place at both acute sites • Largely provider-led work to maximise productivity and value. Some opportunities for shared work HVLC and day care facilities.	• Expected efficiency is already included in provider planning assumptions • Potential to increase VWA, ERF income and RTT delivery, workforce productivity • Supports provider CIPs and ERF income, supports elective recovery.
39	Elective Care Ophthalmology	Maximise community capacity.	• Implementation of Ophthalmology triage service across Derbyshire demonstrated that 42% of referrals could be avoided.	• Ophthalmology plan refresh to address IS choice/contractual sustainability. • Impact data was not available at the point of publication.
40	Elective Care Cancer Faster Diagnosis	Increase efficiency of pathways into acute trusts to expedite diagnosis/ruling out of cancer through faster diagnosis.	• Pathways implemented both trusts.	• Full implementation has a greater impact on performance.
41	Elective Care Cancer Prostate Case Finding	Increase efficiency of pathways into acute trusts to expedite diagnosis/ruling out of cancer through early Diagnosis: Prostate Case Finding Pilot.	• Prostate Case Finding Pilot has engaged up to 1000 men – evaluation complete.	• Evaluation impact was not available at the point of publication.
42	Elective Care Cancer prevention/case finding	Increase efficiency of pathways into acute trusts to expedite diagnosis/ruling out cancer through early Diagnosis: prevention/case finding.	• Early Diagnosis opportunities recommended by the cancer alliance with the system lead to agreeing on targeted opportunities for 2024/20255.	• To be scoped - the impact of early diagnosis on primary/community care pressures.
43	Elective Care Cancer Tele dermatology	Increase efficiency of pathways into acute trusts to expedite diagnosis/ruling out of cancer through Tele dermatology.	• Skin: The region has mandated the implementation of teledermatology. Options appraisal is underway for a system approach to managing skin cancer activity.	• To be scoped - the impact of early diagnosis on primary/community care pressures.

Planned Care (3)			**Driving our work**	
			• Cancer - Improve performance against 28-day Faster Diagnosis Standards to 77% by March 2025. • Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • Increase the proportion of diagnostic tests within 6 weeks to 95% by March 2025. • Eliminate 65-week waits by September 2024 at the latest.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
44	Elective Care Cancer – Lung Health Check	Increase the efficiency of pathways into acute trusts to expedite the diagnosis/ruling out of cancer through Targeted Lung Health Check (TLHC).	• TLHC: a mandate from the region to implement targeted health lung checks- recruitment delays to develop JUCD infrastructure to develop implementation plan/options appraisal.	• Opportunities being scoped.
45	Cancer Alliance Personalised care Prehabilitation	Prehabilitation is a way to prepare the patient's body and mind for surgery, chemotherapy, or other cancer treatments. It involves a structured program that includes exercise, eating well, psychological or emotional support, and other helpful activities.	• Discovery Phase: pending regional sign-off on cancer prehab model and development of business case to pilot in systems.	• Information was not available at the point of publication.
46	Elective Care Diagnostics	Improve access to diagnostics/ maximise care in the community.	• Diagnostic performance complies with the operational plan targets for diagnostic tests within 6 weeks.	• Evaluation impact was not available at the point of publication. • The initiative will be reviewed post-impact evaluation. • Impact of CDC and link to UEC and Planned care pathway improvement. • Supports referral optimisation initiatives. • Potential for lower-cost pathways, although not CRE in the first instance.
47	Elective Care Community Diagnostic Centre	Improve access to diagnostics/ maximise care in the community.	• Diagnostic performance complies with the operational plan targets for diagnostic tests within 6 weeks.	• Implementation of CDC ongoing. • Impact of CDC and link to UEC and Planned care pathway improvement. • Supports referral optimisation initiatives • Potential for lower-cost pathways, although not CRE in the first instance.

Planned Care (4)			**Driving our work**	
			• Cancer - Improve performance against 28-day Faster Diagnosis Standards to 77% by March 2025. • Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • Increase the proportion of diagnostic tests within 6 weeks to 95% by March 2025. • Eliminate 65-week waits by September 2024 at the latest.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
48	Elective Care Musculoskeletal – Clinical Assessment & Triage Service	The Musculoskeletal – Clinical Assessment & Triage Service (CATS) is in place, diverting activity from the acute setting, improving patient experience/outcome and reducing clinical variation.	• Service implemented.	• Evaluation impact was not available at the point of publication.

Children's & Young Peoples Services (1)			Driving our work	
			• Increase the number of children reaching a good level of development at the end of reception. (Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach). • Increase the no. of children at 99.6th centile receiving support to manage their weight (Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach). • Reduce family breakdowns and the number of Care Home Placements a CYP has through support to the CYP and staff closest to them.	
#	Projects	Purpose	2023-24 Summary of impact to date	2024-25 Progress & Impact
49	Early Years (Start Well)	The goal is to improve outcomes and reduce inequalities in children's health, social, emotional, and physical development in the early years (0-5) through school readiness. The initial focus is on SEND and speech-language and communication needs.	• System Agreement to the new model.	• Information was not available at the point of publication.
50	Long Term conditions – pathway(s) re-design	Delivery of transformation of children and young adult's pathways for Long Term Conditions: • Asthma • Obesity • Diabetes • Epilepsy	• Public health-led schemes to support communication and education put in place.	• Further proposals in development. Information was not available at the point of publication.
51	Cancer End of Life	The original plans for investing in Palliative Care and end-of-life match funding received from NHS England for Children and Young People were revised to ensure a greater range of options for families of children and young people entering end-of-life.		• Proposals in development. Information was not available at the point of publication.

Children's & Young Peoples Services (2)			Driving our work	
			• Improve access to diagnostic services and reduce waiting times for Neurodiversity / LD & Autistic Spectrum Conditions. • Reduce the MH emergency admission rate per 100,000 persons with a diagnostic code that includes Autistic spectrum conditions or learning disabilities. • Reduce the proportion of people who are receiving care in a hospital whose care and support needs can be met in the community for those with Neurodiversity / LD & Autistic Spectrum Conditions.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
52	Neurodevelopment Autism in Schools	Autism in Schools - An NHSE-led initiative to support inclusion and access for CYP with Autism in Schools, focusing on transitions from primary to secondary schools.		• Proposals in development. Information was not available at the point of publication.
53	Neurodevelopment Children & Young people's Key working	CYP Key working - An NHSE-led initiative to ensure every CYP with Autism and or a Learning Disability has a key worker to support them		• Proposals in development. Information was not available at the point of publication.
54	Emotionally based school absence project	An NHSE-led initiative to ensure CYP who are not attending school due to emotional needs are supported back into school, an integrated education and health initiative.		• Proposals in development. Information was not available at the point of publication.
55	Neurodevelopment Assessment Community Hubs	Neurodevelopment Assessment Transformation initiative and Wrap Around ND Community Hubs to transform pathways to ensure they are as efficient and effective as possible.		• Proposals in development. Information was not available at the point of publication.

Children's & Young Peoples Services (3)			Driving our work	
			• Increase the proportion of people who receive a response from healthcare professionals when in a mental health emergency. • Increase the proportion of people with a mental illness who have access to early interventions. • Increase the proportion of children and young people waiting 4 weeks or less to start receiving help from community mental health services.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
56	Mental Health Crisis Mental Health Eating Disorders	Deliver the Derby & Derbyshire JUCD priorities identified from the LTP whereby all CYP experiencing MH crisis can access crisis assessment 24/7 and intensive support for seven days. • To improve the outcomes for children with mental health urgent care needs and improve the system's efficiency in delivering these. • We aim to build support around the child and maintain key relationships and positive networks. • Wherever possible, our children and young people should not be moving to placements/hospitals due to lack of support. • To stem escalation and respond by supporting all Derbyshire CYP at the earliest opportunity. • Deliver the Derby & Derbyshire JUCD priorities identified from the LTP for Eating Disorders, whereby access to family therapy is improved.		• Proposals in development. Information was not available at the point of publication.
57	Mental Health Community	To deliver the CYP Transformation to ensure they receive timely and appropriate care to meet their emotional and mental health needs: • Reduce health inequalities with an emphasis on boys / young men and our black and ethnic minority populations. • Improve outcomes for CYP. • Improve participation and co-production. • Improve our response to young adults. • Continue to improve our early Intervention and Targeted Support offer and Expand Mental Health Support Teams in Schools. • Continue to support children in care.		• Proposals in development. Information was not available at the point of publication.

Adult Mental Health & Learning Disabilities (1)			Driving our work	
			• Eliminating inappropriate out-of-area placements. • Increase access to transformed models of the adult community and perinatal and children's and young people's mental health.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
58	Adult- Inpatients	• To improve the quality of Mental Health inpatient services, eliminating inappropriate out-of-area placements. • To improve the quality of Mental Health inpatient services and reduce the use of inpatient high-dependency rehabilitation services (locked Rehab). • To redevelop our estate to enable the elimination of out-of-area and reduce locked rehabilitation – sites: Kingsway Hospital in Derby (PICU), 34 Bedded Female Acute MH Unit (Radbourne Derby), 12 bedded relocations of Older Adult MH Unit (Walton Hospital) & 8 Bedded Female Enhanced Care MH Unit (Audrey House Kingsway Hospital Derby).	• Capital monies secured. Building works were initiated. • Co-production of clinical strategy. • A review of community support offers to enable individuals to receive the care required in their own homes.	• Building works are to be completed, and new wards will be mobilised.
59	Adult Community-Urgent Care Services	To improve access to and timeliness of urgent specialist MH community support via MH Helpline & crisis services to: • Increase urgent access to specialist advice and guidance • Increase in urgent access to specialist MH support for people in Crisis	• Operational policies reviewed.	• Proposals in development. Information was not available at the point of publication.
60	Improve Access to Adult Community - Community Mental Health Team	Improve access to strength-based community support services. Improve identification of increased risk of physical health co-morbidities, increase access to treatment and interventions to reduce risk factors achieve by: • Roll out and embed the 'Living Well' model. • Increase uptake of Annual health checks (AHC) for people with diagnosed severe mental illness (SMI).	• Roll out of transformed service model across all areas. • Increased uptake within primary care of achievement of all 6 health checks.	• Information was not available at the point of publication.

Adult Mental Health & Learning Disabilities (2)			Driving our work	
			• Increase access to transformed models of the adult community and perinatal and children's and young people's mental health. • Reducing the reliance on inpatient care for people with Learning Disabilities and Autistic people- No more than 30 Adults and no more than 3 CYP with LD or Autism per 1 million population. • Deliver Annual Health Checks to 75% of those aged 14+ and on the GP Learning Disability register.	
#	Projects	Purpose	2023-24 Summary of impact to date	2024-25 Progress & Impact
61	Adult Community-Mental Health Perinatal	• Improve access and completed treatments • Increase access to spouse/partner.	• We have increased the number of women accessing specialist perinatal and maternal mental health services by 80% over the 2023/24 and ended the year in the top 10 of ICBs nationally for best access levels.	• Information was not available at the point of publication.
62	Adult Community-Mental Health Talking Therapies	• Improve access and completed treatments - in line with Talking Therapies manual. • Improve reliable recovery and reliable improvement.		• Information was not available at the point of publication.
63	Adult Community-Mental Health Dementia Diagnosis	Improve access and complete diagnostics Improve care and support.	Over the course of 2023/24 we exceeded our target dementia diagnosis rate, achieving 68.2%, which represented a 2pp improvement on the March 2023 position	• Information not available at the point of publication.
64	Learning Disabilities and Autistic Transformation – Inpatient Services	To review the service, offer for people accessing NHS-funded short breaks. To review the inpatient assessment and treatment offered for people with a learning disability.	• Discovery phase complete.	• Information not available at the point of publication.
65	Learning Disabilities and Autistic Transformation Urgent Care Services	To support more people to access urgent assessment and treatment within their own homes and reduce the use of inpatient services for the assessment and treatment of people with learning difficulties and co-occurring mental health/behavioural needs.	• Information not available at the point of publication.	• Information not available at the point of publication.
66	Learning Disabilities and Autistic Transformation Community Services	Access to treatment and interventions to reduce risk factors should be increased to improve the identification of people at increased risk of physical health co-morbidities. One such intervention is to increase the uptake of Annual health checks for people with diagnosed learning disabilities.	• Increase uptake of Annual health checks for people with diagnosed learning disabilities.	• Information not available at the point of publication.

Adult Mental Health & Learning Disabilities (3)			Driving our work	
			• Increase attainment levels of SMI Annual Physical Health Checks in Primary Care to meet NHSE attainment expectation of 75% by the end of 2025 / 26. • Mental Health - Deliver a full annual physical health check in at least 60% people with severe mental illness by March 2025. • Consolidate Eating Disorders Medical Monitoring Pathway between Primary & Secondary Care. • Reduce the number of people dying from suicide and improve bereavement support.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
67	Community Mental Health Access - Annual Health Checks	To improve identification of increased risk of physical health co-morbidities, increase access to treatment and interventions to reduce risk factors via: • Annual health checks for people with severe mental illness (SMI) and people with a learning disability.	• Increased uptake within primary care of achievement of all 6 health checks.	• Information not available at the point of publication.
68	Community Mental Health Access – Eating Disorder Service	To improve the identification of people at increased risk of physical health co-morbidities, access to treatment and interventions to reduce risk factors via eating disorder service pathway improvements will be increased. Locally enhanced service will be introduced for Primary Care.	• Improved pathway of care for patients.	• Information not available at the point of publication.
69	Derbyshire Suicide Prevention Partnership	To improve access to suicide prevention and postvention support.	• Information not available at the point of publication.	• Information not available at the point of publication.

Fragile Services (C@S)			**Driving our work**	
			• Workforce recruitment and retention challenges. • Inability to deliver a sustainable, safe, high-quality clinical care model (service fragility). • Eliminate 65-week waits by September 2024 at the latest.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
70	Ophthalmology	To develop a single Derbyshire Ophthalmology service which addresses current service fragility and delivers a sustainable model of care that meets local needs and delivers the best value. Ophthalmology is one of our highest-risk fragile services, driven by a shortage in the substantive medical workforce, particularly at CRH. The acute providers have agreed to work together to develop a single provider model that enables the best use of the clinical workforce and operates an agreed approach to using acute, independent sector, and community capacity.	• Case for change drafted preferred option identified.	• PID signed off, project team in place, demand and capacity. • Delivery of business case by January 2025, improvements to RTT.
71	Haematology	To reduce inequities in access and service fragility through collaboration and mutual aid		• Mutual aid arrangement is in place; impact will be reviewed from August 2024. • The impact is expected to be an increase in CRH outpatient activity and a decrease in UHDB routine outpatient referrals and backlog.
72	CAMHS	Improve resilience in CAMHS services, reduce unwarranted variation, and improve cost-effectiveness through collaboration.		• Mutual aid arrangement is in place; impact will be reviewed from August 24. • Reduction in reliance on locums, achievement of 5% CIP

Estates Programme (C@S)			**Driving our work**	
			• Use of resources - Deliver a balanced net system financial position for 2024/25.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
74	System Infrastructure Strategy	Set out our overall principles and priorities for the NHS estate over the next five years, including reducing the total number and cost of NHS premises in the ICS, ensuring estates are fit for the future and remodelling how estates are used to deliver integrated care in our places.		• Infrastructure strategy is being drafted and is with NHSE for approval. • We are working with Community Health Partners to develop 5,10,15-year estate plans using ADEPT. • Data collection has been undertaken, core flex and tail premises identified, utilisation data pooled, an initial list of sites to deliver an efficiency plan through improved utilisation developed and socialised, and more detailed proposals for each site are now being worked on.
74	Medium- and long-term plans for estate utilisation	Develop a medium—and long-term plan for estate utilisation driven by our clinical change programmes. This plan sets out what impact this will have on how and where demand is met and helps us transition to an estate profile that is fit for the future.		
75	Efficient use of premises	Work to improve estate utilisation and the efficient use of premises, including sharing space and divesting of no longer required premises.		

Procurement Programme (C@S)			**Driving our work**	
			• Use of resources - Deliver a balanced net system financial position for 2024/25.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
76	Shared procurement workplan	To create efficiencies and deliver better value for money through shared procurement activities.		• Financial Savings range £1.4M to £2.9m (including digital contracts) plus further £0.5m relating to function consolidation
77	Shared procurements	To create efficiencies and deliver better value for money through shared procurement activities.		
78	Improved supply chain management			

Shared Services (C@S)			**Driving our work**	
			• Use of resources - Deliver a balanced net system financial position for 2024/25 • Eliminate 65-week waits by September 2024 at the latest.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
79	Shared Services	The shared services model incorporates individual back-office functions, including finance, procurement, HR, estates, legal, and corporate.		• To develop a business case for a JUCD shared services model incorporating multiple back-office functions.
80	MSK	Improve the MSK service across Derbyshire & Derby through: • Collaboration between community, primary care, and acute care is needed to strengthen referral and assessment and maximise treatment in the community. • Ensuring a focus on pre-op optimisation at the referral point to secondary care. • To support the above, develop a single access point integrated with clinical assessment and onward booking. • Digital platform and data sharing for SPA and referral assessment. • Agreed, consistent pathways and referral criteria across the system, including the independent sector.		• No update was available at the point of publication.
81	Speech and Language Therapy	To improve resilience, reduce unwarranted variation and long waits for children through JUCD single pathway, single point of access & single provider.	• Agreed on a single pathway, developed option appraisal for the future operating model, and agreed on a single provider to be hosted by DCHS.	• Better use of capacity and workforce, improved efficiency markers (time to triage, time to first appt, new to follow up ratios).
82	Primary/Secondary Care Interface	To improve the primary/secondary care interface through process improvements, digital enablement, and clinical network development.		• No update was available at the point of publication.

Integrated Pharmacy & Medicines Optimisation (IPMO) (1)			Driving our work	
			• Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • Support primary care practices to ensure appointments within 2 weeks and urgent assessment same day or the next day. • Nationally contracted Community Pharmacy Services, reducing pressures on other workforces [Fuller Stocktake Report – 2022] • Over-Prescribing Review, National AHSN Polypharmacy Programme.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
83	Integrating community pharmacy services	Fully integrate Community pharmacy services to: • Improve experience of care • Improve patient outcomes • Improve access • Relieve pressures in the primary care workforce • Reducing avoidable medicines harm	• Launch of Pharmacy First scheme to increase access to primary care.	• Increase in the number of Pharmacy First consultations carried out.
84	Hypertension - going Further & Faster	Reduce cardiovascular events by: • Increasing the number of Blood Pressure checks being carried out across Derbyshire to increase detection of those with undiagnosed Hypertension	• The Hypertension case finding project has achieved an increase of 4113 BPs monitored, 1228 of which (30%) were identified as high or very high.	
85	Pharmacy-led lipid management service.	Reduce cardiovascular events by: • Increasing the identification of eligible secondary prevention cases • Increasing capacity within secondary care lipid clinics via a system-wide pharmacy hyperlipaemia team • Increased capacity for PCSK9 inhibitor & inclisiran initiations and monitoring to include administration within Community Pharmacy	• Prevention and health inequalities—By March 2025, Provide lipid-lowering therapy treatment for 65% of people with a CVD risk score of greater than 20%.	
86	Improving chronic non-cancer pain management by reducing harm from opioids.	To work together as a system across Derby and Derbyshire to deliver improvements in pain management that both enhance the care of people living with chronic non-cancer pain and reduce the harm from opioids.	• Reducing harm from opioids programme—work plan delivered, including health and wellbeing Coaches and social prescriber-led patient programme.	• Reduction in the number of patients aged 18+ currently prescribed oral or transdermal opioids for more than 3 months

Integrated Pharmacy & Medicines Optimisation (IPMO) (2)			Driving our work	
			• Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • Support primary care practices to ensure appointments within 2 weeks and urgent assessment same day or the next day. • Nationally contracted Community Pharmacy Services, reducing pressures on other workforces [Fuller Stocktake Report – 2022] • Over-Prescribing Review, National AHSN Polypharmacy Programme.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
87	Antimicrobial Resistance	System Antimicrobial Strategy Implementation To deliver the Derbyshire-wide AMR strategy to: • Minimise infection • Demonstrate appropriate of antimicrobial • Provide safe and effective care • Engage with the public	• Refreshed and progressed implementation of the AMR strategy for 2023 to 2025.	• Reduction in the overall volume of antibacterials prescribed - primary & secondary care in line with national targets. • Increase in Proportion of Amoxicillin 500mg capsule prescriptions issued as 5-day courses in line with national targets. • Reduction in Proportion of total antibiotic treatment days administered intravenously in line with national targets.
88	Optimising & prioritising medication review	Optimise the quality and delivery of medication reviews to: • Improve patient experience by promoting .shared decision-making. • Reduction in harm. • Optimising health resources. • Reduction in polypharmacy.	• Developed approach and work plan.	• Increase in clinicians who have undertaken local training (inc QUEST). • Decrease in Percentage of Pts prescribed 4 or more medicines that can have an unintended hypotensive effect. • Decrease in Percentage of Pts prescribed 4 or more medicines with moderate to high anticholinergic burden. • Decrease in Percentage of Pts prescribed 10 or more unique medicines >75yrs.

Integrated Pharmacy & Medicines Optimisation (IPMO) (3)			Driving our work	
			• Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • Support primary care practices to ensure appointments within 2 weeks and urgent assessment same day or the next day. • Nationally contracted Community Pharmacy Services, reducing pressures on other workforces [Fuller Stocktake Report – 2022] • Over-Prescribing Review, National AHSN Polypharmacy Programme.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
89	Pharmacy workforce	• Create a strong, credible and inclusive voice to speak to and on behalf of pharmacy. • Attract and recruit the required pharmacy workforce. • Provide support and leadership during trainee and foundation years. • Maintain a growing, skilled, agile and resilient workforce with opportunities for career development. • Introduce, facilitate and support new roles and ways of working.	• Pharmacy faculty established with system and external involvement, work developed, and implementation started.	• Reduction in Vacancy rate (primary & secondary care). • Reduction in Staff turnover rate. • Increase in the number of foundation year places for Pharmacists. • Increase in the number of training places for Pharmacy Technicians. • Increase in the number of roles for non-pharmacy registered staff, including Science Manufacturing Technicians/Science Graduates.

Workforce Programme (1)			**Driving our work**	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
90	People Scaling	• Creating a high quality and consistent People Services offering, scaling People Services through improved collaboration by: • Identification of opportunities for scaling recruitment processes, collaboration, and consistency as practicable and beneficial, as well as greater collaboration and improved efficiency within Joined Up Care Derbyshire. • Identifying opportunities for Trusts in Derbyshire to realise benefits of scale through collaborative working, which may lead to collaboration of improvement, shared ideas, aligned or cross-cutting provision(s), alignment of policies, training and documentation and/or streamlined internal movements across Joined Up Care Derbyshire. • Enable a more aligned approach, viewing people as system assets to be deployed wherever their skills fit best through internal movements / sideways transfer.	• Membership established and initial scoping completed.	• Scaling recruitment processes phase 1: identifying opportunities complete. • Trust level recommendations identified. • Impact on a reduction in vacancies and improved retention (note it is impossible to quantify as there will also be many other factors contributing to improvements in these areas).
91	Contingent Workforce/ Reservists	• Developing a comprehensive contingent workforce model that can flexibly support Patient flow and Patient recovery, transcending organisational boundaries. • Develop a system approach to temporary workforce solutions that improve workforce efficiency and increase resilience.	• A workforce sharing agreement is in place, increasing the number of services signed up.	• Reservist programme is in place across the system. • A system 'flexible working' action plan was formulated. • The practice nurse role is planned to be operational by Q2. • Scoping of other roles to help fill gaps at the system level where agency usage for specialist roles not available on banks at each organisation is in process.

Workforce Programme (2)			**Driving our work**	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition. • Use of resources—Reduce agency spending to a maximum of 3.2% of the total pay bill by 2024/25.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
92	Retention Programme	Deliver the national directive of work to improve workforce retention through a system-wide retention programme.	• System definition of retention and framework to govern the programme – four pillars of the employment cycle. • Flexible working system action plan formulated. • Colleague experience app through BETA testing, with further features following initial testing.	• Successful pharmacy workforce retention conference with further learning and projects planned.
93	Agency Reduction	• Develop a System Agency Reduction Plan to drive forward actions agreed upon at a system level, reduce overall agency usage, and share learning across providers to make improvements. • Developing an integrated system rather than an organisational approach to addressing workforce supply (in this case, temporary staffing usage) requirements.	• Improved triangulation with finance and accuracy of data associated with temporary staffing—reasons for agency requests previously captured at 13% have improved to 87%. • Improving understanding of the position - enabling targeted actions. • Off Framework usage has been an area of focus for this group - Off Framework agency exit strategies translated into the 2024/25 workforce plan submission. • Identifying areas where off-framework usage cannot be safely eradicated escalated to NHSE.	• Monthly tracking and monitoring in place. • Steering Group established to progress at pace. • Off framework trajectories/ action plans confirmed. • Reduction in agency usage in line with NHSE expectations/ requirements. • Removal of Off Framework agency usage by 1 July (note exceptions have been submitted as part of the action plans to NHSE).

Workforce Programme (3)			Driving our work	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
94	Derbyshire Academy	• Developing a system approach to assessing workforce supply requirements. • Expand clinical placement capacity across all professional groups to meet future workforce demand and develop our educator workforce correspondingly. • Clinical education expansion requirements (including apprenticeship) for Long Term Workforce plan. • Liaise with HEIs to develop partnership agreements that meet the NHSE requirements. • Increase capability and improve career development for Advanced Care Practitioners across the system • Allied Health Professional preceptorship alignment with HCPC principles and NHSE Standards Framework • Develop a standardised system approach and improve access to apprenticeships. • Lead and deliver system-wide recruitment campaigns and improve the future pipeline by scaling up engagement. • Ensure Quality Placements and expansion to meet training needs and national shortfalls. • Nursing and midwifery - make nursing in Derbyshire attractive and expand future pipelines. • Supporting training capacity for Foundation Year Trainee (FYT) Pharmacists. • Development of digital skills amongst our workforce. • Expanding clinical placement capacity across all professional groups to meet future workforce demand and the corresponding development of the educator workforce.	• Standardised approach to apprenticeship across the system, including system coordination of apprenticeship levy to support growing our current and future workforce into new roles and through upskilling to work differently. £500,000 re-invested across the ICB through levy gifting, which would have been lost through the levy expiration process. • Derbyshire Placement Faculty established (including HEIs and Social Care) to enable placement expansion. • Central point for Placement expansion to meet future training needs and national shortfalls/ICS supply needs. • Increased retention and support for NQNs to support a flexible and adaptable newly qualified workforce with skills to work across the system. Established patient pathway rotations across the system, with the first cohort transitioning into permanent posts. • Developed a matrix of Professional Nurse Advocate activity and where it overlaps health and wellbeing, career development and clinical supervision within the Trusts. • Training offers on organisations' intranets, including the Oliver McGowan System Training Programme rollout.	• Development of Derbyshire Career pathways from entry levels to Enhancing, Advancing Practice and Non-Medical Consultancy. • Collation of Nursing and midwifery data to inform system-wide workforce planning and recruitment strategies. • Development of Derbyshire Apprenticeship Strategy underway. • Building Healthier Communities: Contributing to building a healthier community by implementing various anchor projects to widen career access and focusing on inclusion. • NHS LTWP of 27% Target for placement expansion 28/29 met and continues to increase capacity.

Workforce Programme (4)			Driving our work	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
95	Derbyshire Academy (part 2)	Prioritise investment in training and development in prevention, personalisation, and health inequalities.	• Aligned and agreed the 11 mandatory subjects to reflect the Core Skills Training Framework (CSTF) across the four NHS organisations. This will support staff movement across the system, reduce duplication of training, thus saving time and training costs, and allow benchmarking of compliance. • Derbyshire Advanced Practice Strategy developed. • Pharmacy Workforce Strategy developed • Increase retention among Advanced Care Practitioners (ACPs) through a system-wide approach to standardising e-portfolio, support, and supervision and scaling up the number of ACPs by improving career opportunities. • Multi-sector training posts for Foundation Year Pharmacists and Pre-Registration Pharmacy Technicians.	
96	People Digital - Project Derbyshire	To improve workforce data quality, enabling effective workforce planning and developing a consistent approach to workforce data, reporting, and analytics across Derbyshire ICS.	• Established an initial project plan and project board to oversee the initial development phase.	• Functional Implementation Group established to share best practices and ideas and work on standardisation of coding.

Workforce Programme (5)			Driving our work	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
97	Workforce Planning and Transformation Workforce Supply	• Working with local Places and the wider Provider Collaborative to define the workforce needs across care pathways. This will facilitate the need to accelerate the work on defining the workforce model(s) needed and, where necessary, reshape/scale the currently operational offering. This is vital so all partners know what is needed to enhance the integrated community care offering, and more specific action can be organised to bring it about. • Appraise the limited progress on restructuring how clinicians work across different care settings. • Develop an understanding of the current workforce and the requirements to respond to the integrated care strategy and JFP. Create a joint approach between service leads and People Services to develop plans that bridge the gap by using new approaches to skill mix, expanding/ introducing new roles, and deploying staff closer to service users. • Understand workforce productivity and improvement opportunities by applying nationally developed tools and approaches (e.g., employing the STAR model).	• Established the NHS Trust workforce baseline position and alignment with wage costs.	• This will be an ongoing enabling programme of work needed to support the large-scale programmes as they define their models of care.

Workforce Programme (6)			**Driving our work**	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition. • Use of resources - Deliver a balanced net system financial position for 2024/25.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
98	Workforce Planning and Transformation Managing our Pay Costs to Plan	• Developing an integrated system approach to workforce planning and reporting to monitor the delivery of the strategic workforce objectives. • Utilising the analysis to build workforce planning skills and resources to ensure the required skills and competencies to support and deliver a robust organisational workforce plan. Training and capacity building - developing an achievable workforce plan that focuses on transitioning the current workforce to deliver the requirements described in the 5-year forward plan.	• Established the NHS Trust workforce baseline position and alignment with wage costs. • A workforce dashboard was developed, allowing greater scrutiny of the position.	• Building on the work undertaken in 2023/24, the workforce operational plans have been developed in close alignment with the pay bill. • This position is now being reported routinely to identify areas where the position is going off plan and where remedial actions are needed. • 0.96% increase in the total workforce (including EMAS). • Improved triangulated plans across workforce, finance and activity. • Workforce plans aligned to pathways.
99	Equality, Diversity and Inclusion	• Workplan to deliver the six high-impact actions identified within the National NHS EDI Improvement Plan. • This plan aims to address the widely known intersectional impacts of discrimination and bias, improve equality, diversity and inclusion, and enhance the sense of belonging for NHS staff to improve their experience. • This is central to achieving the EDI vision of 'belonging in Derbyshire; for everyone in the health and social care community to feel that Derbyshire is where they belong'. • Deliver the Active Bystander and CQ Facilitator Programme, supporting effective working across our culturally diverse system and the vision of 'belonging in Derbyshire'.	• Agreement to focus on High Impact Action 2 (embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity) and 6 (Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur) as a system. • Development of inclusive recruitment practices across the system - all training is complete, and focus groups have fed through their recommendations, with the recruitment work programme picking up the implementation of the recommendations.	

Workforce Programme (7)			Driving our work	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition. • Use of resources - Deliver a balanced net system financial position for 2024/25.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
			• The Active Bystander programme has been rolled out across Derbyshire, starting with a Train the Trainer programme.	
100	Leadership Development & Talent Management	• Development of a consistent core offer for leadership development and induction for all new leaders anywhere in the system, which supports a culture of improvement, encouraging learning and promoting system working. • Creating an inclusive talent approach as the driver for recruitment and development. This includes unified approaches to Leadership Development, Talent Management Development, and organisational development (OD).	• New system-wide appraisal process introduced. • Mapped core leadership offers across the system to establish access to leadership development. • Identifying gaps to deliver a consistent core offer of leadership development for aspiring, emerging, middle-level, and senior leaders available to people anywhere in the system. • Reviewed digital booking options for leadership offers to reduce admin time required. • Ongoing delivery of the Mary Seacole programme. • Core Leadership offer embedded across the system and considered “business as usual”.	

Workforce Programme (8)			Driving our work	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition. • Use of resources - Deliver a balanced net system financial position for 2024/25.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
101	Health, Safety and Wellbeing	Collaborative delivery of an equitable range of programmes and initiatives to support all health and social care colleagues across Derbyshire and Derby City – helping colleagues to remain healthy, safe and well in all aspects of life.	• Programme of delivery inc. Mental and Emotional Health, MSK / Physical Health and Health Inequalities to support health, wellbeing and workforce retention, based on a robust Health Needs Analysis. • National recognition as an Inclusive Menopause Friendly Employer and award for cross-sector working. • Over 56k engagements in the programme in 2023/24. Month-on-month growth since 220 colleagues per day. Representing 136% growth in a year. • Demonstrable impact within the Neurodiversity and Menopause workstreams. 20% reduction in sickness absence pilot. • Regular Neurodiverse Cafés, working with a Disability or Health Condition Support Group, and Supporting your team with a Disability or Health condition are embedded within the timetable. • System Health Needs Analysis results complete. • 114% increase in Peer Psychological Support. • The Menopause programme won the Henpicked Menopause Friendly Employer award for 'Most Inclusive Employer' in 2023. • This was a support programme, which is now business as usual.	

Digital Programme			Driving our work	
The Digital Programme is an enabling programme of work that leads and supports digital transformation and innovation in health and social care to transform the lives of our community. Our projects are at the forefront of digitising healthcare processes, enhancing data sharing across various sectors, and integrating technology to improve patient outcomes.			The Digital Programme of Work has been informed by JUCD system-wide and organisational digital priorities and is also directed by national requirements such as Frontline Digitisation. Digital transformation is necessary to support the shift in care from illness to wellness. It provides the tools and technologies required to transform into new models of care delivery and helps address some of the challenges faced across the system.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Forecast impact summary**
102	Derbyshire Shared Care Record (DSCR)	The Derbyshire Shared Care Record is a confidential computer record that joins different records to create a more comprehensive and up-to-date record of you.	Interoperability achieved with partner organisations: **View data**: · Ashgate Hospice - Treetops - Blythe House - DHU - Primary Care Networks - Derbyshire County Council Adults - East Midlands Ambulance Service. Partner organisations: **Viewing and sharing data** · DCHFT · Derby City Council Adult Social Care and Children's Social Care, Derbyshire County Council Adult Social Care and Children's Social Care, Chesterfield Hospital, University Hospitals of Derby and Burton - Primary Care GP Practices.	• Increased interoperability with partner organisations – EMAS to support improved support to emergency crews and expand the local authority data set to include Children's services. • Digitisation of the RESPECT document in the DSCR to further improve end-of-life (EoL) care by sharing up-to-date EoL plans more widely.
103	Electronic Patient Record (EPR)	Implement an Electronic Patient Record for Chesterfield Royal Hospital and University Hospitals Derby and Burton.	• EPR Full business case developed, and national funding approved to progress procurement. • EPR supplier secured via procurement process – NerveCentre. • Implementation and deployment plan agreed. • The benefits realisation plan agreed upon as part of the business case, detailing cash release, non-cash release, and legacy system decommissioning.	• Removal of paper records, optimisation of system and legacy record management – efficiencies quantified. • Improved Patient Safety rollout, e-obs, Assessments, HOOH and Nursing documents
104	Digitisation in Social Care (DiSC)	Implement digital social care records (DSCR) for Adult Social Care (ASC) providers across Derbyshire. This will ensure that data is accurate, is captured at the point of care and can be shared between care settings. National Programme coordinated at the system level. There are approximately 550 ASC providers across Derby and Derbyshire.	73% of care providers are reporting using a digital care record from a starting position in 22/23 of 44%. On average, care providers report: • Saving 20 minutes per day on record activity • Saving 24 hours per year on audit • Saving 20 minutes per day at handover • Saving over £2000 per year on stationery and storage costs.	• Meet the national target of 80% of providers using a digital care record. • Work with providers to maximise functionality within the systems • Consider and plan towards integration with the Derbyshire Shared Care Record.

Population Health Management Programme			Driving our work	
Derby and Derbyshire Health System organisations will collaborate to develop a new Health Intelligence Platform and System's Intelligence Function.			• To enable an increased focus across our NHS organisations on high-quality data and analytics service to provide local teams with a precise analysis of local problems and assets, vital to support the population health management agenda in Primary Care and PLACE more general. • Population Health Management data to plan and target the provision and improvement of care	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
105	Re-design - ICB Business Intelligence Team		• We have established a system analytics network. • Completed the re-design of the ICB Business Intelligence Team. • A data request and triage process have been implemented.	
106	Central database		• Our central database is live in partnership with the NETs (CSU).	
107	Data Sharing Agreement			• We are progressing with our multi-partner data-sharing agreement, which we aim to sign off on in July.
108	Patient Level Costing	Patient Level Costing is operational across all areas of NHS provision, including General Practice.		• No update is available at the point of publication.
109	Better data to make better decisions	Patient-centred outcome measures relating to at least 80% of the disease burden are being reported.		• We are building a system surveillance report available in October 2024.
110	Data Science Training Academy	Develop the skills of our analytical workforce through a fully operational Data Science Training Academy.	• Two staff members completed the L4 Data Analyst Apprenticeship, and one was studying, bringing new skills and enhancing current techniques.	• There has been an increase in the number of team members. Two staff members are completing the L4 Data Analyst Apprenticeship pathway. • The aim is for another five staff members to begin the data apprenticeship this year.

Green Agenda & Net Zero initiatives (1)			Driving our work	
			• Reducing the CO2e impact of inhalers, in line with the commitment of a 25% reduction in 2023/24 on a 2019/20 baseline. • Travel and Transport Modal Shift - 100% of Trusts to have 3 or more schemes/interventions in place to support modal shift.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
111	Low Carbon Inhalers	To reduce the CO2e impact of inhalers, in line with the commitment of 25% in 2023/24. The ICS is predicting an approximate reduction of 34% for the end of 23/24 - by using lower carbon inhalers. Our second priority is to utilise dry powder inhalers, which have a much lower carbon footprint than Metered Dose Inhalers (as above)	• Target to date is 34% by the end of 23/24 – delivered.	• Target continues; however, it will be slower because the ICB has surpassed the 25% NHSE target for 23/25.
112	Inhaler recycling	Encouraging patients to return old or unwanted inhalers to pharmacies for environmentally safe disposal through reminders and promotions		• To reduce emissions and cut down on carbon waste, as inhalers in landfills can still contribute to the carbon footprint. • Proposed awaiting sign-off.
113	Medical Gases	Transforming anaesthetic practice using an alternative to desflurane. • Reducing the proportion of desflurane used in surgery to less than 2% of overall volatile anaesthetic gases volume in all trusts in line with the NHS Standard Contract	• Derbyshire ICS is showing 0.9% usage to Q4 2023/24. Exceeded Desflurane usage reduction target across both acute trusts.	• To reduce to 0% in Derbyshire. Reduction in Emissions(tCO2e) from nitrous oxide and mixed nitrous oxide
114	Cycle to Work	The introduction of a salary sacrifice scheme will enable staff to purchase bicycles.	• There are ten staff at the ICB who are currently using the scheme.	• Information was not available at the point of publication.
115	Car Share Scheme	A lift share policy and communication campaign.	• Scheme in place; however, uptake across Derbyshire is low, and an action plan is in place to increase take-up through comms and engagement among Derbyshire employees.	• Information was not available at the point of publication.
116	Electric vehicle charging points.	Derbyshire providers have schemes and fleet schemes in place; however, currently, the ICS have a high risk due to insufficient EV charging points across the Derbyshire footprint. To identify options to expand the number of electric vehicle charging points.		• Proposals in development.

Green Agenda & Net Zero initiatives (2)			**Driving our work**	
			• Travel and Transport Modal Shift: 100% of Trusts will have three or more schemes/interventions in place to support modal shift. • Harnessing the opportunities presented by digital transformation to streamline service delivery and supporting functions while improving the associated use of resources and reducing carbon emissions.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
117	Our Carbon Footprint	Developing our data on carbon emissions to aid our understanding of organisation and service level carbon performance. Examples include: • Capture data on offering digital appointments instead of patients travelling to a site.		• Proposals in development.

ICB Function (1)		
#	**Driving our Work (2023-24)**	**2024-25 Summary of Progress**
118	Strategic Alignment • Navigating the various strategies, goals, and objectives is more complicated than necessary. It is critical that all teams, whether they are delivering for today or tomorrow, can see a connection between what they are doing and the collective future direction of travel.	• In collaboration with system partners, commission a review of the current portfolio of strategies, goals, objectives, etc to bring greater strategic alignment and simplify the line of sight.

119	Strategic Deployment & System PMO
	
	• Where it is not the case already, all improvement aims will need to be converted into tangible actions with a clear process for tracking, reporting and governing progress; this will include establishing clarity on the following:
	  • Key enabling actions
	  • Critical milestones
	  • Portfolio of improvement activities and programmes/ projects
	  • Goals and expected outputs – covering each year of the plan
	  • Measurement of process and output, as well as the impact of the outcomes.
	  • Large-scale change governance – including the accountable and responsible officers, forums and reporting arrangements.
	  • Interdependency management—ensuring different but related projects are joined up, with identified named leads to enable this. These projects need to be connected to ensure maximum value is realised. This may present challenges, for example, because of traditional contractual arrangements between one constituent organisation and a supplier.
	
	• Reframing the Derby and Derbyshire NHS efficiency improvement programme: By focusing on identifying waste as an organising principle and reducing waste as a core objective, we will be able to address the issue of 'inefficiency' in a more holistic and scalable way across different care and service settings.
	
	• While the Programme Management Office (PMO) capability exists to support collaboration at scale initiatives, we do not have this capability at a system level.
		We are proposing to:
		
		• Setting up an integrated Strategic Deployment and Portfolio Management Office to align our system goals and change initiatives.
		
		• Transition to a new large-scale change governance and assurance framework, which may result in existing projects and programmes being absorbed into others. Ensure that the design of each programme and project has the triple aim of its centre—improving quality, performance, and productivity.
		
		• Conduct a deep-dive review of our portfolio of complex programmes, identifying where we need to accelerate our plans, pause, or recommend stopping initiatives that cannot demonstrate improved quality, performance, and productivity outcomes.
		
		• Map our existing change capability and where it is deployed.
		
		• The delivery of our Primary Care Improvement strategy will be part of the Community Care Improvement programme.
		
		• Bring greater transparency and momentum to the programmes and projects that constitute Collaboration at Scale.

ICB Function (2)		
#	**Driving our Work (2023-24)**	**2024-25 Summary of Progress**
120	The availability of suitably skilled and experienced programme and change managers and practitioners will be a key factor in determining the pace at which improvements occur.	• We are proposing a capacity and capability assessment across our NHS family. In conducting a deep-dive review of our portfolio of complex programmes, we identify where our specialist resource is currently deployed.
121	Change/Improvement science and quality improvement methodologies need to play a key role in facilitating the move from agreed goals to delivering improved outcomes, and the use of the significant QSIR (Quality, service improvement and redesign) capability within the JUCD NHS system will be key in ensuring good quality application of that science.	• Our goal is to ensure an increased focus across our NHS organisations on high-quality project management support to manage change. • To build upon and accelerate the work of the Collaboration at scale PMO team in building capability and capacity of large-scale change and continuous improvement across our NHS family.
122	Operating Framework - Governance & Assurance – Operational Management • Existing governance and delivery arrangements are currently organisation-centred, which can inhibit system collaboration and the added value of working across organisations to achieve a single, shared aim. Governance mechanisms established through Place and several connected work programmes need greater ownership, visibility and system backing.	• Our system of operational governance and assurance continues to evolve. We are working together as partners to reduce the potential tension regarding organisational sovereignty and their differential operating frameworks, as demonstrated through individual policies, procedures, structure, etc., alongside the need for teams of people to work together with shared purposes and aligned goals.
123	Strategic Commissioning • In the transition from CCG (Clinical Commissioning Groups) to ICB, it was widely accepted that the commissioner's commissioning function needed to transition from the tactical level of commissioning (based principally on care pathway development and inter-provider/organisational facilitation) to a strategic level (based principally on understanding the population's health and health needs and commissioning in line with these needs).	• We are developing a strategic Commissioning Prioritisation Policy for the next five-year period. This policy will act as a framework to enable the ICB to prioritise (and thus deprioritise) which healthcare interventions will be commissioned during the JFP period and beyond. This policy will be developed with partners in time for it to be used in the 2025/26 Operational Planning process.

ICB Function (3)		
#	**Driving our Work (2023-24)**	**2024-25 Summary of Progress**
124	Ensuring an increased focus across our NHS organisations on (ii) communication and engagement teams to design and deliver more effective ways of engaging with marginalised and disadvantaged communities;	• Insight Framework exploratory work funded, tool developed to assess readiness for insightful conversations with the public, piloted in c25 settings, ranging from GP practices to communities of geographical interest groups. Collating findings to inform next steps. Findings from Insight Framework pilots to form the basis of system insight strategy. • Hypertension case finding work in Derby developed with community partners, utilising insight-driven intervention and promotion with a significant increase in the collation of BPs and onward referrals. Blueprint for future intervention work, forging strong relationships in the development and delivery phase. This work has led to ICB Communications and Engagement Team members being invited to the Derby Health Inequalities meetings to understand opportunities to strengthen the relationship between the NHS and communities. • The intelligence gained via the deployment of the Framework will support the continuous conversation that needs to occur around the JFP into the 2025 refresh. • We are developing our Lay Reference Group, connected to the Insight Framework, to diversify the pool of citizens wishing to step into more formal involvement, learn more about the NHS, and help shape our approach. The aim is to develop a supportive environment/network to grow people's confidence in formal decision-making structures.
125	Ensure coordinated, consistent and joined-up communications support using appropriate media channels tailored to meet the needs of the target population to improve health	• Introduction of OASIS campaign planning tool to assess audience and outcomes. Used for all major campaigns, including Covid vaccination, MSK digital app and winter planning. • Hypertension case-finding work in Derby was developed with community partners. It utilized insight-driven intervention and promotion, with a significant increase in the collation of BPs and onward referrals. This work provided a blueprint for future intervention work, forging strong relationships in the development and delivery phases. • Commenced adoption of the Health Literacy approach.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th July 2024

Item: 036

Report Title	Derby and Derbyshire Health and Care Research Strategy							
Author	Dr Chris Weiner, Chief Medical Officer							
Sponsor (Executive Director)	Dr Chris Weiner, Chief Medical Officer							
Presenter	Steven Hulme, Chief Pharmacist							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 – Derby and Derbyshire Health and Care Research Strategy							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Population Health & Strategic Commissioning Committee – 13/06/2024							

Recommendations
The ICB Board are recommended to **RATIFY** the Derby and Derbyshire Health and Care Research Strategy.
Purpose
To support the further development of a culture of continuous quality improvement with better community health outcomes and improved staff experience through the active development of the research environment across Derby and Derbyshire.
Background
The NHSE annual assessment of Derby and Derbyshire ICB's performance in 2022/23 noted that: *"There is evidence, within the Joint Forward Plan to the commitment to research, with a named ICB executive lead for research and innovation. The ICS has an established Derbyshire Research Forum, and a research strategy will be developed in 2023/24 to embed an approach to research across the ICS. There is encouraging evidence of planning towards promotion and use of research including in social care as well as health care*." The ICS Research Strategy has been developed taking account of the NHS England guidelines published in March 2023, '*Maximising the benefits of research*: *Guidance for integrated care systems'*. This set out the evidence for research as an essential part of everyday practice for all health and care professionals and decision makers. The guidance identifies that the value of research in transforming health and care is significant; additionally, staff satisfaction, recruitment and retention is higher among staff who are involved in

research. Research active hospitals have lower mortality rates and there is associated benefit from improved service quality and patient and carer experience. An active research ecosystem working in a co-ordinated way and to national standards brings revenue and jobs to regions.

The research strategy supports the delivery of the ICB legal duties in respect of research and working with people and communities and reducing health inequalities. It contributes the evidence on how the ICB is carrying out its duties relating to research for the annual performance assessment of each ICB.

1. **Legal duties relating to research in the Health and Care Act 2022**
   These duties require each ICB, in the exercise of its functions,
   - to facilitate or otherwise promote research and the use of evidence obtained from research. For example, ICBs should facilitate or otherwise promote the use of evidence in care, clinical and commissioning decisions.
   - to include research in their Joint Forward Plans (JFP) and annual reports

2. **Research contributions to ICB legal duties to work with people and communities and to reduce health inequalities.**
   The research strategy is aligned to the Integrated Care Strategy. A co-ordinated approach is recommended across healthcare delivery, research and communities, so that research reflects what matters to people and communities. Engagement with underserved communities around research is an important approach to addressing under-representation of these communities in research. This in turns contributes to the aim of reducing inequalities in access to health services and in health outcomes.

Report Summary

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 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 further risks identified.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

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

Have any conflicts of interest been identified throughout the decision-making process?				
Not applicable to this report.				
Project Dependencies				
Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
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☐	See Appendix A in main document of the Research Strategy.	

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?					
None identified.					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable to this report.					

Joined Up Care Derbyshire

Derby and Derbyshire Health and Care Research Strategy

2024-2029

Executive Summary

This strategy describes how health and care research will be transformed over the next five years for the benefit of the people of Derby and Derbyshire.

The content identifies the national, regional and local context for research and the drivers for change, including the Integrated Care Board's statutory duties in respect of research. The following vision statement and strategic aims summarise the anticipated impact of the Strategy, and how the transformation will be facilitated.

Vision statement

We will positively transform how health and care research is supported, delivered and used in Derby and Derbyshire over the next five years, contributing to reduced health inequalities, improved population health and equitable outcomes

Strategic aims

- ✓ **Grow diversely** - Significantly grow and expand the breadth and diversity of research participation, capacity, and funding, through agreed system-wide actions
- ✓ **Impact equitably** - Ensure research is inclusive and helps to accelerate delivery of the Derby and Derbyshire Integrated Care Strategy, with a positive impact on population health, health inequalities and the lived experiences of underserved communities
- ✓ **Involve meaningfully** - Address the challenges experienced in delivering organisational research strategies, including actions to develop a culture where research and the use of research is prioritised by leaders, and is a core element of everyday work and everyone's role
- ✓ **Collaborate inclusively** - Transform collaborative working and partnership building for the undertaking of research in Derby and Derbyshire, and for how research findings are disseminated and adopted for the benefit of patients, communities and the public

Improvement goals have been drafted for each of the strategic aims. An implementation plan will be produced following approval of the Strategy and the improvement goals will be converted into SMART objectives. Metrics and targets are not included in the Strategy because they will be agreed through the work to produce the implementation plan.

The Strategy has been developed by a Working Group on behalf of the Derbyshire Research Forum (DRF), with input from a broad range of stakeholders, including co-design of the vision and strategic aims by the Derbyshire Research Engagement Network, which is an alliance of research and underserved communities. It will be assessed by the Clinical and Professional Leadership Group (May '24) and ICB Population Health and Strategic Commissioning Group (June '24). It will be agreed by the Integrated Care Board (July '24). It will also be received by the Integrated Care Partnership in August.

Contents

Foreword

Research is essential to transforming health and care. It underpins service advances and the development of evidence-based practice, and results in improved care quality. Staff who are actively engaged in research have greater job satisfaction, role development and levels of retention.

Disseminating, sharing and translating research into practice is vital, with proven benefits for service users, the public, the NHS and local government. However we know there are inequalities in access to research with people living in underserved communities less likely to participate in studies. It is vital therefore that we address the barriers experienced and enable increased research participation within underserved communities, to ensure research is inclusive, delivers health equity, reflects population diversity, and improves lived experiences.

The Joined Up Care Derbyshire Integrated Care System has a key role to play in facilitating research and in ensuring sustainable benefits are gained through evidence-based decision making. We need to ensure there is a clear research thread running through ICS and system partner strategies and plans, if we are to fully achieve our strategic aims for integrated care, and we must develop a health and care environment that encourages and supports research, and ensures the commissioning, development and delivery of services is based upon research generated evidence.

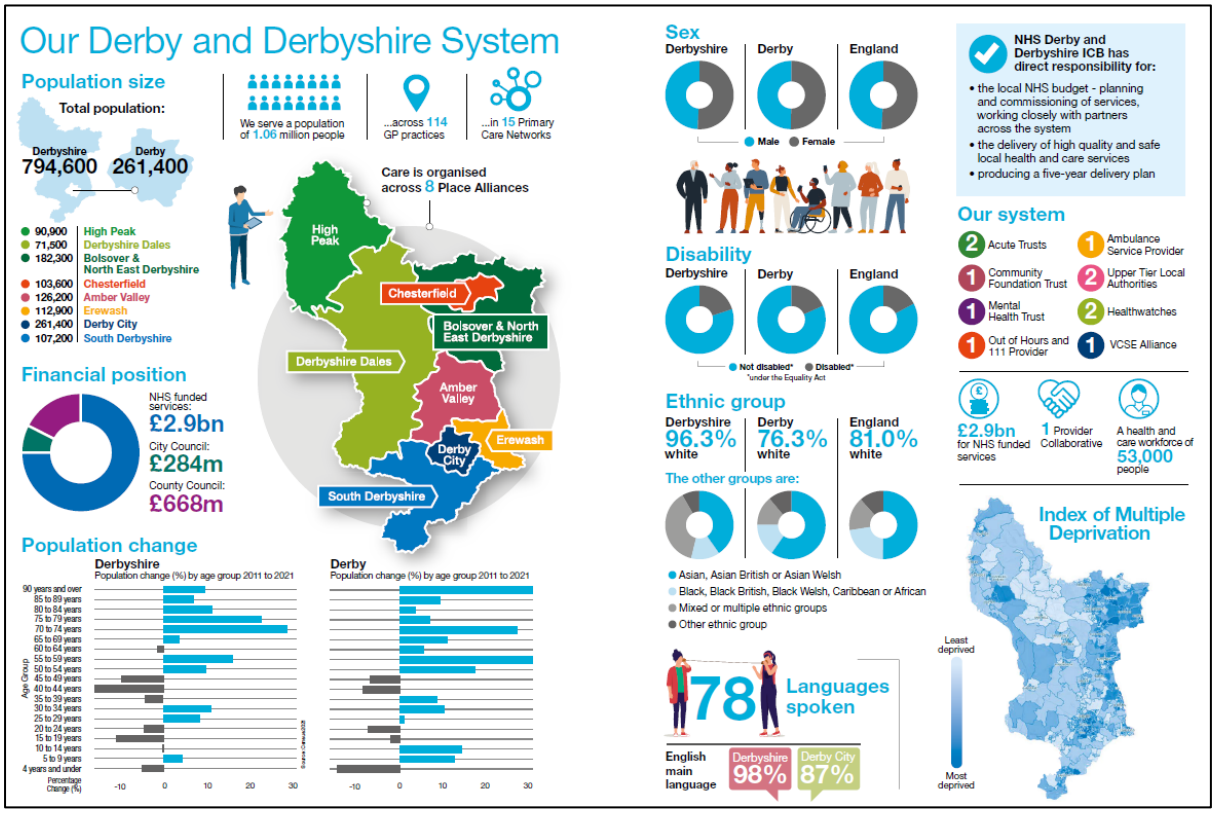
As the Chair of the Derbyshire Research Forum I hope that you find the Strategy informative and engaging, and that it provides a clear understanding of the journey we are on, and how we want to improve and expand research activity in Derby and Derbyshire for the benefit of our local populations, over the next five years.

Dr Chris Weiner
Chief Medical Officer, Derby and Derbyshire Integrated Care Board and Chair of the Derbyshire Research Forum

1. Introduction

1.1 Joined Up Care Derbyshire Integrated Care System

Joined Up Care Derbyshire (JUCD) is the Integrated Care System, responsible for coordinating health and social care across Derby and Derbyshire, and brings together NHS bodies, local authorities and voluntary sector organisations to deliver better care for our whole community. Our health, social care and voluntary sector organisations work together formally through our Integrated Care Partnership.



JUCD's priority is to make improvements to the Derby and Derbyshire populations' life expectancy and healthy life expectancy levels in comparison to other parts of the country and reduce the health inequalities that are driving these differences.

1.2 What is Research?

The definition of research used in this Strategy is the one provided by the NHS Health Research Authority in the *"UK Policy Framework for Health and Social Care Research"* and cited in the NHS England guidance published in March 2023 – *"Maximising the benefits of research: Guidance for integrated care systems"*;

Research is "… the attempt to derive generalisable or transferable new knowledge to answer or refine relevant questions with scientifically sound methods. This excludes audits of practice and service evaluation. It includes activities that are carried out in preparation for or as a consequence of the interventional part of the research, such as screening potential participants for eligibility, obtaining participants' consent and publishing results. It also includes non-interventional health and social care research (that is, projects that do not

involve any change in standard treatment, care, or other services), projects that aim to generate hypotheses, methodological research and descriptive research." UK Policy Framework for Health and Social Care Research - Health Research Authority (hra.nhs.uk) as cited in NHS England » Maximising the benefits of research: Guidance for integrated care systems

The types of research covered by this Strategy are;

- Clinical trials and other clinical investigations into the safety and effectiveness of medicines, devices and health technologies
- Public health research
- Observational studies
- Discovery science and experimental medicine
- Translational research in which results from basic research are developed into results that directly benefit people
- Applied research
- Research to support policymaking and commissioning
- Social care research and research in social care settings
- Research into NHS services and care pathways
- A specific focus on health and wellbeing, wider determinants of health and reduction in health inequalities

1.3 Purpose of the Strategy

The purpose of the Strategy is to develop a vision, strategic aims, and improvement goals for research in Derby and Derbyshire that build on our strengths, address our weaknesses, and align with and influence national policies, legal duties and system plans.

We need the strategy to identify how the JUCD system, working collaboratively, will capitalise on opportunities to increase and broaden research funding and activity, including in sectors where activity is lower when compared to peer systems, and where funding opportunities are not currently being maximised.

We also need to develop strategic actions that will ensure research in Derby and Derbyshire becomes more inclusive, leading to a positive impact on population health, health inequalities and the lived experiences of underserved communities. And we need the Strategy to challenge our system leaders, prompting them to review the support and priority their organisations give to research, with the aim of developing cultures where research becomes a core element of everyday work.

The Strategy does not include measures or metrics for the stated improvement goals. These will be developed within the implementation plan, reflecting the need, through this plan, to develop SMART objectives, with measurable outcomes.

There is a strong evidence base to demonstrate the benefits of investing in a flourishing research culture. These benefits include improved staff satisfaction and lower turnover rates, lower patient mortality rates, and improved patient, public and carer experience.

1.4 Scope of the Strategy

Research activities undertaken in the following sectors are within scope – acute, community, and mental health services, general medical and dental practice, primary care, social care, care homes, public health, higher education institutes (in relation to health and care research), life sciences industry / commercial (in relation to health and care research), and the voluntary, community & social enterprise sector (VCSE).

As well as focusing on research within the areas listed above, the aim is to also support collaboration between organisations and sectors and capitalise on opportunities for multi-sector research studies.

The geographical scope covers the people who live and work in Derby and Derbyshire, whilst recognising that the benefits may extend beyond these boundaries.

The scope of the Strategy excludes innovation activities that fall outside the scope of research studies. However the interrelationship between research and innovation is fully recognised and therefore collaboration with leaders for regional (Health Innovation East Midlands) and local innovation plans will be an important enabler for the delivery of the improvement goals described in this Strategy.

1.5 Governance, Engagement and Involvement

The Senior Responsible Owner (SRO) for the Strategy and Chair of the Derbyshire Research Forum (DRF) is the Chief Medical Officer, Derby and Derbyshire Integrated Care Board.

Strategy development has been led by a Working Group that consists of DRF members and nominated sector leads. The membership includes regional leadership from the Strategy funding partner, the National Institute for Health and Care Research (NIHR), Clinical Research Network (CRN) East Midlands. The Strategy content has been influenced by local organisational research strategies where available, to ensure there is alignment with existing Derby and Derbyshire plans.

The Working Group has developed a stakeholder engagement plan, and this has driven a broad range of stakeholder conversations and meetings, to inform the vision, strategic aims and goals for the Strategy. Engagement will continue and will inform the Implementation Plan. Please refer to **Appendix A** for further information.

Patient and public engagement for the development of the Strategy has been primarily focused through the Community Research Engagement Network, which is an alliance of research and underserved communities.

The Joined Up Care Derbyshire Research Engagement Network was established in 2022-23, funded through the Accelerated Access Collaborative. The project called REBALANCE, stands for REsearch Building ALliances for ActioN with Community Enterprise. It aims to improve access to research for under-served communities, increase participation and help reduce health inequalities in Derby and Derbyshire. Learning from the initial phase is now being applied in 2023/24 to build our community partnerships further following a successful second phase funding application. We are working in

partnership with Voluntary, Community, Social Enterprise (VCSE) partners and the University of Derby this year to co-design a Community Led Participatory Research project in an area of priority for research identified by the communities.

The Network has shaped the language used for the vision and aims for the Strategy and is developing a 'Valued Voices' Charter, to describe the principles for how health and care organisations engage with communities when planning, undertaking and disseminating research studies and findings.

Draft Valued Voices' Charter

Joined Up Care Derbyshire System Partners acknowledge that Health Inequalities persist in Derby and Derbyshire. This means some population groups have significantly worse health outcomes than others. These inequalities are avoidable, unfair, and systematic.

We know that inequalities can be experienced by different groups of people. This includes people with shared protected characteristics; vulnerable or excluded groups in society; socio-economic status and deprivation; and geography. These groups are also usually under-served by health and care services.

Communities can also be affected by 'intersectional' inequalities when they experience multiple or intersecting combinations of these characteristics and as a result their experiences of health inequalities can be worsened.

We recognise that research is the attempt to derive generalisable or transferable new knowledge, but in failing to include a broad range of participants, the results of research may not be generalisable to our real-world diverse population.

As partners we are fully committed to understanding and rebalancing the determinants of inequalities in the Health, Care and Research systems.

We will work together with the REBALANCE Research Engagement Network as valued voices for Health and Care Research in our Integrated Care System.

We will take account of the following in our change actions:

- **Focus on equity and inclusion not just diversity numbers.** If we take time to learn from people's lived experiences as well as the data, we can understand how participant recruitment practices can systematically exclude people from research.

- **Co-produce systematic change to sustain improvements.** Co-producing solutions with communities embedded into the research life cycle, from ideas, to design, delivery, publication, and application will allow root causes relevant to people's real lives to be tackled.

- **Plan for reasonable adjustments in research delivery.** Standardised offers which suit the majority will not meet everyone's needs. Adjustments and adaptations to personalise offers will allow all eligible participants who need this to participate if they choose to.

- **Justify and be transparent on decisions about research populations.** If inclusion criteria restrict participants to fluent English language speakers without providing translators; or if participant recruitment is restricted to specified healthcare settings, which exclude community settings; then these decisions should be justified and the limitations of the results to the real-world population should be made transparent.

- **Agree initiatives with the communities for whom the benefits are intended.** Community focused initiatives to improve involvement needs to be planned with the relevant communities and adequately resourced. The impact of initiatives should be evaluated to include community perspectives.

- **Build research capacity in community settings.** Consistent, visible, and accessible research messages and opportunities across both community settings and health and care settings are necessary. Researchers need to represent communities and be embedded within communities not parachuted in.

- **Take time to build trust in research as a fundamental need.** Well led services should enable individual researchers and the wider research workforce to complete relevant training and apply learning to create culturally safe research environments.

- **Consider adopting the NIHR Race Equality Framework.** This is a tool to help organisations deliver the change needed to address systemic inequities in health and care research. It focuses on race, but the framework principles can be applied to all protected characteristics and wider inequality groups.

There is Patient and Public representation as part of the DRF membership and further sources of feedback are also important. Consideration for wider involvement will be given through development of the Implementation Plan. As part of this work a tile on the JUCD website will include the Strategy, and how members of the public can find out more, including how to get involved in research and the Research Engagement Network.

Helpful discussions are also taking place with Healthwatch Derbyshire regarding the opportunities for 'joining forces' and developing a unified voice on patient and public involvement in research.

Discussion with the Programme Lead for engaging the VCSE sector in the ICS has identified the need to promote and expand the role the VCSE sector plays in identifying priorities for research and in supporting studies, including the contribution VCSE organisations make towards holistic and person-centred care. There is also a need to assess the role a research enabled VCSE workforce can play in demonstrating the value and impact of VCSE contributions, including social return on investment. A focus on improving and expanding research skills within VCSE organisations will be a key enabler for addressing these needs.

Meaningful engagement with the wider VCSE sector will help foster collaborations which align to the principles agreed within the content of the Memorandum of Understanding that exists between the VCSE and the ICB.

2. Strategic Context and Drivers for the Strategy

2.1 National

2.1.1 Duties and Guidance

NHS England guidance - Section 2 of the 2023 guidance (NHS England » Maximising the benefits of research: Guidance for integrated care systems) identifies ICS, ICP and ICB responsibilities in relation to research.

The Health and Care Act 2022 - Sets legal duties on ICBs regarding the facilitation and promotion of research including;

> The ICB duty builds on the previous clinical commissioning group (CCG) duty to promote research, by requiring each ICB, in the exercise of its functions, to facilitate or otherwise promote research on matters relevant to the health service. This duty is intended to include a range of activities to enable research.

The ICS Design Framework - States that ICBs will facilitate their partners in the health and care system to work together, combining expertise and resources to foster and deploy research and innovations.

The NHS Constitution - Includes the following requirements under Principle 3 – 'The NHS aspires to the highest standards of excellence and professionalism';

'…and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population.'

The NHS Pledges - Include the following requirements;

'to anonymise the information collected during the course of your treatment and use it to support research and improve care for others'

'to inform you of research studies in which you may be eligible to participate'

The Care Quality Commission assessment framework applies to providers, local authorities, and integrated care systems. Providers, commissioners and system leaders are required to live up to the commitment of the Quality statements that 'We actively contribute to safe, effective practice and research'.

2.1.2 NHS Contracts

The NHS Standard Contract contains provisions relating to research studies, for example the obligation on every provider of NHS-funded services regarding recruitment of participants to approved research studies - see 03-NHS-Standard-Contract-2024-to-2025-Service-Conditions-full-Length.pdf (england.nhs.uk)

2.1.3 Strategies and Guidance

There are a number of national strategies, papers and sources of recommended practice and guidance that need to be considered in developing this Strategy and the Implementation Plan that will follow. These are listed below;

- NIHR Best Research for Best Health: The Next Chapter
- DHSC's areas of research interest - GOV.UK (www.gov.uk)
- Commercial clinical trials in the UK: the Lord O'Shaughnessy review - GOV.UK (www.gov.uk) and the Government response Full government response to the Lord O'Shaughnessy review into commercial clinical trials - GOV.UK (www.gov.uk)
- UK Health Security Agency | About research (ukhsa.gov.uk)
- UKRI strategy 2022 to 2027: transforming tomorrow together – UKRI
- NIHR Clinical Research Network Primary Care Strategy | NIHR,
- NHS England Making research matter: Chief Nursing Officer for England's strategic plan for research
- Normalising research – Promoting research for all doctors - GMC (gmc-uk.org)
- Allied Health Professions' Research and Innovation Strategy for England | Health Education England (hee.nhs.uk)
- Major conditions strategy: case for change and our strategic framework - GOV.UK
- Supporting A Charter for Social Work Research in Adult Social Care | NIHR SSCR
- Data saves lives: reshaping health and social care with data - GOV.UK
- NHS England - Managing research finance in the NHS
- *To note - DHSC, NHS England, NIHR and other partners were expected to publish a clinical research workforce strategy in 2023/24*, but this is not yet available.

2.1.4 Department of Health and Social Care (DHSC)

The Department of Health and Social Care strategic framework on major, multiple long-term conditions (Major Conditions Strategy referenced in the list above) which together account for over 60% of ill health and early death in England, identifies the three underpinning cross-cutting enablers as **Research**; Leadership; and Digital technologies and innovation, and states '*If we can get these into the right place we can 'make the boat go faster'.*

This shift in focus away from single disease strategies is consistent with the aims of integrated care. The number of people living with multiple conditions is expected to grow and the six groups of conditions identified as national priorities are:

- cancers,
- cardiovascular disease (CVD) (including stroke and diabetes),
- musculoskeletal disorders (MSK),
- mental ill health,
- dementia, and
- chronic respiratory disease (CRD).

2.1.5 National Institute for Health and Care Research (NIHR)

The aforementioned '*Best Research for Best Health: The Next chapter*' published in 2021 re-affirms the NIHR core workstreams and highlights seven 'areas of strategic focus' where the environment is changing and where there is a need to deliver transformative change over the next 5 to 10 years.

2.2 Derby and Derbyshire

2.2.1 Derby and Derbyshire Integrated Care Strategy 2023

The Integrated Care Strategy sets the context for how the System will grow and develop shared approaches for health and care research;

> *Also essential is evaluative capability and capacity to help determine the success of our actions and interventions. A vibrant and collaborative research culture and capability is also key to support the systematic and robust development of new knowledge, in terms of medical and technical advances, but also in the fields of prevention and wider determinants.*

The Strategy includes Key Areas of Focus for integrated care under the headings Start Well, Stay Well, and Age/ Die Well, that sit within the whole system objective for reducing the gap between life expectancy and healthy life expectancy.

The Research Strategy therefore needs to enable and help accelerate the delivery of improvements the System is working towards. To do this there is also a need for the System to recognise research as an enabler and support the development of the system capacity and capability for research to help accelerate the realisation of the strategic aims for integrated care in Derby and Derbyshire.

It will also be important to create joined up spaces for dialogue between the teams charged with implementing the Integrated Care Strategy and local research leads. Such collaborative working environments will help to share and identify research priorities and relevant research studies for participation, as well as research evidence for decision making and implementation, in the provision of new and established services in the System.

Start Well
Initial discussions have been held with the System lead to connect research into the gap analysis currently being undertaken against the ambition to *"improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness"*, and current NIHR research studies that cover Children and Young People have been shared.

Stay Well
The System has established a new governance forum to oversee prevention, population health management and tackling health inequalities prioritisation and activities. It is important that research is recognised as a key enabler for the work of this forum and wider system efforts to improve outcomes in relating the Stay Well aim - *"To improve prevention and early intervention of the three main clinical causes of ill health and early death in the JUCD population - circulatory disease, respiratory disease and cancer."*

One specific area for greater attention identified through the system's Clinical and Professional Leadership Group is the potential for research to support areas that sit in between NHS mental health services and social care provision.

Age/ Die Well

The aim included in the Integrated Care Strategy is *"To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations."*

Discussions have been held with the Senior Responsible Officer for Team Up regarding the enabling role of research and application of research evidence in this area of focus. Team Up is not an initiative driven by a clinical condition (although it does mainly support people living with frailty) or an individual service but is instead about creating the conditions for services and clinicians to work together more cohesively.

To evaluate this type of initiative, the NIHR Health and Social Care Delivery Research (HSDR) programme funds evaluative research with potential to improve health and social care services with a clear focus on the organisation, access and quality of care including a focus on the experience of patients, staff and service users. A variety of study designs are considered, and examples include evaluation of complex frailty hubs; major implementation studies on stroke configuration; evidence synthesis of strengths-based approaches to social work practice; organisational studies on effective board governance, amongst others.

Mental Health and Emotional Wellbeing

The Integrated Care Strategy intends that improving mental health and wellbeing will be a key theme running through the Key Areas of Focus. Integrated care offers the opportunity for holistic support of physical health, mental health and social care needs to meet the health and care needs of the whole person. An imperative identified by the DHSC major conditions strategy is the need to ensure prioritisation of mental health and social care alongside physical health if we are to achieve the strategic aims of integration.

The 2018 Health Foundation Briefing Understanding the health care needs of people with multiple health conditions shows that 82% of people with cancer, 92% with cardiovascular disease, 92% with chronic obstructive pulmonary disease and 70% with a mental health condition have at least one additional condition. However clinical strategies to manage care often focus on single conditions.

Wider Determinants of Health

Improvements to the wider determinants of health and to person-centred care are critical to better health outcomes and can be focused through integrated actions at place and neighbourhood levels. Turning the Curve priorities and local knowledge of communities and geographical areas gained through regular Joint Strategic Needs Assessments are important for enabling local improvement. This is recognised in the NIHR Health Determinants Research Collaborations (HDRCs) which aim to boost research capacity and capability and embed a culture of evidence-based decision making that will enable local authorities to use and conduct high-quality research into wider determinants.

Social Care

There is an opportunity to scale up research in social care, supported by an increased focus by the NIHR with associated funding for this area, and the desire locally to increase research activity, including in priority joint health and care initiatives such as Team Up.

The Research Advisory Group for the Chief Social Worker for Adults (2023) has produced a Charter '*to demonstrate the commitment to the social work profession that is fully engaged*

with research and generating and using research evidence' - Layout 1 (kcl.ac.uk) and this will help inform the approach adopted within the Derby and Derbyshire System.

2.2.2 NHS Derby and Derbyshire Five Year Plan 2023 – 2028

The following content from the Plan describes a set of aspirations for research, upon which this Strategy has sought to build;

Research and innovation
Working as an Integrated Care System provides us with a significant opportunity to co-ordinate and synergise research and innovation works within the NHS and with our partners from the private, public, and academic sector. Over this next period, we will act on the following issues, which have been identified as crucial to resolve:

- Ensuring an appropriate skill mix at board-level and across registered professional leads to promote research and support collaboration
- Ensuring research across local systems addresses ICB health and care priorities
- Providing evidence derived from research to decision makers in a more intuitive and useful way
- Attracting additional research investment into the ICS from external agencies

2.2.3. Current Research Activity
The following table illustrates East Midlands ICS NIHR Portfolio research activity for 2023/24.

2023-24 East Midlands ICS Overview

NIHR | Clinical Research Network East Midlands

East Midlands ICS NIHR Portfolio Research Activity
April 2023 - March 2024

ICS	Recruitment Activity / Number of Studies by ICS				Primary Care		Population
	Total	In NHS Trusts	In GP Practices	In Other Settings	% GP Practices Recruiting	No. GP Practices Recruiting	
Derby & Derbyshire	14,895 / 217	11,202 / 206	3,285 / 12	408 / 6	72%	80 of 111	1,056,000
Leicester Leicestershire & Rutland	27,159 / 420	13,940 / 374	12,889 / 33	330 / 18	94%	123 of 131	1,100,000
Lincolnshire	20,334 / 124	7,552 / 101	12,758 / 22	24 / 4	85%	70 of 82	769,400
Northamptonshire	9,929 / 149	5,535 / 112	4,174 / 35	220 / 3	75%	52 of 69	747,622
Nottingham & Nottinghamshire	31,501 / 537	16,633 / 491	14,252 / 36	616 / 23	81%	98 of 121	1,154,195

This data demonstrates the opportunity for increasing the scale of research participation in Derby and Derbyshire, including the opportunity to address what seems to be a significantly lower level of research participation in GP practices, compared with other three of the other four systems.

2.2.4 Building on good practice
There is already a strong sense of partnership working in Derby and Derbyshire, as demonstrated by the way in which colleagues from across the System have contributed to the development of the Strategy through the Working Group.

2.2.5 Other System Drivers

Research capacity

There is a need to recruit and grow the number of research posts in Derby and Derbyshire, and the number of clinical staff that actively support research. The view of the Working Group is that we currently have a relative lack of Clinical Academics, Chief and Principal Investigator posts and a lack of research design, management, and delivery infrastructure, both of which materially affects the ability to expand research activities.

NHS provider organisations in Derby and Derbyshire have stated (through the Clinical and Professional Leadership Group) their ambition to develop their Nursing and Midwifery, Allied Health Professional and Medical research active workforce, and feedback from local authorities has also evidenced the need to further develop research capability.

Quality management

Research aims to create generalisable knowledge and therefore plays a key role in identifying opportunities to improve health and care, within a broader quality management environment. There are however clear differences between research and quality improvement (which is one element of a holistic quality management approach), meaning separate governance arrangements are required for research studies and QI projects. Health and Care research is a regulated activity and follows the UK Policy Framework for Health and Social Care Research - Health Research Authority, which sets out principles of good practice in the management and conduct of health and social care research that take account of legal requirements and other standards.

The following extract from the paper *Quality improvement into practice, Backhouse and Ogunlayi, BMJ 2020;368:m865 doi:10.1136/bmj.m865 (Published 31 March 2020))* offers a description of the differences;

> *Both research and QI are interested in the environment where work is conducted, though with different intentions: research aims to eliminate or at least reduce the impact of many variables to create generalisable knowledge, whereas QI seeks to understand what works best in a given context. The rigour of data collection and analysis required for research is much higher; in QI, a criterion of "good enough" is often applied.*

The same paper also offers the following description of the relationship between research and QI;

> *QI offers a way to iteratively test the conditions required to adapt published research findings to the local context of individual healthcare providers, generating new knowledge in the process. Areas with little existing knowledge requiring further research may be identified during improvement activities, which in turn can form research questions for further study.*

This description illustrates the interconnections to consider for how research and quality improvement can link together, to have the best combined impact on improving standards through evidence-based approaches to pathways of care.

Partnerships
There is the opportunity, through this Strategy to review current partnership arrangements, including between local universities and the health and care sector. During the development of the Strategy there has been support from the University of Nottingham and the University of Derby. The latter has confirmed there is interest from multiple university disciplines in developing further research initiatives and collaborations with organisations from across the ICS. Networking meetings and scoping exercises are taking place to support this ambition.

Knowledge services
The Health Education England '*Strategic Framework for NHS Knowledge and Library Services in England 2021-2026*' states *"Applying knowledge into action is the currency of a successful healthcare organisation. Taking the 'heavy lifting' out of getting evidence into practice to improve the quality of care, NHS Knowledge and Library Service teams offer the 'gift of time' to healthcare professionals."*

As part of the Research Strategy we therefore need to ensure there are effective knowledge and library services available to help staff working in all sectors assess current service quality and evidence-based opportunities for improvement, including outputs from research. This applies to teams working both in commissioning and provision and therefore we need to assess what services are available in the ICB, Local Authorities, NHS Providers and what access teams in the VCSE sector have to knowledge services and support.

Health data and data driven technologies
Use of health and care data for research has significant potential for new discoveries that lead to advances in prevention and disease management as described in the policy paper Data saves lives (www.gov.uk). Locally access to high quality joined up data will have the power to support improvements in health outcomes, diversify research, and reduce health inequalities.

Information governance is a key enabler to accessible high-quality data for patient benefit.

Secure Data Environments (SDEs) are data storage and access platforms that will make health and social care data available for research and analysis. The East Midlands SDE is in the early stages of development and data resources will be added to the collection over time. ICBs will be expected to facilitate, promote, and enable the use of these rich data sources for research.

Technological developments, use of big data and the potential of Artificial Intelligence offer incredible opportunities for the health and care system. It will be important to be ready to embrace these whilst maintaining safeguards for public and staff confidence that data is safe and used appropriately. At the heart of this will be the need to ensure communities that are already underserved are not further left behind.

3. Vision and Strategic Aims

3.1 Vision Statement

The following vision statement for health and care research in Derby and Derbyshire has been developed with the Strategy Working Group, the Derbyshire Research Forum, and through discussions with the Research Engagement Network.

We will positively transform how health and care research is supported, delivered and used in Derby and Derbyshire over the next five years, contributing to reduced health inequalities, improved population health and equitable outcomes

3.2 Strategic Aims

A set of strategic aims have been agreed to guide our progress towards the Vision Statement, and to respond to the strategic context and the drivers for change described in Section 2.

The aims have been co-developed in the same way as the vision.

- ✓ **Grow diversely** - Significantly grow and expand the breadth and diversity of research participation, capacity, and funding, through agreed system-wide actions
- ✓ **Impact equitably** - Ensure research is inclusive and helps to accelerate delivery of the Derby and Derbyshire Integrated Care Strategy, with a positive impact on population health, health inequalities and the lived experiences of underserved communities
- ✓ **Involve meaningfully** - Address the challenges experienced in delivering organisational research strategies, including actions to develop a culture where research and the use of research is prioritised by leaders, and is a core element of everyday work and everyone's role
- ✓ **Collaborate inclusively** - Transform collaborative working and partnership building for the undertaking of research in Derby and Derbyshire, and for how research findings are disseminated and adopted for the benefit of patients, communities and the public

4. Improvement Goals

4.1 Introduction

Improvement goals have been drafted by the Working Group for each of the strategic aims. These goals will be added to and amended as further work is undertaken, including through the implementation plan for the Strategy (see Section 6). Measures and metrics for the goals will be developed as part of the implementation plan, and targets will be set where it is possible and helpful to do so.

4.2 Goals and Enabling Actions for each Strategic Aim

Grow diversely - Significantly grow and expand the breadth and diversity of research participation, capacity, and funding, through agreed system-wide actions

Improvement Goal	Actions
Increase research activity and income where current levels benchmark lower than those achieved by peers	• Identify current comparative performance in each sector/ organisation • Agree stretch improvement targets by sector/ organisation covering the 5 years of the Strategy • Identify specific actions to double commercial research activity by 2027, in line with the national strategy • Explore ways to increase funding to enable more research involvement from General Practice
Expand the breadth of research undertaken	• Use current comparative performance and current/ planned studies information to identify opportunities to undertake research in areas/ sectors where low levels of activity currently takes place • Include a specific focus on public health, wider determinants of care and social care
Improve the quality of experience of research participants	• Ensure we have a qualitative focus, including a commitment as a system to engage in, capture and evaluate Participant Research Experience Survey (PRES) data
Increase research participation levels within underserved communities, to ensure research is inclusive, delivers health equity, reflects population diversity, and improves lived experiences	• Further develop alliances and partnerships, working through Place arrangements, with all relevant stakeholders • Ensuring the visibility and engagement of the voluntary, community and social enterprise sector • Implement agreements and actions in line with the 'Valued Voices Charter' being developed with the REN

Impact equitably - Ensure research is inclusive and helps to accelerate delivery of the Derby and Derbyshire Integrated Care Strategy, with a positive impact on population health, health inequalities and the lived experiences of underserved communities

Improvement Goal	Actions
Identify how applied research can support delivery of • Start Well, Stay Well and Age/ Die Well priorities, including a clear focus on mental health priorities • JUCD annual priority objectives	• Identify NIHR current/ planned studies that align to system objectives • Collaboration with ARC East Midlands where ARC's key themes align with system priorities • Discuss with system leads and agree studies that will support transformation plans, including in areas where we have a strong track record in research, so we build on our strengths • Connect with regional/ national research leads in prioritised specialties/ topics • Include a focus on person-centred care, behavioural aspects, and cultural conditions for change as well as medical/ clinical interventions • Explore the relationship between research and quality improvement activities, recognising organisations will need to decide how governance arrangements are best managed
Increase research activity that supports Health and Wellbeing Board priorities including the "Turning the Curve" wider determinants of health, with a focus on reducing inequalities	• Actions as above, supported by discussions with Public Health and Social Care colleagues • Ensure there is a focus on joining research studies that can support priority improvements for our population's health • Ensure Joint Strategic Needs Assessments (JSNAs) help to inform selection of research studies, and that research outputs inform updates to JSNAs • Consider the development of the East Midlands Secure Data Environment to enhance research capability

Involve meaningfully - Address the challenges experienced in delivering organisational research strategies, including actions to develop a culture where research and the use of research is prioritised by leaders, and is a core element of everyday work and everyone's role

Improvement Goal	Actions
Increase the number of research posts in Derby and Derbyshire	• Undertake a mapping exercise to identify current research posts (and sort by organisation, sector, profession) • Include a balanced approach between actions that support 'growing our own' and appointing already qualified and experienced researchers • Ensure there are talent management plans for post holders including training, education and development support

Improvement Goal	Actions
	• Support staff to get onto a research career pathway by increasing posts that can facilitate this e.g. Fellowships, Associate Principle Investigators • Embed research awareness skills and confidence across disciplines and roles in General Practice • Develop clinical leadership in General Practice e.g. Research Champion roles, to broaden participation across the workforce
Increase the number of clinical and care staff with dedicated time and skills for research	• Discuss with NHS (Medical and Nursing / AHP) and LA Directors • Funding requirement will need to be recognised and will require discussion within the system and with the ICB • Increase research skills within teams that are key to the delivery of the Integrated Care Strategy and JUCD annual objectives
Establish research as a core element of clinical and care job descriptions and appraisals	• Discuss with NHS (Medical and Nursing / AHP) and LA Directors /other professional group leads
Ensure that CEOs and Boards in all JUCD organisations better understand the benefits and opportunities of research and agree proactive actions that will increase support for research within their organisations	• Produce communications for CEOs and Boards that illustrate the opportunities and benefits of research • Directors accountable for research agree a set of actions with their Boards and Committees • Boards to use the Knowledge Mobilisation self-assessment toolkit (Self-assessment tool | Knowledge and Library Services (hee.nhs.uk)) to consider how they are using external evidence and organisational knowledge
Ensure that senior/ middle managers and lead clinicians in all JUCD organisations better understand the benefits and opportunities of research and engage with library and knowledge services to obtain the latest evidence and research outputs that relate to service development and new service models	• Produce communications, training and provide support for senior/ middle managers and clinicians to help them engage with knowledge/ evidence services and research teams • Align with Knowledge for Healthcare ambition • Share NIHR schedules of current/ planned studies, so people can identify studies that may support service changes and developments they are working on • Develop and widely communicate a live list of the research studies underway and planned in Derby and Derbyshire, covering all sectors • Ensure dissemination of research outputs within and across organisations • Promote the general benefits to staff of being research active and the opportunities to expand competencies

Collaborate inclusively - Transform collaborative working and partnership building for the undertaking of research in Derby and Derbyshire, and for how research findings are disseminated and adopted for the benefit of patients, communities and the public

Improvement Goal	Actions
Create a Derby and Derbyshire network for researchers and staff from all sectors who are interested in research, that supports collaboration opportunities, sharing knowledge, skills and experiences, and demonstrating impact	• Hold quarterly research network events • Develop a system level research site/ portal which includes a live list of the research studies underway and planned in Derby and Derbyshire, with contact points, covering all sectors, and which links to all relevant local websites e.g. JSNAs website • Produce a network annual report on collaborative and organisational specific research activity and its impact on delivering our strategic aims • Use research experienced teams in General Practice to help other surgeries with research activities and establish mentorship programmes connecting experienced researchers with GPs new to research • GP surgeries experienced in research to become hubs to help enhance research across the System, assisting with study set-up, coordination, data management • Share outputs from Community of Practice for Social Care, (Community of Practice for PH is currently being established) • Ensure input from the VCSE sector • Ensure input from the Research Engagement Network
Increase collaborative research that runs across sectors	• Identify NIHR current/ planned studies that will facilitate cross-sector collaboration • Promote and identify research opportunities through JUCD system delivery groups e.g. Planned Care, UEC, Primary and Community Care • Work with ARC on their key themes that align with Derby and Derbyshire priorities • Increase partnerships and collaboration between Universities and all ICS sectors • Plan for NIHR Health Determinants Research Collaborations • Plan for NIHR Mental Health Research Groups
Increase public awareness and understanding around research, leading to increased participation with improved equity and diversity.	• Co-design ways to increase dissemination and public awareness/ understanding via PPI routes including the REN • Implement agreements and actions in line with the 'Valued Voices Charter' being developed with the REN • Build on the increased public-facing communication about the research currently underway in Derby and Derbyshire • Join forces with Healthwatch to develop a unified voice on patient and public involvement and feedback • Support from VCSE Alliance

5. Enabling Plans

The following enabling plans will support delivery of the improvement goals and actions included in Section 4. Where required more specific objectives for the enablers will be developed as part of the implementation plan for the Strategy.

Funding

- Additional funding will be required to facilitate the achievement of some of the improvement goals included within the Strategy
- Whilst options for reducing the financial impact on the System will be fully explored e.g. hybrid funding/ roles and commercial funding opportunities, additional funding will be needed to support our ambitions for expanding research capacity and capability

Partnership Working

- Improve partnership working with universities, particularly in areas where research is comparatively lower than peers.
  - The University of Nottingham is a significant contributor to the health sector within Derby and Derbyshire, developing the medical workforce of the future, and funding research-active, clinical academic colleagues who are a significant, valuable and valued part of the research landscape of healthcare.
  - Build on the University of Derby ambition to develop further research initiatives and collaborations with organisations from across the ICS
- Further develop partnership working with East Midlands organisations/ bodies that support research including the CRN, ARC, and HIEM
- Develop closer partnership working with the VCSE sector as described in Section 1
- Work with regional CRN leads and JUCD/ regional professional network leads to ensure speciality and professional links are maximised
- Use partnership arrangements at Place and Neighbourhood levels to strengthen collaboration across the NHS, 2nd Tier Local Authorities and the VCSE sector
- Establish links with the JUCD "Transformation Co-ordinating Group" and the JUCD Improvement Network, to improve connections with leads for transformation

ICB & Commissioning

- ICB to actively promote its duties regarding research and ensure these duties are reflected in system and organisational plans
- Health and care commissioners demonstrate the use of evidence in commissioning decisions and ensure NHS Standard Contract requirements (for commissioning of NHS services) are assured, including the requirement that *"The Provider must put arrangements in place to facilitate recruitment of Service Users and Staff as appropriate into Approved Research Studies"*
- Support the development of a virtuous circle whereby commissioners ask providers to identify how research has been used by staff in delivering and developing services, which results in provider staff more actively using knowledge/ evaluation and research teams to ensure there is a strong evidence base for service development and delivery

Communications and Engagement

- Develop a communications plan to accompany the Strategy and implementation plan

- Develop public-friendly and staff-friendly versions of the Strategy
- Consider developing a logic model for communicating the Strategy and driver diagrams for illustrating how the strategic aims will be delivered
- ICB and all JUCD organisations to support marketing/ communications

Patient and Public Involvement

- Maximise the benefits of the partnership with the REN, including co-design of the 'Valued Voices' charter for how organisations conducting research reach out to and involve communities, and how research outputs are disseminated, ensuring there is a positive legacy within communities for supporting future research activities
- Consider use of I/ We statements to support better communication of principles
- Undertake broader PPI activities, in collaboration with ICB and organisational engagement leads, and with Healthwatch to ensure a 'unified voice'

Workforce

- Develop a research workforce plan that facilitates achievement of the improvement goals, particularly those under the 'Involve Meaningfully' strategic aim, and which aligns with the JUCD Workforce Plan and regional workforce strategies, including the forthcoming CRN Nursing, Midwifery and AHP East Midlands workforce strategy

Leadership and Governance

- Ensure we have the appropriate level of expertise and support on the DRF and ensure the DRF effectively connects with elements of JUCD governance architecture
- Ensure there is adequate resource and dedicated system level management capacity for developing and mobilising the Implementation Plan
- In line with the NHS Five Year Plan – *"Ensure an appropriate skill mix at board-level and across registered professional leads to promote research and support collaboration"*
- Where necessary further develop governance and support arrangements within organisations

Library and Knowledge Services

- Strengthen Library and Knowledge Services so they can source, provide access to, and interpret evidence, and train others in searching, handling and publishing information

Data, Information and Data Sharing

- Work with Information Governance functions to facilitate access to routinely collected data to support the choice of approved research for patients along care pathways and across organisational boundaries
- Agree how NIHR data, plus data from other sources e.g. for commercial studies can be better disseminated to support achievement of the improvement goals
- Agree how information on current and forthcoming studies can be made more widely available, including to managers and clinicians involved in service improvements and service developments
- Agree a set of peers for comparing activity and funding for JUCD activity, to enable fair comparisons and set stretch improvement targets

6. Strategy Implementation, Oversight and Evaluation

An implementation plan will be produced to identify how the improvement goals and actions will be prioritised over the five year planning period and converted into SMART objectives, with measures and targets (where applicable), and to describe how progress will be monitored and the Strategy evaluated.

The DRF will be accountable for the implementation plan and for overseeing progress against measures and/ or targets relating to the improvement goals, and for undertaking system-level corrective action to address risks and issues. This will include overseeing key enabling actions as listed in Section 5.

Regular updates on progress against the goals and enabling actions, and risks and issues, will therefore need to be provided to the DRF. A system level resource for producing this information and for managing strategy implementation will need to be established.

Methods for evaluating the Strategy will need to be considered over and above the monitoring arrangements flagged above, as will the question of whether the evaluation will be undertaken within the system and/ or by an external partner.

Appendix A – Stakeholder Engagement

Integrated Care Board
The Chief Medical Officer for Derby and Derbyshire Integrated Care Board is the Chair of the Derbyshire Research Forum and the Accountable Officer for the Strategy.

The following forums are responsible for agreement of the Draft Strategy, ahead of ICB approval.

- Derbyshire Research Forum
- Clinical and Professional Leadership Group

Strategy Working Group
The following organisations/ sectors are represented on the Working Group that has been responsible for the development of the Strategy.

- Chesterfield Royal Hospital NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust
- University Hospitals of Derby and Burton NHS Foundation Trust
- General Practice
- NIHR Clinical Research Network East Midlands
- Derby City Council
- Derbyshire County Council
- University of Derby
- University of Nottingham

These organisations/ sectors were also given the opportunity to provide feedback on the Draft Strategy through their governance arrangements. Where feedback has been received, this has been assessed and if deemed appropriate for inclusion it has been reflected in the final content.

Wider stakeholder engagement
The Draft Strategy was shared for comment with the organisations/ groups listed below. Meetings or presentations to discuss the strategy took place when stakeholders accepted the offer to do so. Where feedback has been received, this has been assessed and if deemed appropriate for inclusion it has been reflected in the final content.

- Derbyshire Voluntary, Community & Social Enterprise (VCSE) Alliance
- Derbyshire Research Engagement Network
- Healthwatch Derbyshire
- East Midlands Ambulance Service NHS Trust
- NIHR Applied Research Collaborative (ARC) East Midlands
- Health Innovation East Midlands (HIEM)
- NHS provider leads for Knowledge/ Evidence Services
- DHU Healthcare
- ICS Strategy theme leads and Professional leads (through the Clinical and Professional Leadership Group and individual interactions)

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th July 2024

Item: 037

Report Title	Final Operational Plan 2024/25							
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 – 2024/25 Operational Plan on a page							
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 **RATIFY** the Final 2024/25 Operational Plan.

Purpose

To inform the Board as what elements of the Derby and Derbyshire NHS' 2024/25 Operational Plan, as submitted on the 2nd May 2024 to NHS England, subsequently changed and thus confirm the full and final set of key deliverables for 2024/25.

Background

As part of the process for finalising the Derby and Derbyshire NHS' 2024/25 Operational Plan and submission to NHS England on the 2 May 2024, the ICB Board agreed (29th April 2024 refers) to a plan which committed to deliver the following:

- compliance against core quality and access standards, apart from the adult learning disability and autism inpatient rate target;
- a reduction in workforce across the four JUCD Foundation Trust Providers of 927 WTEs or 3.6%, before factoring in WTE growth linked to planned (and funded) investments; and
- a financial deficit of £68.8m.

Following the submission of the plan and joint review/dialogue with NHS England, three changes have been actioned, which meant that a revised 2024/25 Operational Plan was submitted to NHS England on the 12th June 2024.

Report Summary

The three changes to the 2024/25 Operational Plan are as follows:

1. Reducing the value of the Derby and Derbyshire NHS' financial deficit plan

The financial planning submission made on 2nd May 2024, indicated a planned deficit of £68.8m for JUCD for the 2024/25 financial year. This excluded a technical adjustment relating to the treatment of University Hospitals of Derby and Burton NHSFT's Private Finance Initiative, in relation to valuations made under UK GAAP vs. IFRS16.

JUCD High Level Plan 2024/25	2nd May Submission (Exc. Technical Adj) £m
NHS Derby & Derbyshire ICB	6.0
Chesterfield Royal Hospital	(20.6)
Derbyshire Community Health Care	0.0
Derbyshire Healthcare	(6.4)
East Midlands Ambulance Service	0.0
University Hospitals Derby & Burton	(47.8)
	(68.8)

Following discussion with National and Regional NHS England colleagues, the Derby and Derbyshire NHS agreed to reduce its planned deficit of £68.8m to £50.0m, which is broadly like 2023/24 outturn, with the c£18.8m movement driven by:

- non-recurrent balance sheet adjustments;
- refining expenditure assumptions;
- recasting Chesterfield Royal Hospital's Value Weighted Activity Plan by 2%; and
- tactical service review and reconfiguration.

These items did not affect the value of the Derby and Derbyshire NHS' Cost Improvement Programme (CIP), which remains at £169.7m, of which c. 60% is planned to be delivered recurrently.

2. Improving the Derby and Derbyshire NHS' utilisation of virtual ward capacity

The revised submission factored in all virtual ward capacity and assumed a better utilisation rate of at least 80% from October 2024.

3. Category 2 ambulance mean response time

As co-ordinating Commissioner for the East Midlands Ambulance Service NHSFT's Contract, we took the opportunity to reflect a more up-to-date trajectory for this metric. The objective of achieving an overall mean response time of 30 mins in 2024/25 has not changed. However, there was a change in the monthly trajectory as shown below:

Mean Category 2 Response Time (minutes:seconds)												
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
2 May 2024 submission	34.0	34.0	23.0	20.0	21.0	31.0	35.0	33.0	42.0	33.0	25.0	24.0
12 June 2024 submission	23.0	24.0	28.0	25.0	26.0	30.0	37.0	29.0	39.0	35.0	34.0	30.0

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.	☒
No further risks identified.					

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

Have any conflicts of interest been identified throughout the decision making process?
Not applicable to this report.

Project Dependencies

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

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

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

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

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐
Not applicable to this report.					

Appendix 1

2024/25 operational plan on a page

Workforce and Finance

- **Workforce:** Reduce the baseline level of workforce across the four FTs by 927 FTEs or 3.6% by the end of March 25 (relative to March 24), before accounting for growth associated with planned (and funded) investments.
- **Finance:** Deliver a deficit of £50.0m, including £169.7m of CIP of which 60% is recurrent.

Planned Acute Care and Cancer

- **Referral to Treatment:** Ensure nobody is waiting longer than 65 weeks for treatment by the end of September 2024.
- **Faster Cancer Diagnosis:** By the end of March 2025, at least 77% of suspected cancers are, on average, diagnosed and/or ruled out within 28 days of being referred.
- **Cancer Treatment:** By the end of March 2025, at least 70% of first definitive treatments for cancer are, on average, delivered within 62 days of referral.
- **Diagnostic waits:** By the end of March 2025, no more than 5% of people will, on average, wait longer than 6 weeks to receive a diagnostic test.

Urgent and Emergency Care

- **A&E 4 hr**: By the end of March 2025, at least 78% of people arriving at an A&E department will be admitted to hospital, transferred to a more appropriate care setting, or discharged home within four hours.
- **Virtual Wards:** From the beginning of October 2024, at least 80% of virtual ward capacity will be utilised.
- **General and acute bed occupancy:** Ensure that average bed occupancy operates at between 94-95% across both Trusts.

Mental Health, Learning Disabilities and Autism

- **Inappropriate out of area placements:** Reduce to zero by the end of March 2025.
- **Perinatal Mental Health Service :** Ensure at least 1,111 people access the service by the end of March 2025.
- **Children and Young Persons:** Ensure that at least 14,555 people access CYP services by the end of March 2025.
- **Talking Therapies:** Ensure that, on average, at least 67% of people achieve reliable improvement and at least 50% a reliable recovery.
- **Physical health checks for people with a severe mental illness**: At least 78% of people with a SMI receive a full annual health check by the end of March 2025.
- **Physical health checks for people with a learning disability and/or autism (LD and/or A):** At least 75% of people aged 14 or over with LD and/or A receive a health check by the end of March 2025.
- **Transformed Community MH Services:** At least 8,150 adults with severe mental illness are accessing community services by the end of 2024/25.
- **Dementia diagnosis**: Deliver an average dementia diagnosis rate of at least 68% in 2024/25.
- **Inpatient care for people with a learning disability and/or autism:** For every 1 million population, ensure that no more than 3 people aged under 18 yrs and 32 adults, are receiving care in an inpatient facility.

Primary and Community Care

- **Dental:** Increase dental activity to restore pre-pandemic access.
- **GP appointments :** At least match 2023/24 appointment activity in 2024/25, with at least 75% of appointments delivered within 2 weeks of booking.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th July 2024

Item: 038

Report Title	Performance Report							
Authors	Jo Hunter, Deputy Chief Nurse Sam Kabiswa, Assistant Director, Planning and Performance Craig West, Associate Director of Finance (System Planning) Sukhi Mahil, Assistant Director Workforce Strategy, Planning and Transformation							
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer							
Presenters	• Quality – Prof Dean Howells, Chief Nurse Officer and Jill Dentith, Non-Executive Member • Performance – Michelle Arrowsmith, Chief Strategy and Delivery Officer and Richard Wright, Non-Executive Member • Finance – Keith Griffiths, Chief Finance Officer and Jill Dentith, Non-Executive Member • Workforce – Linda Garnett, Interim ICB Chief People Officer and Margaret Gildea, Non-Executive Member							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Performance Report Appendix 2 – Committee Assurance Reports for Quality & Performance Committee; Population Health & Strategic Commissioning Committee; and Finance, Estates & Digital Committee.							
Assurance Report Signed off by Chair	• Quality & Performance Committee – Jill Dentith, Non-Executive Member • Population Health & Strategic Commissioning Committee – Richard Wright, Non-Executive Member • Finance, Estates & Digital Committee – Jill Dentith, Non-Executive Member							
Which committee has the subject matter been through?	Quality & Performance Committee – 30 May 2024, 27 June 2024 Population Health & Strategic Commissioning Committee – 9 May 2024, 13 June 2024 Finance, Estates & Digital Committee – 25 June 2024 ICB People and Culture Committee - 27 June 2024							

Recommendations
The ICB Board are recommended to **NOTE** the Performance Report and Committee Assurance Reports.
Purpose
To update the ICB Board on the Month 2 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
- workforce.

Background

Quality and 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 the 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; and
- 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 25 to March 24. 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 25 relative to March 24.

The report attached represents M01/M02 assessment of progress against our 24/25 planning objectives for those measures where data has been validated and published by NHSE. Due to time lags in data being validated and published data, we currently only have data for a limited number of measures with further data expected to be published on the 14th of July.

Finance

On the 2nd May 2024 JUCD submitted a financial plan for 2024/25 to deliver a planned deficit of £68.8m (excluding the technical adjustment relating to UK GAAP treatment of the PFI).

There was a national requirement for all systems to re-submit their plans on the 12th June 2024 and JUCD submitted a revised financial plan to deliver a planned deficit of £50.0m, in line with the Revenue Financial Plan Limit set for the ICS. This is an improvement of £18.8m on the plan submitted on the 2nd May 2024.

Updated guidance indicates systems who have submitted a plan in line with their Revenue Financial Plan Limit will receive a non-recurrent deficit support revenue allocation in 2024/25, effectively taking them to an in-year breakeven position.

Workforce

The final 2024/25 workforce plan was submitted on the 2nd May. In developing this plan, significant effort was made to ensure stronger alignment with the finance pay-bill plans, at the outset.

Systems were asked to resubmitted plans on the 12th June (this was also required of activity and finance). From a workforce perspective, the specific reason for the resubmission was to ensure plans reflected the 2023/24 M12 out-turn. As a system we had already ensured the 2024/25 baselines reflected the M12 out-turn (see baseline review below) and therefore no further changes were made for the 12th June submission.

Workforce

The final 2024/25 workforce plan was submitted on the 2nd May. In developing this plan, significant effort was made to ensure stronger alignment with the finance pay-bill plans, at the outset. Systems were asked to resubmitted plans on the 12th June (this was also required of activity and finance). From a workforce perspective, the specific reason for the resubmission was to ensure plans reflected the 2023/24 M12 out-turn. As a system we had already ensured the 2024/25

baselines reflected the M12 out-turn (see baseline review below) and therefore no further changes were made for the 12th June submission.

Report Summary

Quality

Whittington Moor Surgery

Following the CQC inspection in February the final report was published in May 2024 with the Practice remaining rated as Outstanding overall.

UDHBFT

Following an unannounced CQC IR(ME)R inspection the Trust have received a number of enforcement notices (5 in total). The Trust are currently developing the action to address these and implementation will be monitored through CQRG.

Ellern Mede (Derby)

Despite ongoing collaborative work with the Provider Collaborative additional safeguarding concerns were identified at the unit. Commissioners have now been notified that the organisation has made a temporary suspension of services as of the 16th June. Of the two remaining service users, one was discharged home and the other individual was moved to another Ellern Mede facility.

Performance

There are several areas where no data is available because it has not yet been published or is published on a quarterly basis. For the areas where we have the data the report provides a snapshot whether the projected has been achieved or not by way of a rag rating. It is not yet possible to draw any firm conclusions from the snapshot on any trends in performance. However, where feasible, a brief assessment against our assumptions/plans has been set out including any underlying issues or risks. Where possible a view on anticipated progress against our objectives including the actions being undertaken to ensure we achieve the stated objectives is also included.

In terms of performance key areas to note include:

Urgent and Emergency Care

- In relation the key 4-hour performance measure UHD and CRH are off trajectory if compared against the operational 24/25 operational plan projected performance. Performance was on average 3% behind plan as at end of May 2024 (system wide) with 6% more attends recorded than projected over the same period.
- Bed occupancy is still above target at both RDH and CRH. We are however seeing a reduction in delays in P1 pathway at county which is improving flow as a result of the ongoing local authority transformation programme.
- Regional category 2 mean response time was met in April with a C2 actual response time of 33m 56s against a trajectory of 34m 24s, however the trajectory for May was above target being exceeded by 35s.

Acute Planned Care, Cancer & Diagnostics

- Incomplete 78 week waits: Behind planned trajectory and current forecast is 0 by July 2024.
- Incomplete 65 week waits: Behind planned trajectory.
- Cancer 62 days: Both Trusts meeting planned trajectory.
- 28-day Faster Diagnosis: UHDB slightly behind planned trajectory (71% vs. 74% target).
- Number of people waiting 6 weeks or longer for a diagnostic test/procedure: Behind trajectory with 27% of diagnostic waiting list 6 weeks+, vs a plan of 23%.

Appointments in General Practice

- 12% more appointments than plan in April 24 (adjusted for working days).
- 75% of appointments delivered within 2 weeks (as per plan).

Finance

Due to timing of a further plan submission, the national reporting requirements for month two are based on information included in the original plan submission (2nd May). This paper therefore includes figures in line with those nationally reported.

As at 31st May 2024 the system has a year to date position of £23.4m deficit compared with the planned deficit of £23.0m, an adverse variance to plan of £0.4m. The annual forecast is for the position to be in line with the total planned deficit by the end of the financial year.

The main reason for the variance to plan to date is the under-delivery of efficiencies. In light of the current under-delivery, together with a planned increase in delivery from quarter two there is a pressing need to quickly identify and develop opportunities into deliverable schemes in order to recover the shortfall and deliver the full efficiency target for the year. It is also important to ensure delivery is on a recurrent basis to reduce the risk to the underlying position and the impact in future financial years. Providers have more schemes in the pipeline that have not yet been accounted for in ePMO which will increase assurance on delivery.

All organisations remain committed to delivering the planned position for the financial year.

Risks and issues for 2024/25 related to Capital are still emerging and will require more review over the coming months, in order to quantify the impact on scheme delivery and the impact on meeting expected expenditure targets.

Both CRH and UHDB have requested cash support from NHSE/DHSC to help manage cash balances in 2024/25.

Workforce

Baseline review

An important lesson from the 2023/24 planning round was that the out-turn positions and the plan baselines were not aligned. We have ensured this is not the case for the 2024/25 plan and the planned baselines; all Trusts, with the exception of EMAS matched the 2023/24 M12 out-turn position. The reason for the EMAS difference is due to planning alignment which is now based on contracted (previously worked) so that this is consistent with other Trusts.

2024/25 Workforce Plan Position: Month 2

The total workforce across all areas (substantive, bank and agency) was 440.09WTE below the plan at M2. Compared to M1, there was an increase in substantive positions (+153.87WTE) and agency usage (+23.42WTE) but there was a decrease in bank usage (-191.09WTE). The majority of the increase in substantive positions was from Support to Clinical Staff (+106.00WTE) and Allied Health Professionals (+24.21WTE) and there was a decrease from Registered Nursing, Midwifery and Health Visiting staff (-5.85WTE).

The growth in substantive workforce corresponds with the change in bank and agency staff, the latter has seen a reduction to 240 WTEs compared to 473 WTE in March. This suggests that the agency controls and targeted actions to reduce agency usage are having an impact. This will continue to be monitored and supported through the work of the system wide agency reduction steering group, alongside individual Trust actions.

Other controls and measures to ensure the position remains on plan include individual Trust vacancy control processes; mechanisms to review the outcomes of the panels are being put in

place at a system level to monitor where further actions may be necessary and/or identify areas where alternative workforce solutions may be considered.

This time last year the system was over-plan at M2 by 512 WTEs, whereas this year the position is 440 WTEs below plan. This suggests that the improvements made in the baseline position as stated above, have resulted in an improved starting point and should enable closer tracking of the actual position to plan. Whilst all Trusts continue to make concerted efforts to manage the workforce position it is important to note caution, as we do not yet know any potential impacts as a result of recent industrial action.

The primary care data contained in the pack is up to M12. This is due to data availability. The data identified that at M12, the total workforce was only 6 WTE below plan. The position was observed from Direct Patient Care roles (ARRS funded) (-134WTE), GPs excluding registrars (+53WTE), and Other – admin and non-clinical staff (+40WTE). Discussions are taking place with GPPB colleagues to identify improvements to the primary care reporting in order to provide a better understanding of primary care workforce.

Workforce establishment: M2 actuals (WTE) comparison to pay-bill (£)
In the absence of the national requirement for monthly establishment plans, local arrangements have now been embedded, to monitor the workforce plan against the actual staffing levels that we have the budget for (i.e. costed WTE establishment).

As described earlier all organisations remain below plan at M2 (WTEs); the pay-spend is also below plan by £1m (year to date the underspend is £1.5m) and the total workforce is 318 WTE under-established.

All providers are under their respective planned establishment positions with the exception of CRH which is over-established by 89 WTEs. However CRH has managed this within the planned pay-bill (underspend of £0.1m). DCHS and EMAS overspent against the planned pay-bill by £0.4m and £0.2m respectively, even though both organisations are under established at M2. This requires further investigation given their minimal variance from plan.

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 KPIs are:

Agency KPI	M2 Position
Total Agency Spend	• JUCD planned to spend £2.4m on agency staff in M2 The actual spend was £3.6m. This is an overspend against plan of £1.2m (YTD over-spend against planned agency spend is £1.4m) • In M2 JUCD had an increase in agency usage by 22.52 WTE from the previous month, however it remained 72.78 WTE under their planned usage.
Agency spend as a % of total staff spend	• YTD JUCD agency cost amounted to 2.4% of total pay costs, 0.8% under the national target of 3.2%

% of Off Framework shifts	• In M2, off-framework usage was 152 shifts which is 3.9% of the total agency shifts
% Non-price cap compliant shifts	• There were 2,008 non price cap compliant shifts, 48.2% of the total agency shifts.

Infrastructure Support, particularly Admin and Estates agency usage came to 269 shifts which is 3.6% of total agency shifts in M2. The agency reduction steering group is also reviewing this particular staffing group to identify exit strategies where possible.

Actions

Workforce plan:

- Further work is required to breakdown all pay elements including sickness, maternity, study leave, overtime etc to develop understanding of the impact on workforce costs and/or where temporary staffing is being utilised to cover such elements. This requires support from the finance community as the data will need to be extracted through the ledger systems.
- Developing a more rounded view of workforce by exploring some of the qualitative and staff satisfaction measures alongside the WTE plan to see if there are ways to identify cause and effect and impacts on productivity.

Agency Reduction:

- Accuracy of data associated with temporary staffing/ reasons for agency requests has improved from 13% to 87%, this now provides a better understanding of the position; enabling targeted actions.
- Further work is underway to enable a more granular breakdown of the data to ensure consistency with regards to the highest paid/longest serving agency workers and identify opportunities for reduction in these areas.
- Agency Reduction Steering Group holding a dedicated session to review the action plan and identify where other opportunities exits to improve the position.
- Accessing support offered by the Midlands Agency Programme Improvement Team, in targeted areas.

Risks

- Ongoing re-banding issues (Bands 2 to 3 and potentially other bands) resulting in significant increases in the pay bill.
- 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.

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.
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

July 2024

Dr Chris Clayton ICB Chief Executive Officer
Prof Dean Howells, Chief Nurse Officer
Michelle Arrowsmith, Chief Strategy and Delivery Officer
Keith Griffiths, Chief Finance Officer
Lee Radford, Chief People Officer and Linda Garnett, Interim ICB Chief People Officer

Quality

Prof Dean Howells, Chief Nurse Officer
Jill Dentith, Non-Executive Member

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

Derby and Derbyshire Integrated Care Board

Key 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 Intensive Surveillance	Safer Maternity Care	Maternity Service	Assurance	UHDB: Following the Inadequate rating for safe and well led maternity care in 2023 • Monthly tier 3 meetings led by NHS England and DDICB to provide assurance that progress is being made against the section 29a and 31 recommendations issued in August 2024 • Trajectories have been set to meet the requirements of an exit plan later this year. • LMNS Board reviews CQC progress monthly • Maternity Improvement advisors are working with the trust to provide support in meeting the priorities within the maternity improvement plan. • NHS Midlands perinatal team have completed a 90-day support package around postpartum haemorrhage, fetal monitoring in labour, triage, escalation processes using the Each Baby Counts toolkit and QI. They are currently reviewing the feasibility of extending the offer. • Perinatal Quality and Safety Group gains assurance monthly on patient safety outcomes. PPH rates are stabilising, and perinatal mortality is showing a downward trajectory.
2	New Concern Enhanced Surveillance	Radiology	UHDB	The Trust received an unannounced CQC IR(ME)R inspection within the last month, and they have received 5 enforcement notices which are; – Regulation 8: Exposure/oversight of unintended exposure – Regulation 14: Medical physics expert staffing cover – Regulation 15: Equipment and the maintenance of this – Regulation 6: Procedures and written protocols – Regulation 17: Oversight of training	Currently there are no specific details awaiting the final report before actions/mitigations can be developed.

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	New Enhanced Surveillance	Primary Care : General Practice	Whittington Moor Surgery	CQC inspection 19th of February – Inspection Report published 31st May – The practice remains rated as outstanding overall. It is rated as outstanding in the key questions caring and well-led, and good in the key questions safe, effective, and responsive. Breach of Regulation 12 – Safe Care and Treatment	CQC found that systems within the practice were not fully effective to mitigate risks, the practice is subject to a breach (of regulation 12), the practice is subject to an action plan to remedy the breach. CQC found that the practice had a proactive and positive culture of safety based on openness and honesty, in which concerns about safety were listened to, safety events were investigated and reported thoroughly, and lessons were learned to continually identify and embed good practices. Medicines and treatments mostly met people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen. The provider maximised the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing, and communication needs with them. The practice actively sought out and listened to information about people who were most likely to experience inequality in experience or outcomes. They tailored the care, support and treatment in response to this. There were clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. The Primary Care Quality Team are meeting with the practice re action plan and follow consideration of areas where the CQC states mostly achieved. Also review of those areas not inspected by CQC where ratings are based on the previous inspection of 2015.

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
4	Ongoing Enhanced Surveillance	CAMHS ED	Ellern Mede Derby	Concerns regarding clinical model across all Ellern Mede sites. Additional safeguarding concerns identified by the PC at the Derby site. In April 2024, a further Ellern Meade Unit in South Yorkshire was also rated as Inadequate by CQC. DDICB has been notified of temporary suspension of their service on the 16th of June. The PC is attending the DDICB Quality Subgroup on 18th June.	• London Region leading national oversight • EM CAMHS PC escalated concerns to the CQC and LADO • CQC inspection took place 7 and 8 November 2023 with report published 15/01/24. Rated Requires Improvement Overall. • Quality Oversight Meeting in place, led by the PC. NHSE Quality Team attending. • 20/01/24 National Quality Assurance Meeting held. Progress noted re engagement from Ellern Mede Group. • 12/03/24 Peer Review undertaken at Derby site and awaiting the formal outcome of this. Next Quality Oversight meeting to be held on 15/05/2024

Quality & Performance Committee Assurance Report – 30th May 2024

Derby and Derbyshire Integrated Care Board

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	The following items were approved by the Group: • **Integrated Performance Report:** The Committee were keen to understand the levels of assurance within UHDB Maternity Services relating to the cultural transformation work which is being undertaken. To be included in the next Maternity update. • **Board Assurance Framework:** It was agreed that the Committee recommends to Board that the risks posed by the current system financial pressures should be added to BAF Risk SR1 as a threat (Threat 4). • System Quality and Performance Committee Terms of reference were approved.
Major actions commissioned or work underway	**Positive assurances received**
The following pieces of work will be regularly presented to the Committee: • Deep Dives as per the Committee forward plan.	The following papers were presented for assurance: • Deep Dive into Nursing and Midwifery Excellence Programme • Integrated Performance Report: the improvements in Cancer waits were noted recognising there are still some breeches. • Board Assurance Framework • System Quality Group Assurance Report
Comments on the effectiveness of the meeting	
Those present agreed that the meeting had been effective, with sufficient opportunity for discussion and that the papers presented were appropriate.	

Quality & Performance Committee Assurance Report – 27th June 2024

Derby and Derbyshire Integrated Care Board

Matters of concern or key risks to escalate	Decisions made

No matters of concern or key risks to escalate.	The meeting was not quorate due to representation from Provider NED's. The following papers were presented:
	• **Derby & Derbyshire Integrated Care Board Quality Framework 2024/25 - draft proposal:** The paper was presented to provide the 2023/24 Quality Framework end of year position, to discuss & note the 2024/25 Quality Framework Quality Improvement proposal and next steps.
	• **Risk 09:** The Q&P Committee were recommended to agree a reduction in the risk score for Risk 09. Following discussion, the members of the committee felt that in light of current system pressure it would not reduce the current risk level.
	• **Quality and Performance Committee Annual Report and Self-Assessment:** Presented to the Committee to formally review and agree the Committee's Annual Report and Self-Assessment.
	• **Board Assurance Framework:** The Committee was asked to consider the following risk scores:
	  ○ Strategic Risk 1 - given the current extremely challenging financial constraints across the system the risk score is increased from a high score of 12 to a very high score of 16; and
	  ○ Strategic Risk 2 - Following the June review at the Quality and Performance BAF Operational Group, recognising that there is more embedment now within the system, the risk score is recommended to be decreased from a very high score of 16 to a high score of 12. Due to quoracy it was agreed that the requests would be sent out electronically for agreement but in principle it was agreed to increase the risk score for Strategic Risk One, but further information was required to support a reduction for Strategic Risk 2.

Major actions commissioned or work underway	**Positive assurances received**
The following pieces of work will be regularly presented to the Committee: • Update on Integrated Performance Report and the use and Implementation of SPC charts. • Deep Dives as per the Committee forward plan.	The following papers were presented for assurance: • **Deep Dive – Virtual Wards:** Update on the current position and planned next steps. • **Deep Dive – IPC:** Update on the performance position and actions taken during 2023/24. • **Output from Development session on 29th February 2024:** The purpose of the meeting was to review the effectiveness of the Quality and Performance Committee in line with the Deloitte Audit report. • **Integrated Performance Report (IPR):** Update the Committee members on how the ICB is performing against the 2023/24 operational plan objectives/commitments and quality standards. • **System Quality Group Assurance Report:** Brief summary of the items transacted at the meeting on the 4th of June 24. **Items for Information:** Quality and Performance Committee Terms of Reference – formal ratification
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.	

Performance

Michelle Arrowsmith, Chief Strategy and Delivery Office
Richard Wright, Non-Executive Member

Key Points to Note

NHS
Derby and Derbyshire
Integrated Care Board

Urgent and Emergency Care

- In relation the key 4-hour performance measure UHD and CRH are off trajectory if compared against the operational 24/25 operational plan projected performance. Performance was on average 3% behind plan as at end of May 2024 (system wide) with 6% more attends recorded than projected over the same period.
- Bed occupancy is still above target at both RDH and CRH. We are however seeing a reduction in delays in P1 pathway at county which is improving flow as a result of the ongoing local authority transformation programme.
- Regional category 2 mean response time was met in April with a C2 actual response time of 33m 56s against a trajectory of 34m 24s, however the trajectory for May was above target being exceeded by 35s.

Acute Planned Care, Cancer & Diagnostics

- Incomplete 78 week waits: Behind planned trajectory and current forecast is 0 by July 2024.
- Incomplete 65 week waits: Behind planned trajectory.
- Cancer 62 days: Both Trusts meeting planned trajectory.
- 28-day Faster Diagnosis: UHDB slightly behind planned trajectory (71% vs. 74% target).
- Number of people waiting 6 weeks or longer for a diagnostic test/procedure: Behind trajectory with 27% of diagnostic waiting list 6 weeks+, vs a plan of 23%.

Appointments in General Practice

- 12% more appointments than plan in April 24 (adjusted for working days).
- 75% of appointments delivered within 2 weeks (as per plan).

Planning Compliance with Operational Plan – Cancer and Planned Acute Care

Derby and Derbyshire Integrated Care Board

Area	Objective	Level	Actual	Plan
			Apr-24	
Planned Acute Care and Cancer	No person waiting longer than 65 weeks on an RTT pathway at the end September 2024.	CRH	239	359
		UHDB	868	795
		DDICB	1,057	1,054
	Total RTT incomplete waiting list	CRH	28,450	29,680
		UHDB	107,129	109,019
		DDICB	125,086	129,941
	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	CRH	69.9%	76.5%
		UHDB	74.5%	79.5%
	Total diagnostic waiting list	CRH	7,240	6,616
		UHDB	22,426	21,505
		DDICB	27,226	26,020
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	CRH	77.2%	75.3%
		UHDB	71.2%	74.2%
	Improve performance against the headline 62-day standard to 70% by March 2025	CRH	76.9%	71.2%
		UHDB	60.2%	57.3%

Cancer and Planned Acute Care

NHS
Derby and Derbyshire
Integrated Care Board

Performance Requirements	Actions Being Taken, Risks & Mitigations
No person waiting longer than 65 weeks on an RTT pathway by Oct-24	➢ The close of 2023-24 saw the expectation of a route to zero for 65-week breaches by the end of Sept-24. Again, the high volume of patients add a significant challenge for the system, but providers have been working to expedite first outpatient appointments for this cohort by end of June-24. ➢ Both providers have developed speciality level route to zero trajectories which are being monitored through internal, and Exec led system performance routes. ➢ **CRH:** ➢ Ahead of trajectory, 469 less than expected with actual of 2023 against target 2499 ➢ 59% of patients within the 65-week cohort for non-admitted still require a First Appointment. 32.4% have appointments booked before end of June and 35% have appointments booked between July and September, an increase of 3.5% when compared to previous week. Work to expedite booking continues at pace. ➢ **UHDB:** ➢ Despite the slight worsening position in actuals , UHDB remain on track to achieve the likely/best case scenarios, and % of patients dated has been increasing. ➢ OPA Backlog concentrated in ENT, Dermatology, Bariatrics- all have significant insourced capacity. ➢ Most of the cohort are currently on a non-admitted pathway. 64% of which have had or are booked in for their first appointment ➢ Most specialties are on track to have all patients first seen by the end of June. ➢ ENT have made significant improvements having gone from 35% without a date to 5% in the last two weeks. ➢ The focus in 2023/24 was zero 78-week breaches by the end of March-24. Due to the volume of referrals held in JUCD (primarily at UHDB) this has been a particular challenge for the system. ➢ Success in these pathways has been a result of internal productivity activities and reorganisation in how care is provided, and pathways expedited. Mutual Aid, including opportunities to work across JUCD providers alongside increased use of the Independent Sector and Insourcing/Outsourcing activities have driven us to a much better position. ➢ Ongoing challenges through April/May are the result of enhanced internal validation processes, clinical complexity, long waits for genomics results and specialist equipment. ➢ JUCD and NHSEI are supporting a weekly review of each patient line by line to support progression of these patients as soon as possible. ➢ Providers are working to mitigate impacts of industrial action on plans to clear 78w in July.
Cancer Improvement	➢ Improvement teams across UHDB and CRH have been focussed on developing the diagnostic and treatment pathways to expedite implementation of the national Best Practice Timed Pathways (BPTP) across key tumour sites which support achieving diagnosis of cancer within 28 days of referral or excluded cancer as soon as possible. ➢ Teams are currently focussing on improvement plans in gynae, skin and urology (non-prostate) pathways. ➢ We are waiting on response to national bids submitted to NHSE for cancer improvement in 2024-24 which will help boost capacity

Planning Compliance with Operational Plan – Urgent and Emergency Care

Derby and Derbyshire Integrated Care Board

Area	Objective	Level	Actual	Plan	Actual	Plan
			Apr-24		May-24	
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	CRH	62.13%	69%	65%	70%
		UHDB	67.66%	69%	66%	71%
		DUCC	*99.67%*		*99.8%*	
	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	EMAS	00:33:49	00:34:00	00:34:51	00:34:00
	Increase virtual ward capacity.	ICB	170	181	170	181
	Increase virtual ward utilisation.	ICB	32%	37%	42%	40%
	Average general and acute bed occupancy rate	CRH	96.80%	93%	96.0%	94%
		UHDB	94.60%	92%	93.3%	91%
	Percentage of beds occupied by patients no longer meeting the critera to reside - adult	CRH	16%	20%	16%	21%
		UHDB	8%	7%	8%	7%

Urgent Care

NHS
Derby and Derbyshire
Integrated Care Board

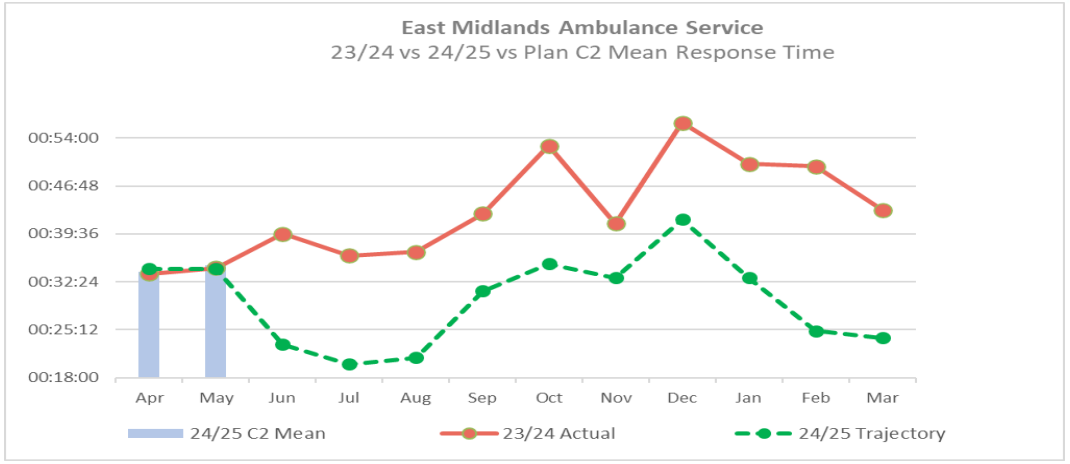
Performance Requirements	Actions Being Taken, Risks & Mitigations: Monthly tier 3 meetings in place monitoring our position against 76% standard & EMAS 30 min mean
UHDB 78% 4 Hour	➢ Weekly internal P78 meetings Chaired by COO/DDM ➢ Monthly Tier 3 meetings with regional team & ICB ➢ Detailed project plan developed for short term actions to address performance gap ➢ Increased focus on 4hr breaches – admitted/non admitted using BI data and tools RDH/QHB. ➢ Improvements identified for streaming to assessment areas and in reach pathways – RDH ➢ Planning increased SDEC capacity RDH/QHB ➢ Aligned to NEC PG/OPG for governance, oversight and escalation ➢ Medium/longer term 24/25 Winter plan and bed modelling improvement work ongoing
CRH 78% Hour	➢ **SDEC pathways** –Work underway to increase the activity pushed through to MSDEC from ED and UTC daily, Reviewing the benefit of moving SDEC to the front door. ➢ **Ambulatory Redesign** - Increased beds waits and resus activity has adversely impacted on maintaining a flow enhancing staffing profile within Ambulatory. Plans in place to trial an extra HCA in Triage area to speed up triage of patients. ➢ **UTC Capacity** – continued embedment of System One to support increased throughput of activity and performance. Daily focus to maximise GPOOHs 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 IP wards (Beds identified as being available later) and later discharges from EMU and Medicine Short Stay. ➢ **Overnight breaches** – focussed work continues ensuring the department is on top of the waits in the afternoon and that all patient's requiring admission has plans. Thresholds for breaches for evening and overnight now set and communicated. Higher resus and majors' acuity last week has exacerbated the overnight breach position. Paediatric pressures overnight also impacted on breaches due to high attendances and admissions. ➢ **Other** – Stand up of a weekly Exec Led Taskforce to understand short, medium and longer terms work plan for UEC improvement;
System 78% Hour	➢ **Decrease in performance due to patients seen OOA** ➢ Continuation of Clinical call validation through our clinical navigation hub (CNH) ➢ Continued integration with Place/UCR and enhanced frailty/falls ➢ Supporting prevention, population health and HIU schemes ➢ Improving P1 and D2A capacity ➢ Improving Acute internal pathways ➢ Implementation of SHREWD and improved escalation ➢ Continue to support UTC improvement
NHS 111/DHU	The new Midlands wide NHS 111 contract went live on the 9th April 2024 ➢ There has been 580,238 calls answered with 34,231 abandoned calls this gives a 5.48% abandonment rate, which is lower than the national call abandonment rate of 6.0% ➢ The average time to answer a call is 1m 10s, the Midlands are currently the best performing region and are 29s seconds better than the national average call answer time ➢ The Midlands have the second highest number of calls referred to the ambulance service, with 12.5% of calls received being referred.

Ambulance Category 2 Regional

The ICS' Operational Plan which was submitted to NHSE assumes a category 2 mean response time (for all EMAS' portfolio) of 29 mins 59 seconds average across the 2024/25 financial year.
The Trajectory has been phased across 2024/25 to account for seasonal trends.

Regional category 2 mean response time was met in April with a C2 actual response time of 33m 56s against a trajectory of 34m 24s, however the trajectory for May was above target being exceeded by 35s

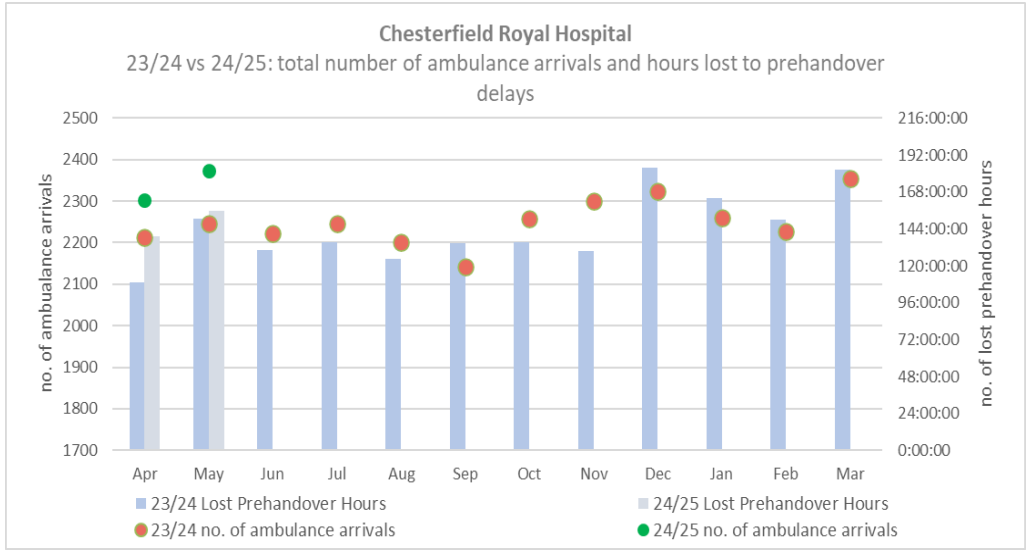
Performance seen during April and May has deteriorated slightly when compared to the same time period as last year, with increases of +18s and +27s respectively, however we have seen a slight increase in on scene which are currently +1.8% higher than 2023/24 activity levels

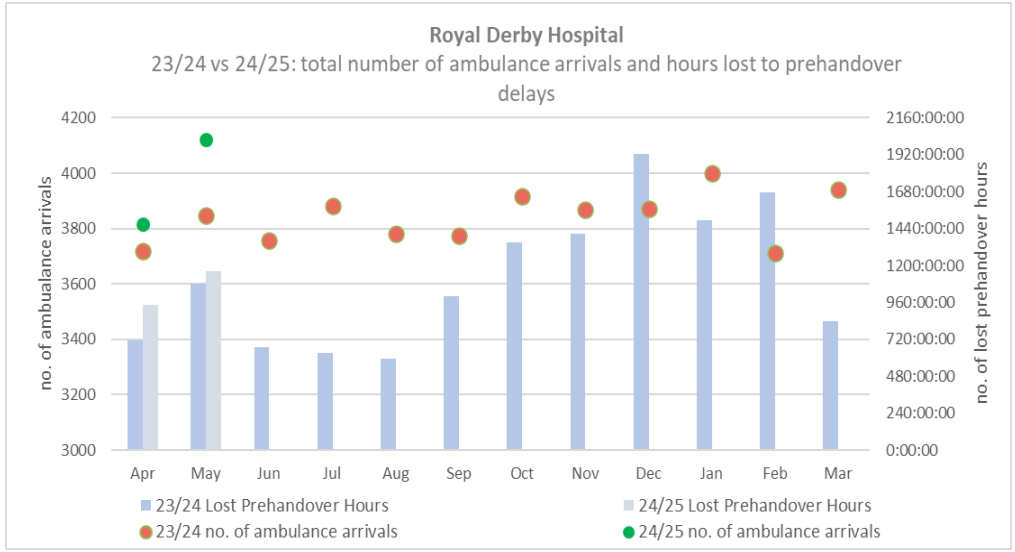


Ambulance handover delays:

At **CRH**, during April and May there has been an increase in lost prehandover hours compared to the last financial year, this is linked to a higher number of Ambulance arrivals. CRH have submitted a pre handover improvement trajectory for 24/25, this was missed by 26 seconds in April, and met in May.

At **RDH**, April and May saw an increase in lost hours due to clinical handover delays when compared to the same time period last year, this was accompanied by an increase in ambulance arrivals. The submitted 24/25 pre handover improvement trajectories were met for both April and May





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

NHS Derby and Derbyshire Integrated Care Board

Area	Objective	Level	Actual	Plan	Actual	Plan
			Apr-24		May-24	
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	ICB	68%	68%	68%	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				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	70.0%	69.6%		67.8%
	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	50.0%	51.9%		50.5%
	Increase the number of people accessing transformed models of adult community mental health in 2024/25 (Quarterly Target).	ICB		7,885		7,934
	Increase the number of women accessing specialist perinatal services in 2024/25 (12 month rolling).	ICB		1,111		1,111
	Increase the number of children and young people accessing a mental health service in 2024/25 (12 month rolling).	ICB		13,825		13,925
	Ensure that 75% of individuals listed on GP registers as having a learning disability will receive annual health check (Quarterly Target).	ICB	3%			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	33		31	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	Quarterly Target
	Reduce out of area placements	ICB	*24*	30		28

Mental Health Services data is delayed while it is transitioning to MHSDS V6, as the data is available the tables will be refreshed.

Mental Health

NHS
Derby and Derbyshire
Integrated Care Board

Area	Performance Requirements	Actions Being Taken, Risks & Mitigations
Adult MH Community Services	Talking Therapies Increase in access	➢ Performance against access rate has dipped however standards have been reduced nationally and will be replaced in 24/25 with recovery rates. ➢ Continuing to exceed national standards re 6 week wait (86%, standard=75%) and 18 week wait (99% standard=95%) ➢ Recovery rates all achieving or exceeding national target, BME recovery rate = 50% against 50% standard ➢ 1-2nd treatment <90d timescales currently 20% against target of 10%. Plans agreed with providers to improve position.
	Recover dementia diagnosis rate to 66.7%	➢ Continue to exceed national standard for diagnosis rate & Derbyshire system significantly above national average for <65 diagnosis rate (90%) ➢ Discussions being held regarding impact of new therapeutics on service model
	Improve Access to Perinatal Services	➢ Exceeded plan in relation to number of women accessing perinatal services ➢ This represents growth of 161% in the past year. ➢ Demand for the service is expected to plateau once the target has been achieved in line with local birth rates.
	Community MH Services increase in access	➢ Continuing to achieve stretching target representing 14% increase on 2022/23 activity ➢ Exceeding plan in delivery of 'transformed' contacts in line with CMHF
	SMI Annual Health Checks increase in access	➢ As at end March 71.1% of people on SMI register received ALL 6 aspects of AHC in previous 12 month - national standard = 60% ➢ Improved engagement with primary care, GP clinical champions in place ➢ Significant uptick in performance in Q4 as anticipated. ➢ Awareness raising comms plan in place to promote across public and primary care teams utilising social media platforms ➢ HCA pilot showing sustained improved performance, positive feedback patient and staff experience
Adult MH Urgent Care Services	Reduction in use of Out of Area Placements	➢ Exceeding plan for OAP placement days – standard based on 3mth rolling total. ➢ Exceeding national standard for % of people admitted into AMH who have avLos >60days ➢ Recovery action plan in place focussing on admission avoidance, improving therapeutic offer and improving discharges. ➢ Aim to achieve increase in discharge rate, reduction in avlos <32days, Bed occupancy = 85%, readmission rate <8%, reduction in CRFD ➢ MADE event held w/c 29/4/24 – impact – 21 people where discharge expedited. 24 people identified as ready for discharge.
Children & Young Peoples Services	CYP Increase in Access	➢ Work completed with regional and national team to resolve data issues with CRH, national team still working to resolve Kooth issues, assured will be resolved in Q4, however due to rolling 12 mth target performance achievement will still be impacted. ➢ Plans mobilised to increase CYP access to NHS funded mental health services, including an increase in digital services capacity such as Kooth; initiatives to support CYP with early interventions including 3 new x Mental Health Support Teams.

Learning Disabilities and Autism

Derby and Derbyshire Integrated Care Board

Area		Actions being taken, Risks & Mitigations
Inpatient services	Number of adults in ICB commissioned beds Number of adults in Secure inpatient care Number of CYP In Specialised /secure inpatient care	➢ Recovery Action Plan for adult services supported improvement in performance from a high of 49 adults in receipt of inpatient care to 36 adults as at end March 24 which represents a 27% reduction in year. Main achievements ➢ Reduction in monthly admissions from high of 11 people in May 23 to 2 people in March 24 (in line with RAP aim) ➢ Reduction in admissions for people with ASC from high of 14 admissions in Q2 to 4 admissions in Q4. ➢ Minimised admissions into adult secure care = 1 person admitted within 23/24 ➢ Maintained low level of admissions for CYP Areas of continued challenge ➢ Discharges from secure care ➢ 51% of cohort have been in hospital for over 5 years ➢ 9 individuals are currently receiving long term high dependency rehabilitation care 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	➢ End year performance below trajectory – 71.6% against 75% standard ➢ Ongoing issues with coding affecting the denominator for Derbyshire linked to Systm1/TPP sites – solutions being explored ➢ Recovery actions to be identified to ensure achievement for 24/25. Actions in place include: • Flag added to SystmOne to identify to secondary care clinicians' individuals AHC status so they can promote and undertake (if appropriate) within secondary care consultation. SoP agreed and rolled out. • GP training – Strategic Health Facilitation Team (SHFT) deliver continual training to GPs, inc. bespoke action plans for surgeries below 75% compliance in 2022-23. • Targeted work in place with Specialist schools to promote AHC to 14 yr + including collaboration with EHCP's
LeDeR Program	Achievement of LeDeR timescales & standards	➢ 21% of reviews completed as focused reviews (NHSE KPI is 35%) ➢ 57% of reviews completed within 6 months of notification (NHSE KPI is 100%) ➢ Constraints within LeDeR reviewer capacity due to wider system operational pressures.

Planning Compliance with Operational Plan – Primary and Community Care

NHS Derby and Derbyshire Integrated Care Board

Area	Objective	Level	Actual	Plan	Actual	Plan
			Apr-24		May-24	
Primary and Community Care	Increase General Practice appointment activity	ICB	578,772	471,753	580,127	538,841
	% of appointments delivered on same day	ICB	41%		41%	
	% of appointments delivered within 2 weeks	ICB	75%	75%	76%	75%
	Increase dental activity - improving units of dental activity (UDAs) towards pre-pandemic levels	ICB				Quarterly Target
	Community Waiting List - Over 52 Weeks	ICB	2,020			Quarterly Target
	Community Waiting List - total size	ICB	25,821			Quarterly Target

Performance Requirements/Theme	Actions Being Taken, Risks & Mitigations:
Primary Care Access Recovery Plan 24/25	Continue to work with our practices to make progress against the plan to: ➢ Meet with our PCNs to assess their year-end position against the Capacity & Access plans throughout June. ➢ Agree 24/25 Capacity & Access Plans with the PCNs. ➢ Work with the GPPB to implement the new clinical model for General Practice to ensure the two plans complement each other. ➢ Work with PCNs that have an ARRS underspend to maximise their allocation and recruitment in 24/25. ➢ Establish a baseline of permanent ARRS staff vs temporary, additional overtime etc. and look to increase the permanent WTE. ➢ We will apply greater flexibility to the ARRS scheme and support PCNs to recruit other direct patient care, non-nurse and non-GP MDT roles to increase capacity
Primary Care – Dental Commissioning	➢ Derbyshire Oral Health Needs Assessment has been developed and seeking feedback from Local Authorities in June/July and formal governance approval in August ➢ East Midlands Dental Commissioning Principles have been developed and agreed by the East Midlands Joint Commissioning Group ➢ Draft Dental Commissioning Plans have been developed and work is continuing to finalised for formal governance approval in October/November 2024 by East Midlands Joint Commissioning Committee ➢ Commissioning Decision Tree and Quality Framework being developed to underpin dental commissioning arrangements ➢ Non-recurrent investments are being developed for governance approval in mid-July to improve access over the next 1-2 years whilst longer term plans are finalised and implemented e.g. 110% over performance, UDAs and flexible commissioning schemes

ICB Performance Against Constitutional Standards – Urgent Care

Derby and Derbyshire Integrated Care Board

ICB Dashboard for NHS Constitution Indicators

Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire ICB Current Month	NHS Derby & Derbyshire ICB YTD	NHS Derby & Derbyshire ICB consecutive months non-compliance	Chesterfield Royal Hospital FT Current Month	Chesterfield Royal Hospital FT YTD	Chesterfield Royal Hospital FT consecutive months non-compliance	University Hospitals of Derby & Burton FT Current Month	University Hospitals of Derby & Burton FT YTD	University Hospitals of Derby & Burton FT consecutive months non-compliance	NHS England Current Month	NHS England YTD	NHS England consecutive months non-compliance
Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	76%	May-24	↑	75.1%	75.4%	1	75.0%	74.4%	8	75.2%	75.7%	1	73.4%	73.6%	104
	A&E 12 Hour Trolley Waits	0	May-24					147	289	46	876	1,630	26	42,555	84,633	46

EMAS Dashboard for Ambulance Performance Indicators

Area	Indicator Name	Standard	Latest Period	Direction of Travel	East Midlands Ambulance Service Performance (NHSD&DICB only - National Performance Measure) Current Month	East Midlands Ambulance Service Performance (NHSD&DICB only - National Performance Measure) YTD	East Midlands Ambulance Service Performance (NHSD&DICB only - National Performance Measure) consecutive months non-compliance	EMAS Performance (Whole Organisation) Current Month	EMAS Performance (Whole Organisation) YTD	EMAS Performance (Whole Organisation) consecutive months non-compliance	EMAS Completed Quarterly Performance 2024/25 Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25	NHS England Current Month	NHS England YTD	NHS England consecutive months non-compliance
Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	May-24	→	00:08:56	00:09:03	47	00:08:54	00:08:55	46					00:08:16	00:08:13	37
	Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	May-24	→	00:15:20	00:15:36	8	00:15:45	00:15:45	3					00:14:41	00:14:37	0
	Ambulance - Category 2 - Average Response Time	00:18:00	May-24	↓	00:36:22	00:35:08	46	00:34:51	00:34:24	47					00:32:44	00:31:33	46
	Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	May-24	↓	01:15:17	01:13:41	46	01:12:48	01:12:08	46					01:08:52	01:06:32	38
	Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	May-24	↓	05:45:19	05:18:05	46	05:18:53	05:01:15	46					04:45:38	04:20:39	38
	Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	May-24	↓	05:20:50	04:27:33	38	04:01:01	03:51:39	38					05:28:44	05:00:08	38

111 Indicators

Area	Indicator Name	Standard	Latest Period	Direction of Travel	DHU Performance Current Month
111 Key Indicators	Abandonment Rate	5%	Mar-24	↑	3.5%
	Average Speed of Answer	00:00:27	Mar-24	↑	00:00:56

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 Performance Against Constitutional Standards – Planned Care and 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

Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire ICB Current Month	NHS Derby & Derbyshire ICB YTD	NHS Derby & Derbyshire ICB consecutive months non-compliance	Chesterfield Royal Hospital FT Current Month	Chesterfield Royal Hospital FT YTD	Chesterfield Royal Hospital FT consecutive months non-compliance	University Hospitals of Derby & Burton FT Current Month	University Hospitals of Derby & Burton FT YTD	University Hospitals of Derby & Burton FT consecutive months non-compliance	NHS England Current Month	NHS England YTD	NHS England consecutive months non-compliance
Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Apr-24	↑	56.1%	56.1%	75	53.6%	53.6%	60	53.1%	53.1%	76	58.3%	58.3%	98
	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Apr-24	↑	5,705	5,705	51	1,213	1,213	49	4,992	4,992	50	302,589	302,589	204
	Number of 78 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Apr-24	↓	28	28	37	3	3	37	32	32	37	5,013	5,013	37
	Number of 104 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Apr-24	↔	2	2	4	1	1	1	2	2	3	275	275	37
Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Apr-24	↑	28.02%	28.02%	71	30.02%	30.02%	49	24.58%	24.58%	50	23.00%	23.00%	128
28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of All Referrals	75%	Apr-24	↓	71.8%	71.8%	2	77.2%	77.2%	0	71.2%	71.2%	2	73.5%	73.5%	1
31 Days Cancer Waits	First & Subsequent Treatments Administered Within 31 Days Of Decision To Treat	96%	Apr-24	↓	85.5%	85.5%	22	93.8%	93.8%	10	83.1%	83.1%	22	89.2%	89.2%	22
62 Days Cancer Waits	First Definitive Treatment Administered Within 62 Days Of All Referrals	85%	Apr-24	↓	64.4%	64.4%	22	76.9%	76.9%	22	60.2%	60.2%	22	66.6%	66.6%	22

Data Source

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 Local Data
	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	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)

Population Health & Strategic Commissioning Committee Assurance Report – 9th May 2024

Derby and Derbyshire Integrated Care Board

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	• **Commissioning Decisions:** The committee approved the intention to award the service contract on a confidential service procurement. • **Board Assurance Framework:** The Committee agreed the closing Quarter 4 position for 2023/24 and the opening Quarter 1 position for 2024/25. • **Risk Register:** The Committee approved the closure of confidential risk 10C.
Major actions commissioned or work underway	**Positive assurances received**
None to report.	• **Risk Register:** The committee ran a development session in addition to the normal business meeting in May. The development session was specifically on risk. Firstly, reviewing risk against the responsibilities of PHSCC; and secondly the current Board Assurance Framework risks and the PHSCC Corporate risks. The committee considered 4 new risks: o Resource allocation and effectiveness o 5 year strategic ambitions and plans o Demand, health inequalities, prevention o Fragile services Further work is now underway to develop these risks and understand the risk mitigations and actions required. • **Board Assurance Framework:** Received and discussed the strategic risks responsible to the Committee.
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.	

Population Health & Strategic Commissioning Committee Assurance Report – 13th June 2024

NHS Derby and Derbyshire Integrated Care Board

Matters of concern or key risks to escalate	Decisions made

No matters of concern or key risks to escalate.	• **Commissioning Decisions:**
	  ○ agreed to approve the commissioning of a Derby Derbyshire wide clinical health service to support children with physical health needs in Education;
	  ○ noted the current risks for CYP in Education due to inconsistent models of care;
	  ○ approved the commencement of procurement to identify a preferred provider to deliver the Clinical Health Service for Schools; and
	  ○ approved the plan for Procurement of Derbyshire Orthotics Services Contract.
	• **Board Assurance Framework:** discussed and approved Strategic Risks 7, 8 and 9 for the final quarter 1 2024/25 position and the current risk scores for the Strategic Risks 7, 8 and
	• **Risk Register:** approved the closure of risk 03 and confidential risk 04C and approved new risks 28, 29, 30 and 31. Risk (32) will also be added once further review has occurred outside of the committee and then subsequently approve.

Major actions commissioned or work underway	**Positive assurances received**

The committee is striving to ensure it looks forward to tomorrow and in doing so puts a medium to longer term lens on its work. This committee will take accountability to oversee delivery of the Joint Forward Plan (JFP). We have recently taken a stocktake view of progress to date and we have more work to do to support the delivery of the JFP including ensuring clarity on the roadmap for the next 3 years. It is important that the committee takes its role in strategic commissioning by ensuring a longer-term view of the pipeline of commissioning and procurement. The new subgroup will support this work. Both the JFP and strategic commissioning will help us to ensure we improve population health and drive our integration across health and social care partners. Whilst doing this the committee understands its role in listening to the patient and citizen voice through the DDICB insights programme and understanding the population needs through the JSNA. We intend the work underway on the Integrated Performance Report will support our measure of impact.	• **Risk Register:** Received and discussed the risks responsible to the Committee.
	• **Board Assurance Framework:** Received and discussed the strategic risks responsible to the Committee.
	• **Final Draft of Joined Up Care Derbyshire Health and Care Research Strategy:** Agreed.
	• **Other items received:**
	  ○ update from last Development session, including Terms of Reference and Development Framework;
	  ○ presentation on the Derby and Derbyshire Joint Forward Plan;
	  ○ confidential presentation on the 24/25 Operational Plan;
	  ○ presentation on the Integrated Performance Report development. The project plan for this has 5 stages with full delivery planned for January 2025 with a first report delivered in the Autumn;
	  ○ report from the Commissioning and Procurement Subgroup;
	  ○ paper on the clinical health service to support children with physical health needs in Education;
	  ○ confidential paper on the utilisation of the national funding for the Women's Health Hub;
	  ○ confidential paper from the Primary Care sub group; and
	  ○ confidential update report on ImpACT+ Specialist Respiratory Service;
	  ○ paper on the system Research Strategy.
	• **The following items were received for information:** CPAG updates; Derbyshire Prescribing Group report/minutes; JAPC; Bulletin; CPLG minutes; and 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.	

Finance

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

Month 2 System Finance Summary – Financial Position

Derby and Derbyshire Integrated Care Board

As a national requirement JUCD submitted a revised financial plan on 12th June 2024 to deliver a planned deficit of £50.0m, in line with the Revenue Financial Plan Limit set for the ICS. This is an improvement of £18.8m on the plan submitted on 2nd May 2024.

Updated guidance indicates systems who have submitted a plan in line with their Revenue Financial Plan Limit will receive a non-recurrent deficit support revenue allocation in 2024/25, effectively taking them to a breakeven position.

National reporting for month 2 is based on the original plan submission (2nd May). As at 31st May 2024 the system is reporting a year to date adverse variance to plan of £0.4m, relating to under-delivery of efficiencies. The forecast position for the year is in line with plan.

Total system planned deficit is £50.0m, which includes the assumption that the £6.5m risk of UHDB moving to UK GAAP can be mitigated, with further support required from NHSE and their Technical team.

Month 02 Position	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's
NHS Derby and Derbyshire ICB	(0.7)	(0.7)	0.0
Chesterfield Royal Hospital	(5.1)	(5.1)	0.0
Derbyshire Community Health Services	(0.6)	(0.5)	0.1
Derbyshire Healthcare	(2.0)	(1.9)	0.1
EMAS	1.1	0.5	(0.6)
University Hospital of Derby and Burton	(15.7)	(15.7)	0.0
JUCD Total	(23.0)	(23.4)	(0.4)

Month 2 System Finance Summary – Efficiencies

Derby and Derbyshire Integrated Care Board

The annual efficiency plan is to deliver £169.7m. Year to date delivery is behind plan but all efficiencies are expected to be achieved by the end of the year.

JUCD has agreed that ePMO will be the main reporting tool. £142.1m of schemes have been recorded on the system as at month 2. Providers have more schemes in the pipeline that have yet to be accounted for in ePMO so this is a prudent estimate.

The level of recurrent efficiencies planned for the year is £102.8m, equating to c61% of the total plan. There is an urgent need to identify and mobilise recurrent schemes.

Efficiencies by Provider Month 02 Position	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	Full Year Plan £m's	Full Year Forecast £m's	Forecast Variance £m's
NHS Derby and Derbyshire ICB	4.8	4.0	(0.8)	47.0	47.0	(0.0)
Chesterfield Royal Hospital	1.4	0.6	(0.8)	19.8	19.8	(0.0)
Derbyshire Community Health Services	1.2	1.2	(0.0)	11.5	11.5	0.0
Derbyshire Healthcare	0.9	0.6	(0.3)	12.5	12.5	0.0
EMAS	2.7	1.1	(1.6)	16.1	16.1	(0.0)
University Hospital of Derby and Burton	4.4	4.4	0.0	62.7	62.7	0.0
JUCD Total	15.4	12.0	(3.4)	169.7	169.7	(0.0)

Month 2 System Finance Summary – Capital

Derby and Derbyshire Integrated Care Board

The JUCD capital provider plan for 2024/25 is £54.0m. The notified capital allocation is £51.4m, with an allowed 5% planning variance.

The IFRS16 Right of Use asset allocation is currently £12.4m against a need of £30.3m. Discussions are still ongoing with regional and national colleagues on the need for additional uplift to support this issue.

Risks and issues for 2024/25 are still emerging and will require more review over the coming months, in order to quantify the impact on scheme delivery and the impact on meeting expected expenditure targets.

There is an ongoing £7.5m risk in relation to the Eradication of Mental Health dormitories and PICU schemes. Further funding has been requested from NHSE to support with this pressure.

Regional Funded Capital by Provider Month 02 Position	YTD Plan £'m	YTD Actual £'m	Variance £'m	Full Year Plan £'m	Full Year Forecast £'m	Variance £'m
Chesterfield Royal Hospital	0.9	0.3	0.5	7.1	7.1	0.0
Derbyshire Community Health Services	3.0	0.2	2.8	10.7	10.7	0.0
Derbyshire Healthcare	0.1	0.1	0.0	2.6	2.6	0.0
EMAS	0.1	0.1	0.0	9.7	9.7	0.0
University Hospital of Derby and Burton	2.4	2.6	(0.1)	23.9	23.9	0.0
JUCD Total	**6.5**	**3.3**	**3.2**	**54.0**	**54.0**	**0.0**

Month 2 System Finance Summary – Cash

Derby and Derbyshire Integrated Care Board

The cash balance at month 2 includes cash held for capital commitments, this amounts to £12.8m.

Both CRH and UHDB have requested cash support from NHSE/DHSC to help manage cash balances in 2024/25.

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

Month 02 Position Organisation	May 2024 Total Cash Closing Balance £m's
Chesterfield Royal Hospital	23.7
Derbyshire Community Health Services	33.1
Derbyshire Healthcare	24.0
East Midlands Ambulance Service	15.0
University Hospitals of Derby And Burton	37.3
JUCD Total	133.1

System Finance, Estates & Digital Committee Assurance Report – 25th June 2024

NHS Derby and Derbyshire Integrated Care Board

Matters of concern or key risks to escalate	Decisions made
Financial position 2024-25: As of 31 May 2024, with a deficit of £23.4m the JUCD position is £0.4m away from its planned position of a 23m deficit. CIP shortfall is being covered by reductions in routine expenditure in all organisations except EMAS. This position is reported against the earlier £68m planned system deficit. We are now working to an agreed deficit position of £50m which will form the basis for reporting as we move forwards. The Committee were also made aware that NHSE will underwrite the £50m deficit non recurrently which will need to be repaid in full. The full details of this will be confirmed. **Financial planning 2025-26:** considered the predicted underlying deficit for 2025-26 based on the existing national financial policy framework. Assuming 2024-25 delivers on plan, a shortfall ranging from £215m to £250m exists for 2025-26. **System Efficiency 2024-25:** With the 5% CIP target totalling £169.7m for the System for the financial year, £15.4m was planned to be delivered by M02. Only £12m was delivered, with £6.4m of this being non recurrent against a plan of £6.4m. Accordingly the shortfall in delivery is against recurrent schemes. Offsetting this are underspends on pay and drugs, mitigate the CIP shortfall year to date in all organisations except EMAS which has a reported adverse income and expenditure position of £600k which drives the System into the adverse position reported above. CIP delivery remains the largest underlying risk for the System given the scale and pace of delivery committed to by all in the plan for 2024-25 which requires £154.3m to be delivered over the next 10 months. **Other 2024-25 Risks:** Delivering the £50m deficit as per the 2024-25 agreed plan also requires a high degree of collaboration and prioritisation between NHS and local authority partners, and these discussions are continuing. **Final 2023-24 Outturn:** were advised that the organisation were still waiting for a final written position statement form NHSE Midlands regarding the £42m deficit position which was delivered on plan.	**Month 2 System financial report:** accepted the report as presented. **Risk Register and Board Assurance Framework:** reviewed both documents to consider if they still accurately reflected the risks, risk ratings and mitigations assigned to the Committee for 2024-25. The Committee reviewed the same in the light of the final 2024-25 agreed system plan and recommended some changes accordingly.
Major actions commissioned or work underway	**Positive assurances received**
System Improvement and Transformation Plan 2024-25: The Committee heard the emerging transformation priorities for 2024-25 and the intention to develop a cross-system approach to benefits realisation. Particularly, the Provider Collaborative have committed to integrating support functions across the NHS partners as well as making operational changes within UHDB to help manage the fragile services at CRH. Further work on these critical areas will be reported to the July Committee meeting, as further work is required on the scope within the ePMO. **Primary Care and Pharmacy, Optometry and Dentistry financing arrangements:** The ICB Chief Finance Officer will prepare a presentation on this for the July meeting to support and align with the ICB Board' s Joint Forward Plan.	**Financial position 2024/25 of Regional and National comparisons:** noting that the System is forecasting an unacceptable deficit position, the ICB has one of the lowest deficits in the midlands region and is not being put in turnaround by NHSE. **System Efficiency 2024-25:** acknowledged the scale of the 5% CIP ask and despite the work that lies ahead were encouraged by the transparency and energy being put into de-risking our plans in the early part of the year. **Underlying 2025-26 system position:** welcomed the early view on next year driven by the application of national financial policy.

Comments on the effectiveness of the meeting
There was excellent representation across the System 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 effectively to the confirm and challenge discussions.

Workforce

Linda Garnett, Interim ICB Chief People Officer
Margaret Gildea, Non-Executive Member

Reminder: JUCD 2024/25 Workforce Plan Headlines

Derby and Derbyshire Integrated Care Board

Across the 4 JUCD Providers (excluding EMAS), we are planning to see a **0.02% increase** in the number of WTEs from the March 2024 baseline to March 2025 plan

		SIP Outturn (Baseline) Mar-24	Plan M12 Mar-25	Overall Plan Variance (growth/ reduction) Mar-24 to Mar-25	
				WTE	%
JUCD TOTAL (excl. EMAS)	Total Workforce	**25,821.92**	**25,827.19**	**5.27**	**0.02%**
	Substantive	24,035.20	24,355.20	320.00	1.33%
	Bank	1,541.19	1,252.19	-289.00	-18.75%
	Agency	245.53	219.80	-25.73	-10.48%

CRH	SIP Outturn (Baseline) Mar-24	Plan M12 Mar-25	Overall Plan Variance (growth/ reduction) Mar-24 to Mar-25	
			WTE	%
Total Workforce	**5,039.21**	**4,936.30**	**-102.91**	**-2.04%**
Substantive	4,621.58	4,541.67	-79.91	-1.73%
Bank	310.86	299.86	-11.00	-3.54%
Agency	106.77	94.77	-12.00	-11.24%

DCHS	SIP Outturn (Baseline) Mar-24	Plan M12 Mar-25	Overall Plan Variance (growth/ reduction) Mar-24 to Mar-25	
			WTE	%
Total Workforce	**3,851.24**	**3,833.32**	**-17.92**	**-0.47%**
Substantive	3,714.65	3,710.73	-3.92	-0.11%
Bank	99.16	95.16	-4.00	-4.03%
Agency	37.43	27.43	-10.00	-26.72%

DHcFT	SIP Outturn (Baseline) Mar-24	Plan M12 Mar-25	Overall Plan Variance) (growth/ reduction) Mar-24 to Mar-25	
			WTE	%
Total Workforce	**3,160.74**	**3,349.33**	**188.59**	**5.97%**
Substantive	2,972.16	3,164.48	192.32	6.47%
Bank	164.16	164.16	0.00	0.00%
Agency	24.42	20.69	-3.73	-15.27%

UHDB	SIP Outturn (Baseline) Mar-24	Plan M12 Mar-25	Overall Plan Variance (growth/ reduction) Mar-24 to Mar-25	
			WTE	%
Total Workforce	**13,770.73**	**13,708.24**	**-62.49**	**-0.45%**
Substantive	12,726.81	12,938.32	211.51	1.66%
Bank	967.01	693.01	-274.00	-28.33%
Agency	76.91	76.91	0.00	0.00%

The total system position (including EMAS) indicates a **0.96% increase** in the number of FTEs from the March 2024 baseline to March 2025 plan

		SIP Outturn (Baseline) Mar-24	Plan M12 Mar-25	Overall Plan Variance (growth/ reduction) Mar-24 to Mar-25	
				WTE	%
JUCD TOTAL	Total Workforce	**30,074.75**	**30,363.85**	**289.10**	**0.96%**
	Substantive	28,209.37	28,818.20	608.83	2.16%
	Bank	1,593.85	1,304.85	-289.00	-18.13%
	Agency	271.53	240.80	-30.73	-11.32%

As above +

EMAS	SIP Outturn (Baseline) Mar-24	Plan M12 Mar-25	Overall Plan Variance (growth/ reduction) Mar-24 to Mar-25	
			WTE	%
Total Workforce	**4,252.83**	**4,536.66**	**283.83**	**6.67%**
Substantive	4,174.17	4,463.00	288.83	6.92%
Bank	52.66	52.66	0.00	0.00%
Agency	26.00	21.00	-5.00	-19.23%

2024/25 Workforce Baseline Review

Derby and Derbyshire Integrated Care Board

		2024/25 Baseline Review		
		M12 Actual	Plan Staff In Post (SIP) Outturn (Baseline - March 24)	Variance: Baseline (Plan) to M12 Actual
CRH	Total Workforce	5,039.21	5,039.21	0.00
	Substantive	4,621.58	4,621.58	0.00
	Bank	310.86	310.86	0.00
	Agency	106.77	106.77	0.00
DCHS	Total Workforce	3,851.23	3,851.24	-0.01
	Substantive	3,714.63	3,714.65	-0.02
	Bank	99.17	99.16	0.01
	Agency	37.43	37.43	0.00
DHcFT	Total Workforce	3,160.74	3,160.74	0.00
	Substantive	2,972.16	2,972.16	0.00
	Bank	164.16	164.16	0.00
	Agency	24.42	24.42	0.00
EMAS	Total Workforce	4,641.30	4,252.83	388.47
	Substantive	4,354.18	4,174.17	180.01
	Bank	59.28	52.66	6.62
	Agency	227.84	26	201.84
UHDB	Total Workforce	13,770.80	13,770.73	0.07
	Substantive	12,726.90	12,726.81	0.09
	Bank	966.99	967.01	-0.02
	Agency	76.91	76.91	0.00

An important lesson from the 2023/24 planning round was that the out-turn positions and the plan baselines were not aligned. We have ensured this is not the case for the 2024/25 plan; as can be seen from the table above the planned baselines for all Trusts, with the exception of EMAS match the out-turn position. The reason for the EMAS difference is due to planning alignment which is now based on contracted (previously worked) so that this is consistent with other Trusts.

2024/25 Workforce Plan Position: Month 2

(NHS Foundation Trusts including EMAS)

NHS
Derby and Derbyshire
Integrated Care Board

ICB Total	Reporting Period: May 2024					
	Month M2			Trend		
	Plan	Actual	Variance from plan	Previous month	Changes in actual vs previous month	Trend (Actual) previous 12 months
Workforce						
Total Workforce (WTE)	30,484.09	30,044.00	440.09	30,057.79	↓	
Substantive (WTE)	28,626.37	28,309.87	316.50	28,155.99	↑	
Bank (WTE)	1,564.08	1,494.48	69.60	1,685.57	↓	
Agency (WTE)	293.64	239.65	53.99	216.23	↑	
Cost						
Pay Cost (£'000) ^	135,600	134,600	1,000	133,200	↑	

^ For the Pay Cost, all trusts are using 'Total employee benefits excluding capitalised costs' for both budget & actual.

- The total workforce across all areas (substantive, bank and agency) was 440.09WTE below plan at M2.
- Compared to M1, there was an increase in substantive positions (+153.87WTE) and agency usage (+23.42WTE) but there was a decrease in bank usage (-191.09WTE).
- The majority of the increase in substantive positions was from Support to Clinical Staff (+106.00WTE) and Allied Health Professionals (+24.21WTE), and there was a decrease from Registered Nursing, Midwifery and Health Visiting staff (-5.85WTE).

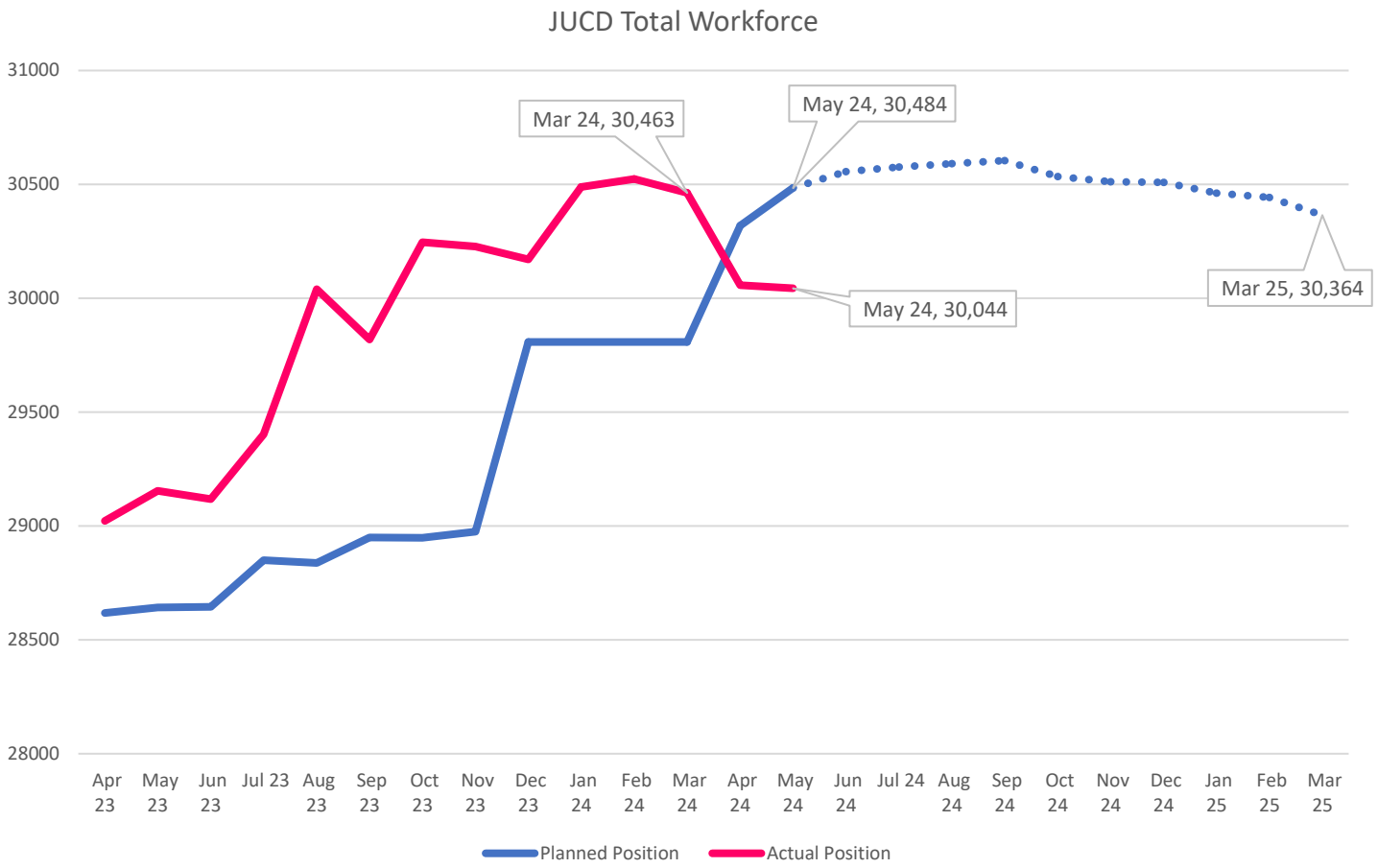
2024/25 Workforce Plan Position Month 2 - Provider Summary

NHS Derby and Derbyshire Integrated Care Board

2024/25		M2 Plan	M2 Actual	Variance from plan
CRH	Workforce (WTE)			
	Total Workforce	5,039.21	5,008.79	30.42
	Substantive	4,621.58	4,637.60	-16.02
	Bank	310.86	283.28	27.58
	Agency	106.77	87.91	18.86
	Cost (£)			
	Pay Cost (£'000) ^	£22,500	£22,400	£100
DCHS	Workforce (WTE)			
	Total Workforce	3,972.22	3,935.08	37.14
	Substantive	3,843.63	3,822.81	20.82
	Bank	95.16	93.48	1.68
	Agency	33.43	18.79	14.64
	Cost (£)			
	Pay Cost (£'000) ^	£14,500	£14,900	-£400
DHcFT	Workforce (WTE)			
	Total Workforce	3,235.15	3,204.30	30.85
	Substantive	3,018.46	2,957.16	61.30
	Bank	164.16	218.19	-54.03
	Agency	52.53	28.95	23.58
	Cost (£)			
	Pay Cost (£'000) ^	£14,200	£13,900	£300
EMAS	Workforce (WTE)			
	Total Workforce	4,423.59	4,286.95	136.64
	Substantive	4,346.93	4,209.63	137.30
	Bank	52.66	59.31	-6.65
	Agency	24.00	18.01	5.99
	Cost (£)			
	Pay Cost (£'000) ^	£17,700	£17,900	-£200
UHDB	Workforce (WTE)			
	Total Workforce	13,813.92	13,608.88	205.04
	Substantive	12,795.77	12,682.67	113.10
	Bank	941.24	840.22	101.02
	Agency	76.91	85.99	-9.08
	Cost (£)			
	Pay Cost (£'000) ^	£66,700	£65,500	£1,200

^ For the Pay Cost, all trusts are using 'Total employee benefits excluding capitalised costs' for both budget & actual.

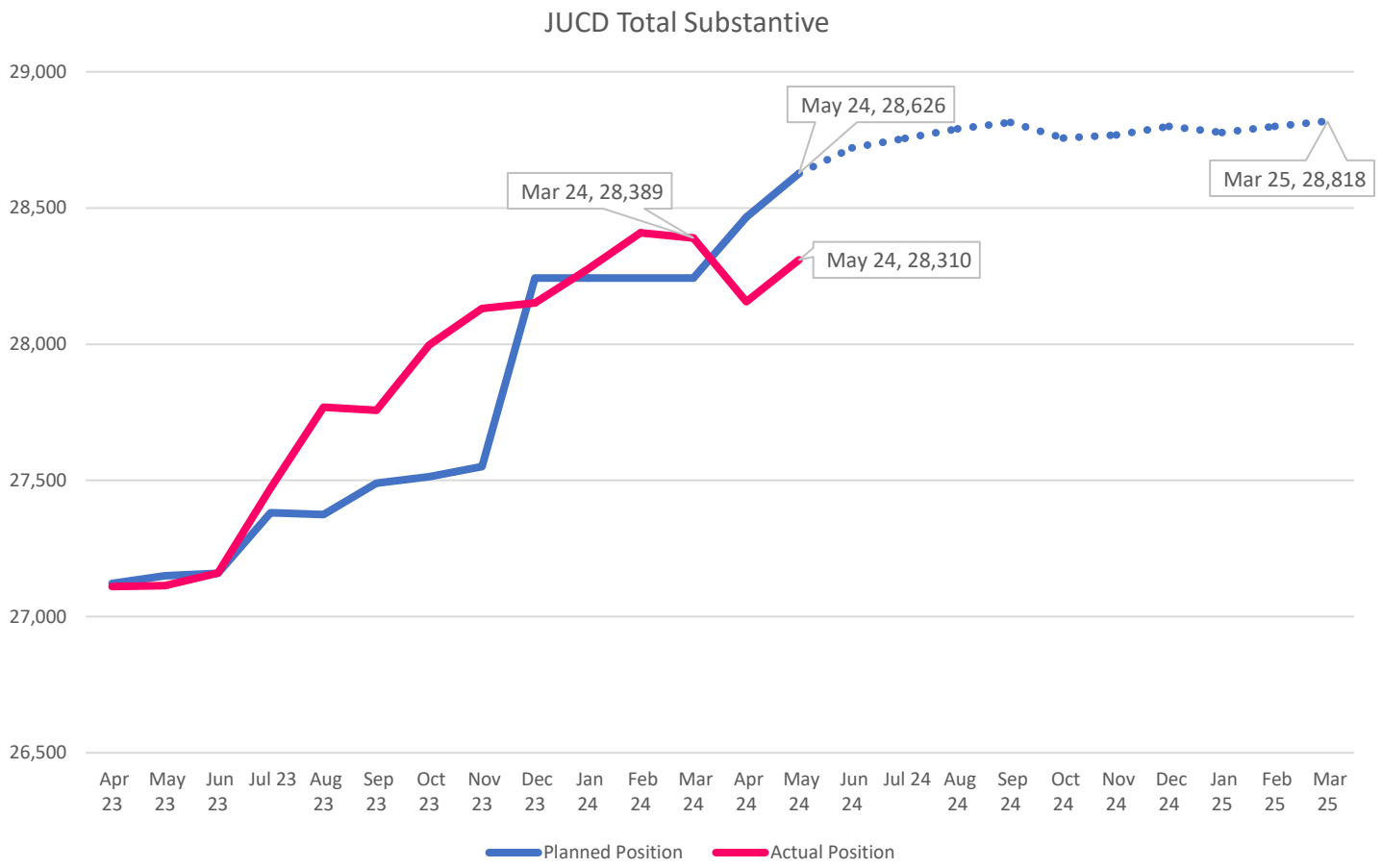
JUCD Workforce Trend (Total WTE)



- The **total** workforce position at M2 is 1.4% (440.09WTE) less than plan.
- All Providers are below plan.

Workforce Total WTE	2023 - 2024												2024 - 2025											
	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12
	Apr 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	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Planned	28,617	28,642	28,645	28,849	28,838	28,950	28,948	28,974	29,807	29,807	29,807	29,807	30,319	30,484	30,556	30,577	30,591	30,604	30,534	30,512	30,508	30,462	30,443	30,364
Actual	29,022	29,154	29,117	29,402	30,039	29,818	30,246	30,227	30,170	30,489	30,523	30,463	30,058	30,044										
Variance	-405	-512	-473	-552	-1,201	-868	-1,298	-1,252	-363	-681	-716	-656	261	440										

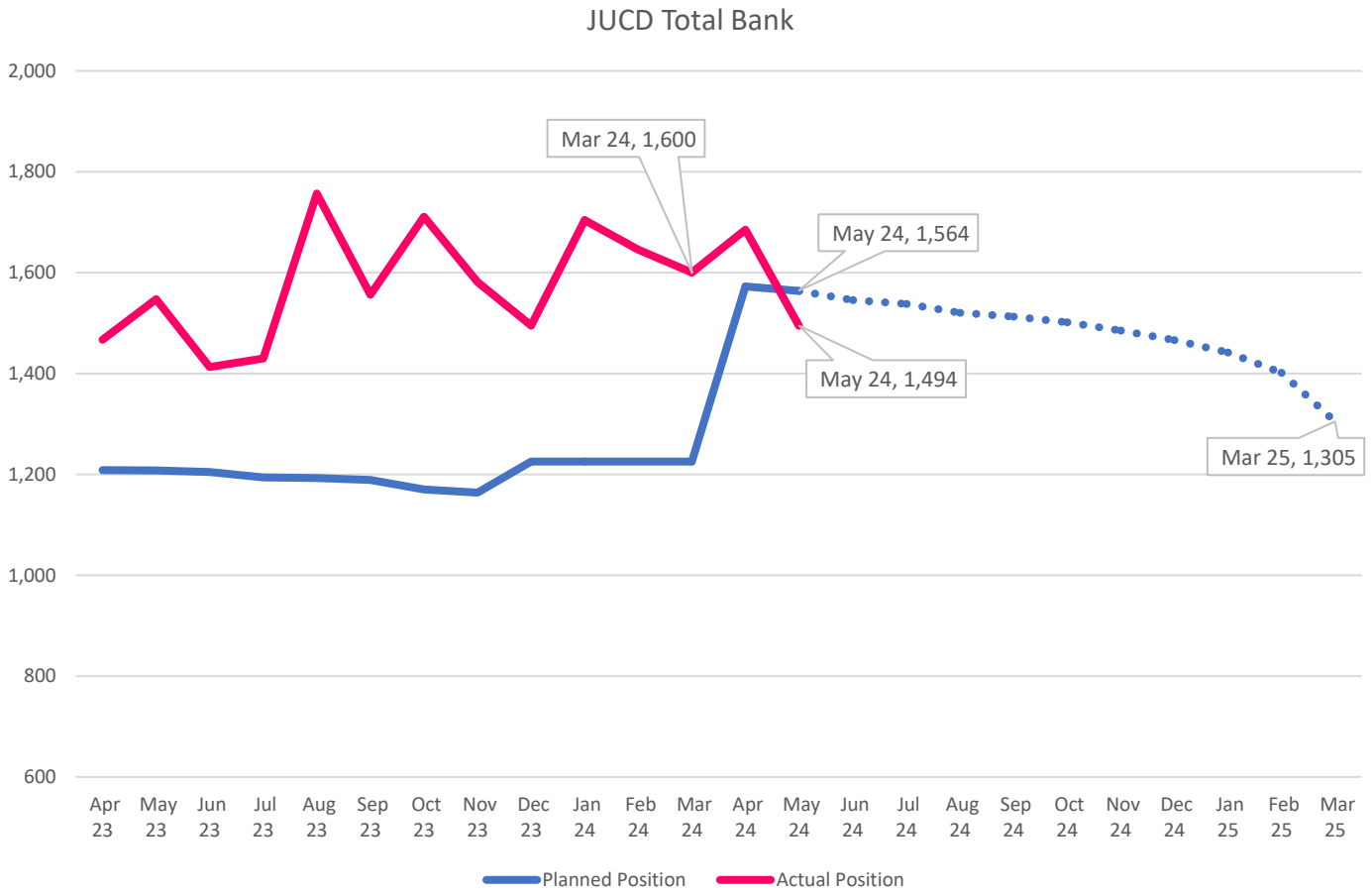
JUCD Workforce Trend (Substantive WTE)



- The **Substantive** workforce position at M2 is 1.1% (311WTE) less than plan.
- All Providers are under plan, except for CRH, which has an over plan position of 16.02WTE

Substantive Total WTE	2023 - 2024												2024 - 2025											
	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12
	Apr 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	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Planned	27,122	27,150	27,159	27,381	27,375	27,490	27,514	27,551	28,243	28,243	28,243	28,243	28,466	28,626	28,720	28,755	28,790	28,814	28,756	28,767	28,799	28,777	28,799	28,818
Actual	27,110	27,114	27,160	27,472	27,769	27,757	27,997	28,131	28,152	28,276	28,409	28,389	28,156	28,310										
Variance	12	36	-1	-91	-394	-267	-483	-580	91	-33	-166	-146	310	317										

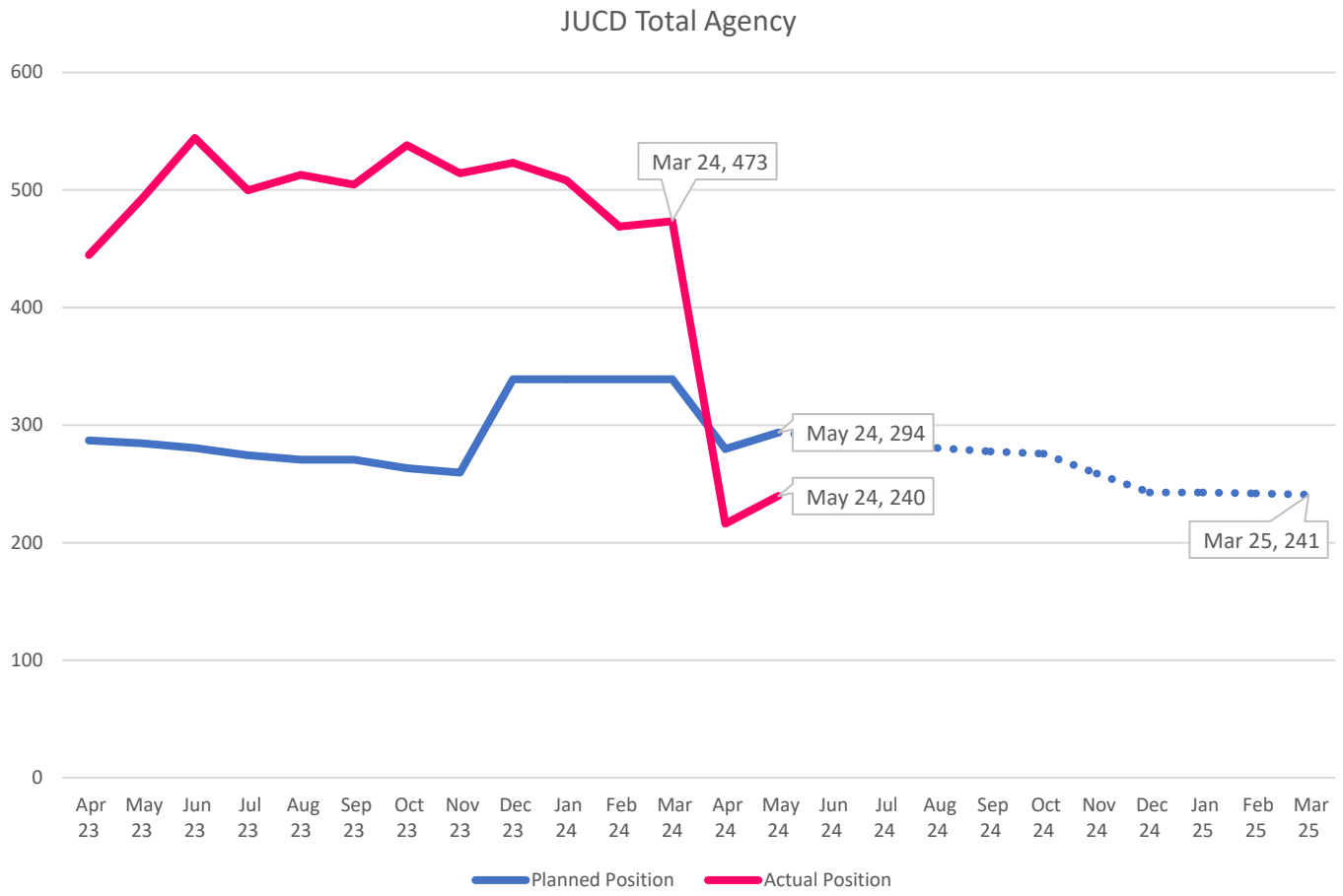
JUCD Workforce Trend (Bank WTE)



- The **Bank** workforce position at M2 is 4.5% (69.60WTE) less than plan.
- CRH, DCHS and UHDB are all below plan.
- 2 organisations are over their respective planned position:
  - DHcFT: 54.03 WTE
  - EMAS: 6.65 WTE

Bank Total WTE	2023 - 2024												2024 - 2025											
	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12
	Apr 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	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Planned	1,209	1,208	1,205	1,194	1,193	1,189	1,170	1,164	1,226	1,226	1,226	1,226	1,573	1,564	1,546	1,538	1,521	1,513	1,502	1,486	1,466	1,442	1,401	1,305
Actual	1,467	1,548	1,413	1,430	1,757	1,557	1,711	1,581	1,495	1,704	1,646	1,600	1,686	1,494										
Variance	-258	-340	-208	-236	-564	-368	-541	-417	-269	-478	-420	-374	-113	70										

JUCD Workforce Trend (Agency WTE)



- The **Agency** workforce position at M2 is 18.4% (53.99 WTE) less than plan.
- All Providers continue to make concerted efforts to ensure effective agency controls are in place. The only provider that over plan in M2 is UHDB with a marginal over plan position of 9.08 WTE.
- EMAS has now aligned planning and reporting with other system providers to record contracted WTE. As a result the 3rd party provider data is no longer included in the agency count. This has resulted in a decrease of ~ 200 WTE compared to the figures reported in 2023/24.

Agency Total WTE	2023 - 2024												2024 - 2025											
	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12
	Apr 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	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Planned	287	284	280	274	270	270	263	259	339	339	339	339	280	294	290	284	281	278	276	259	243	243	242	241
Actual	445	492	544	500	513	505	538	514	523	508	469	473	216	240										
Variance	-158	-208	-264	-225	-242	-234	-275	-255	-184	-169	-130	-134	63	54										

2023/24 Primary Care Workforce (M12)

Primary Care data is up to M12 due to the data availability from GP team. The data below provides a high-level overview of the primary care data to plan. Discussions continue to develop this further to provide a better understanding of primary care workforce.

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 STP	Year End	As at the end of			As at the end of	As at the end of			As at the end of	As at the end of			As at the end of	As at the end of			As at the end of
	(31-Mar-23)	Apr-23	May-23	Jun-23	Jun-23	Jul-23	Aug-23	Sep-23	Sep-23	Oct-23	Nov-23	Dec-23	Dec-23	Jan-24	Feb-24	Mar-24	Mar-24
Workforce (WTE)	Total WTE	Total WTE			Total WTE	Total WTE			Total WTE	Total WTE			Total WTE	Total WTE			Total WTE
Total Workforce	**3,378**	**3,367**	**3,377**	**3,385**	**3,439**	**3,394**	**3,434**	**3,424**	**3,548**	**3,447**	**3,469**	**3,505**	**3,614**	**3,554**	**3,573**	**3,641**	**3,647**
GPs excluding registrars	766	748	740	742	767	736	762	756	795	749	747	758	789	748	742	724	778
Nurses	364	353	354	353	365	349	343	341	363	337	337	338	363	337	342	342	361
Direct Patient Care roles (ARRS funded)	465	512	506	523	510	541	558	556	580	578	603	626	636	688	726	803	669
Direct Patient Care roles (not ARRS funded)	282	270	268	267	286	267	268	271	290	273	273	275	293	274	269	269	298
Other – admin and non-clinical	1,502	1,485	1,509	1,501	1,512	1,501	1,503	1,500	1,519	1,509	1,509	1,508	1,532	1,506	1,495	1,502	1,542

Summary

- At M12, the total workforce was only 6 WTE below plan. The gap was observed mainly from Direct Patient Care roles (ARRS funded) (-134WTE), GPs excluding registrars (+53WTE), and Other – admin and non-clinical staff (+40WTE).

Caveats to the data:

- Primary Care data is up to M12 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

Workforce establishment: M2 actuals (WTE) comparison to pay-bill (£)

Derby and Derbyshire Integrated Care Board

	M2 Pay Budget	M2 Pay Actual	M2 Pay Variance	YTD Pay Budget	YTD Pay Actual	YTD Pay Variance	Establish-ment (as per Finance)	Staff in Post (Substantive) M2 Actual	Vacancy *	Vacancy Rate *	Bank M2 Actual	Agency M2 Actual	Net Staffing (Substantive, Bank & Agency Total) M2 Actual	Establish-ment V Actual Variance
	£'000	£'000	£'000	£'000	£'000	£'000	WTE	WTE	WTE	%	WTE	WTE	WTE	WTE
ICB Total	135,600	134,600	1,000	269,300	267,800	1,500	30,362	28,310	2,052	6.76%	1494	240	30,044	318
CRH	22,500	22,400	100	44,600	44,900	-300	4,920	4,638	282	5.74%	283	88	5,009	-89
DCHS	14,500	14,900	-400	28,500	29,000	-500	4,022	3,823	199	4.94%	93	19	3,935	86
DHcFT	14,200	13,900	300	28,400	27,700	700	3,263	2,957	306	9.37%	218	29	3,204	59
EMAS ^	17,700	17,900	-200	35,300	35,700	-400	4,450	4,210	240	5.39%	59	18	4,287	163
UHDB	66,700	65,500	1,200	132,500	130,500	2,000	13,708	12,683	1,025	7.48%	840	86	13,609	99

Notes:

* For the purpose of this comparison exercise the vacancy numbers are based on the difference between establishment and staff in post as a proxy measure. It is recognised that there is a slight variance in the figures compared to those submitted in PWR and this is because of the establishment figures being extracted from the finance ledger whereas the vacancy actuals submitted on PWR are derived from ESR.

In the absence of the national requirement for monthly establishment plans, local arrangements have now been embedded, to monitor the workforce plan against the actual staffing levels that we have the budget for (i.e. costed WTE establishment).

At M2 there is an underspend against the pay budget of £1.00m with 318WTE under-establishment (total workforce). From the table above it can be observed that CRH is over-established (89WTEs), however CRH managed this within the planned pay-bill (underspend of £0.1m). DCHS and EMAS overspent by £0.4m and £0.2m respectively, even though both organisations are under established at M2.

Data Sources:
Provider Finance Return (PFR)
Finance – Deputy DoFs (extracted from Finance Ledgers)
Provider Workforce Return (PWR)

Agency Usage

Derby and Derbyshire Integrated Care Board

The planning guidance set out the following requirements in relation to agency usage:

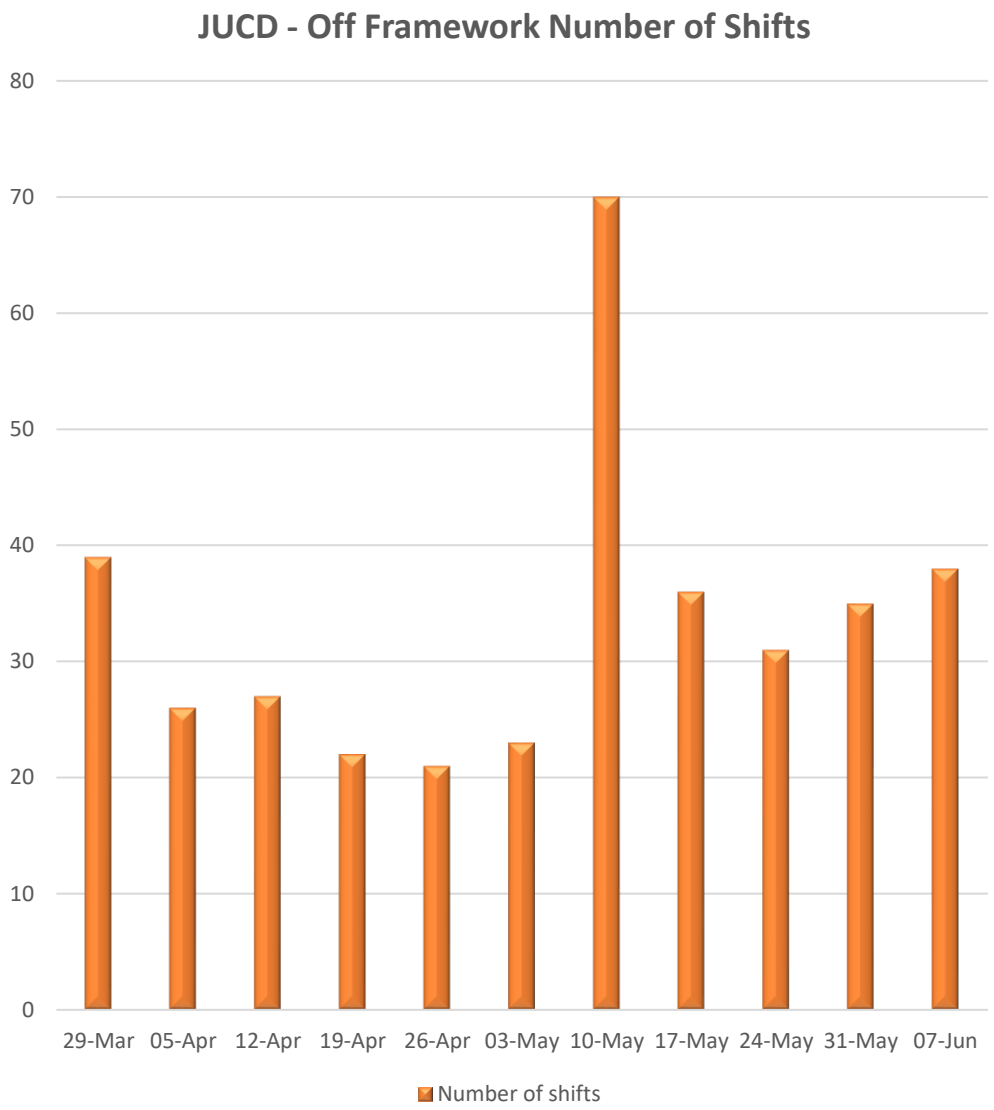
- Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill in 2024/25
- Improve agency price cap compliance and eliminate off-framework agency use (where this exceeds national framework rates). By July 2024, trusts are expected to end the use of all off-framework agencies, and in the intervening period all off-framework use must be signed off at chief executive level or through a designated deputy.

The table below shows summary of 2024/25 Planned Agency Spend as per 2 May Submission (Source: Finance)

Provider - Agency Cap	Joined Up Care Derbyshire ICB	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	EAST MIDLANDS AMBULANCE SERVICE NHS TRUST	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST
	System Total					
	Plan	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**
	31/03/2025	**31/03/2025**	**31/03/2025**	**31/03/2025**	**31/03/2025**	**31/03/2025**
	Year Ending	**Year Ending**	**Year Ending**	**Year Ending**	**Year Ending**	**Year Ending**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Agency & contract staff excluding capitalised staff costs	**(27,691)**	(5,691)	(1,134)	(6,283)	(953)	(13,630)
Total pay bill – substantive, bank, agency and other excluding capitalised staff costs	**(1,588,322)**	(258,313)	(169,998)	(170,193)	(220,507)	(769,311)
Agency costs as % of gross staff costs	**1.7%**	**2.2%**	**0.7%**	**3.7%**	**0.4%**	**1.8%**
System level agency cap	(41,731)					

Efforts continue to meet the requirement to end the use of all off-framework agencies by 1 July 2024, with action plans submitted on 24 May. A non-compliant plan was submitted because of the associated risks to achieving this target due to national staff shortages e.g. CAHMS consultants and we continue to explore what can be done in these areas. Arrangements for ongoing monitoring of this position are in place via the weekly return which is submitted to NHSE.

JUCD Off Framework Agency Usage



- There is a national requirement to eliminate all off-framework usage by 1 July 2024. JUCD submitted an action plan to NHSE on 24 May, at this stage it is not possible to meet this requirement due to the clinical risks associated with some of the roles where this usage is required.
- The reason for the ongoing utilisation is due to national challenges of filling posts such as Oncology Consultants and CAMHS consultants.
- Currently JUCD use on average 33 off framework shifts per week making up 4.0% of total agency shifts used.
- Providers are engaged in discussions to identify potential areas where there may be scope to transition agency staff members to on-framework providers and also looking at ay other solutions to remove off framework usage whilst managing the clinical risks of doing so.
- For the week ending 10 May the heightened use of off framework was due to clarification that Mental health practitioners at CRH were previously recorded as on framework but were actually off framework providers. CRH are addressing this issue.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th July 2024

Item: 039

Report Title	People and Culture Committee Assurance Report – June 2024							
Author	Lucinda Frearson, Executive Assistant							
Sponsor (Executive Director)	Linda Garnett, Interim ICB Chief People Officer							
Presenter	Margaret Gildea, Non-Executive Member and Chair of People & Culture Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Margaret Gildea, Non-Executive Member and Chair of People & Culture Committee							
Which committee has the subject matter been through?	People and Culture Committee – 27 June 2024							

Recommendations
The ICB Board are recommended to **NOTE** the People and Culture Committee Assurance Report.
Items to escalate to the ICB Board
No items to escalate.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the People and Culture Committee on the 27 June 2024.
Background
The People and Culture Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The People and Culture Committee's Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made; • major actions commissioned or work underway; • positive assurances received; and • comments on the effectiveness of the meeting.

Identification of Key Risks					
SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐

SR3	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 Not applicable to this report.		**Has this been signed off by a finance team member?** Not applicable.

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

Not applicable to this report.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable to this report.

Appendix 1

Derby and Derbyshire Integrated Care Board

Board Assurance Report

People and Culture Committee on 27th June 2024

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	It was decided to recommend to the ICB Board changes to the Board Assurance Framework (BAF) Strategic Risk 05 which involved amending the description to be more encapsulating of the risk along with a review of the controls.
Major actions commissioned or work underway	**Positive assurances received**
Committee were provided with a presentation and questions around the system culture and organisational development.	Due to the focus being mainly around financial recovery meant that not as much progress had been made but some had, and work was ongoing at the moment to update the JFP and it was felt there was a huge amount of skills and expertise within the system that would enable the creativity and delivery of the kind of interventions that were needed such as training, coaching and facilitation.
Latest Workforce Report update.	There was a significant challenge around the overall baseline position last year, work has been ongoing to ensure that those baseline positions reflect M12 out turn, with the exception of EMAS. The M2 position shows all providers are either on or below plan which is a good position to be in at this stage. Also, we are under in terms of the pay bill position, other systems are already experiencing a significant overspend at M2.
The system agency steering group will be having dedicated time out on the 9 July 2024 to look at some targeted areas. Going through detailed plan and highlighting specific tasks reliant on others such as finance or quality.	MG commented that there was significant assurance that the focus was there and that the processes were there, and that people were working together with best endeavours but significant assurance in terms of the actual output measures was not and that was limited assurance.
The health and wellbeing system programme or Hub has been disbanded for the time being due to withdrawal of NHS funding. The	

mental health and wellbeing hubs will continue in a revised format with commitment from both Local Authorities and the GP taskforce to continue the programme.	

Comments on the effectiveness of the meeting
The meeting was well attended and generated a lot of discussion covering several topics.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th July 2024

Item: 040

Report Title	ICB Staff Survey and Action Plan							
Author	James Lunn, Assistant Director of Human Resources & Organisational Development							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Staff Survey Action Plan							
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 results of the 2023 Staff Survey for NHS Derby and Derbyshire ICB and to **NOTE** the Action Plan.
Purpose
To provide assurance that the organisation will deliver an Action Plan as a consequence of the results of the NHS Staff Survey and this will align with the NHS People Plan.
Background
The 2023 National Staff Survey is the fifth survey that NHS Derby and Derbyshire ICB (formerly CCG) have undertaken. Our response figure at 84% is a slight decrease on last year (88%) but above the comparative average for similar organisations, which is 72%. Picker was commissioned by 29 Integrated Care Boards, including the Derby and Derbyshire ICB. For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements: 

In support of this, the results of the NHS Staff Survey are measured against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale).

The ICB is able to measure progress against the 7 People Promise themes compared to the 2022 survey data and with the previous 3 surveys for the Staff Engagement and Morale themes.

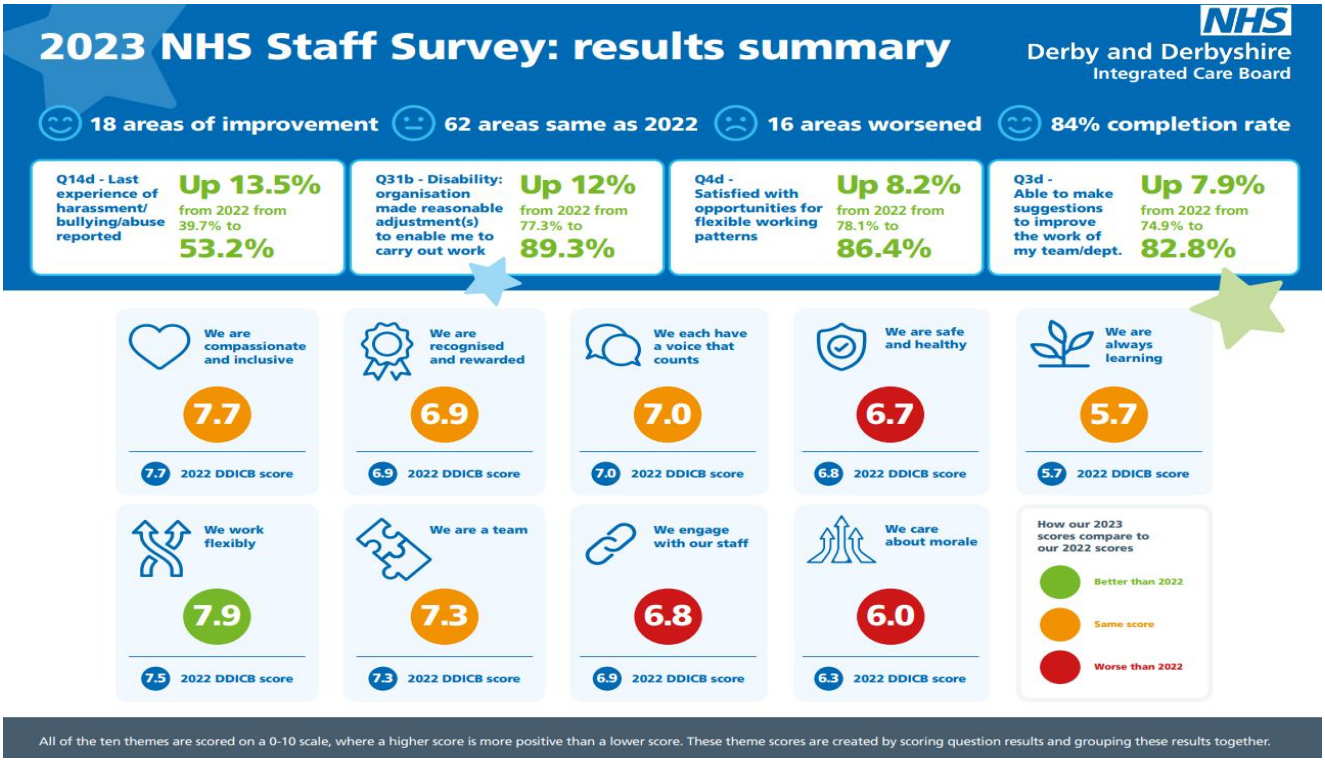
The organisational response to this report will be pivotal in driving forward improvement measures relating to our people. The staff survey results are shared with the Organisational Effectiveness and Improvement Group (OEIG) and the Diversity and Inclusion Network (DIN) and used to develop an Action Plan for the ICB.

From the 2022 staff survey Action Plan, the ICB have:

- Introduced:
  - Fair and Inclusive recruitment training, making it mandatory for all recruiting managers;
  - a new Dignity, Civility and Respect at Work policy;
  - a new appraisal process;
  - a leadership induction – to include values and behaviours expected of new leaders; and
  - a practical HR induction for new line managers.
- Continued to promote and embed the:
  - Disability and Long-Term Conditions Policy, including the Reasonable Adjustment Passport; and
  - Freedom to Speak Up Policy, appointed a FTSU Guardian.
- Commenced a Building Leadership for Inclusion Programme for the ICB Board and Executive Team.
- Promoted regular Health and Wellbeing initiatives in partnership with our System partners.

Report Summary

The infographic below provides a summary of the results of the staff survey.

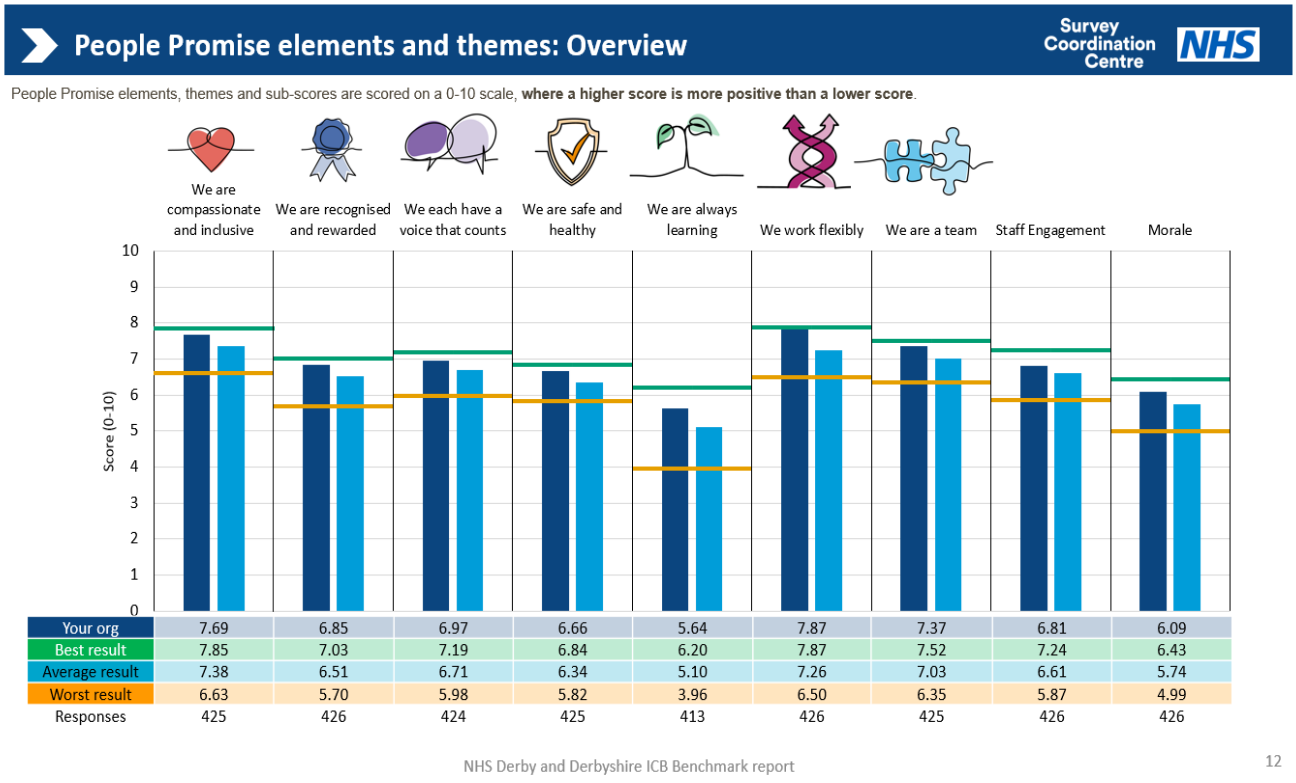


The ICB is able to measure progress against the 7 People Promise themes compared to the 2022 survey data and with the previous 3 surveys for the Staff Engagement and Morale themes. When compared with the previous year's staff survey results, the ICB has improved in one area, stayed the same in 5 areas and worsened in 3 areas (see table 1 below).

Table 1 – Staff Survey 2023 results compared to 2022.

	2022	2023
We are compassionate & inclusive	7.7	**7.7**
We are recognised and rewarded	6.9	**6.9**
We each have a voice that counts	7.0	**7.0**
We are safe and healthy	6.8	**6.7**
We are always learning	5.7	**5.7**
We work flexibly	7.5	**7.9***
We are a team	7.3	**7.3**
Staff Engagement	6.9	**6.8**
Morale	6.3	**6.0**

When compared to the similar organisations, DDICB is above average in all the themes. When compared to similar organisations the DDICB has the highest score for We Work Flexibly.



Derby & Derbyshire 2023 v 2022

Of the 100 questions, 96 can be compared to 2022. Of these, 18 questions scored significantly higher in 2023 (Table 2), with 62 no significant difference, and 16 areas scoring lower (Table 3).

The questions seeing the largest increase are:

- Last experience of harassment/bullying/abuse reported (+13.52%)
- Disability: organisation made reasonable adjustment(s) to enable me to carry out work (+ 11.95%)
- Satisfied with opportunities for flexible working patterns (+8.28%)

(A threshold of 3% is set to identify significant increase or decrease)

Table 2 – Derby and Derbyshire ICB 2023 V Derby and Derbyshire ICB 2022 – Significantly higher

Question	DDICB 2023	DDICB 2022	Difference
Able to make suggestions to improve the work of my team/dept	82.8%	74.9%	7.84%
Satisfied with level of pay	63.2%	55.8%	7.45%
Satisfied with opportunities for flexible working patterns	86.4%	78.1%	8.28%
Organisation is committed to helping balance work and home life	76.1%	71.0%	5.02%
Can approach immediate manager to talk openly about flexible working	92.0%	88.0%	4.04%
Team members often meet to discuss the team's effectiveness	70.5%	64.3%	6.27%
Team deals with disagreements constructively	65.0%	60.4%	4.60%
Feel valued by my team	78.4%	74.2%	4.14%
Immediate manager works with me to understand problems	85.2%	81.7%	3.46%
Immediate manager listens to challenges I face	86.8%	82.8%	3.98%
Immediate manager cares about my concerns	87.1%	83.3%	3.76%
Not felt pressure from manager to come to work when not feeling well enough	90.7%	86.8%	3.94%
Last experience of harassment/bullying/abuse reported	53.2%	39.7%	13.52%
Staff involved in an error/near miss/incident treated fairly	69.9%	64.9%	5.05%
Received appraisal in the past 12 months	92.8%	89.6%	3.22%
Organisation offers me challenging work	73.6%	70.4%	3.16%
Disability: organisation made reasonable adjustment(s) to enable me to carry out work	89.3%	77.3%	11.95%

The questions seeing the largest reduction are:

- Enough staff at organisation to do my job properly (-15.75%)
- There are opportunities for me to develop my career in this organisation (-10.90%)
- Care of patients/service users is organisation's top priority (- 7.76%)

Table 3 - Derby and Derbyshire ICB V Picker Average – Significantly lower

Question	DDICB 2023	DDICB 2022	Difference
Enough staff at organisation to do my job properly	24.9%	40.6%	-15.75%
Appraisal helped me improve how I do my job	16.5%	20.7%	-4.20%
There are opportunities for me to develop my career in this organisation	36.9%	47.8%	-10.90%

Equality, Diversity & Inclusion

Over the past 12 months, there has been a continued focus in activity designed to make diversity and inclusion part of our DNA. We have reviewed the terms of reference of the diversity and inclusion network, promoted key inclusion dates, implemented the Freedom to Speak Up Policy and implemented the Fair and Inclusive recruitment and selection training developed with the Diversity and Inclusion Network. The ICB has appointed a staff Freedom to Speak up Guardian and an additional Freedom to Speak up Ambassador. The ICB Board are participating in the building leadership for inclusion programme and this has recently been extended to the Delivery Group.

In the 2023 survey the experiences of our colleagues with a Disability are significantly worse in 69 areas and significantly better in just 2 areas. In the 2022 Staff Survey. 33 areas were significantly worse and 1 area better.

The biggest areas of difference between colleagues with a disability and those without are detailed in table 4**.**

Table 4

Question	Disability – Yes	Disability - No	Difference
Involved in deciding changes that affect work	41.1%	59.4%	-18.26%
Team members have a set of shared objectives	58.9%	77.1%	-!8.18%
In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	58.5%	82.5%	-23.94%
In last 12 months, have not felt unwell due to work related stress	51.6%	71.0%	-19.38%
In last 3 months, have not come to work when not feeling well enough to perform duties	28.2%	57.0%	-28.77%
Never/rarely find work emotionally exhausting	17.7%	36.2%	-18,44%

Never/rarely feel burnt out because of work	26.6%	45.1%	-18.44%
Never/rarely exhausted by the thought of another day/shift at work	31.5%	52.1%	-20.60%
Never/rarely worn out at the end of work	13.7%	30.5%	-16.77%
Never/rarely feel every working hour is tiring	48.4%	68.5%	-20.11%
Never/rarely lack energy for family and friends	33.9%	54.1%	-20.60%
Feel organisation respects individual differences	64.5%	81.5%	-16.77%
There are opportunities for me to develop my career in this organisation	24.2%	42.8%	-16.61%
Have opportunities to improve my knowledge and skills	57.3%	74.3%	-17.06%
Able to access the right learning and development opportunities when I need to	44.4%	65.8%	-21.40%
Care of patients/service users is organisation's top priority	55.6%	73.7%	-18.07%

The experiences of colleagues with a disability as assessed under the Workplace Disability Equality Scheme (WDES) are detailed in table 5.

Table 5

Disability (q31a)	Disability Yes 2023	Disability No 2023	Disability Yes 2022	Disability No 2022
Description	**n = 124**	**n = 293**	**n = 125**	**n = 314**
Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients, managers or colleagues	26.6%	12.6%	31.2%	12.4%
Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	50.0%	58.1%	40.0%	40.6%
Percentage of disabled staff compared to non-disabled staff believing that their trust provides equal opportunities for career progression or promotion	56.2%	58.7%	51.6%	66.0%
Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	12.5%	7.3%	15.7%	10.5%
Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	37.1%	52.7%	45.6%	59.2%
Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	89.3%	*	77.3%	*
Staff Engagement Score	6.2	7.0	6.6	7.1

The experiences of our minority ethnic colleagues (Mixed, Multiple, Asian, Asian British, Black, African, Caribbean, Black British and Other Ethnic Group) are significantly better than white colleagues in 27 areas with relationships within the team being overall more positive, our minority ethnic colleagues feel they have realistic time pressures and are more likely to feel that their role makes a difference to patients and service users

However, there are 32 questions which are significantly worse, which is an increase from the 26 areas in the 2022 Survey. Most notably, our minority ethnic colleagues feel less satisfied with the level of pay, and *less satisfied that the organisation acts fairly regarding career progression*, and less satisfied with recognition for good work. In addition, minority ethnic colleagues feel that they are less likely to be treated fairly if involved in an error/near miss/incident, that the organisation respects individual differences or that the organisation ensures near misses, errors or incidents are not repeated.

The 10 questions with the highest difference between white colleagues and colleagues from mixed/multiple ethnic groups, Asian, Asian British, Black/African/Caribbean/Black British, Other ethnic groups are detailed in Table 6.

Table 6

Questions	White	Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups	Difference
Satisfied with recognition for good work	69.6%	52.5%	-17.08%
Satisfied with extent organisation values my work	50.1%	35.0%	-15.13%
Satisfied with level of pay	66.5%	35.0%	-31.49%
Never/rarely feel burnt out because of work	41.5%	25.0%	-16.53%
Never/rarely lack energy for family and friends	50.9%	30.0%	-20.93%
Organisation acts fairly: career progression	61.3%	33.3%	-28.00%
Staff involved in an error/near miss/incident treated fairly	72.4%	47.4%	-25.06%
Organisation ensure errors/near misses/incidents do not repeat	76.0%	50.0%	-26.00%
Feel organisation respects individual differences	78.5%	65.0%	-13.51%
Feel organisation would address any concerns I raised	57.9%	40.0%	-17.94%

Table 7 – Comparison of WRES questions

	2023 Minority ethnic	2023 White	2022 Minority ethnic	2022 White	2021 Minority ethnic	2020 Minority ethnic	2019 Minority ethnic
Not experienced physical violence from patients/service users, their relatives or other members of the public	100%	97.5%	95.3%	93.9%	100%	100%	96%
Not experienced harassment, bullying or abuse from other colleagues	97.5%	100%	86%	88.5%	87.1%	80%	85%
Organisation acts fairly: career progression	33.3%	61.3%	37.2%	64.8%	45.7%	45%	56%
Not experienced discrimination from manager/team leader or other colleagues	97.4%	99.7%	88.4%	94.9%	88.6%	71%	85%

The experiences of colleagues from a minority ethnic group are worse in 3 out of 4 areas assessed under the Workplace Racial Equality Scheme (WRES). See table 8

Table 8

Ethnicity summary (q28)	White 2023	Mixed/ Multiple ethnic groups, Other ethnic groups 2023	White 2022	Mixed/ Multiple ethnic groups, Other ethnic groups 2022
Description	n = 378	n = 40	n = 392	n = 43
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	5.6%	0.0%	6.1%	4.7%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	12.7%	15.0%	11.5%	14.0%
Percentage of staff believing that trust provides equal opportunities for career progression or promotion	61.3%	33.3%	64.8%	37.2%
Percentage of staff experiencing discrimination from staff in last 12 months	4.6%	12.5%	5.1%	11.6%

The experiences of our colleagues who identify as Gay, Lesbian, Bisexual and Other are significantly worse in 56 areas (worse in 50 areas in 2022). Gay, Lesbian, Bisexual and Other colleagues were significantly better in 19 areas in 2023 which is an increase of 4*.

*When compared to heterosexual colleagues. The biggest areas of difference are detailed in table 9 below.

Table 9

Question	Heterosexual/straight	Gay / Lesbian/ Bisexual, Other	Difference
Opportunities to show initiative frequently in my role	74.3%	52.6%	-21.69%
Can approach immediate manager to talk openly about flexible working	94.9%	73.7%	-21.18%
Team members often meet to discuss the team's effectiveness	72.8%	52.6%	-20.19%
Immediate manager gives clear feedback on my work	83.2%	52.6%	-30.52%
Immediate manager asks for my opinion before making decisions that affect my work	80.8%	52.6%	-28.13%
Immediate manager values my work	89.4%	68.4%	-21.01%
Immediate manager works with me to understand problems	87.8%	68.4%	-19.38%
Immediate manager listens to challenges I face	89.4%	68.4%	-21.01%
Immediate manager cares about my concerns	89.7%	68.4%	-21.28%
Immediate manager helps me with problems I face	82.9%	57.9%	-25.03%
Disability: organisation made reasonable adjustment(s) to enable me to carry out work	94.1%	70.0%	-24.12%

The equality data from the survey has been shared with members of the Diversity & Inclusion Network with a view to better understanding the reasons and to develop the recommended action plan (Appendix 1). Further discussions will also be held with the Diversity and Inclusion Network to review the Too Hot to Handle Report into racism in the NHS, as well as the Gender Pay Gap, Workplace Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) data.

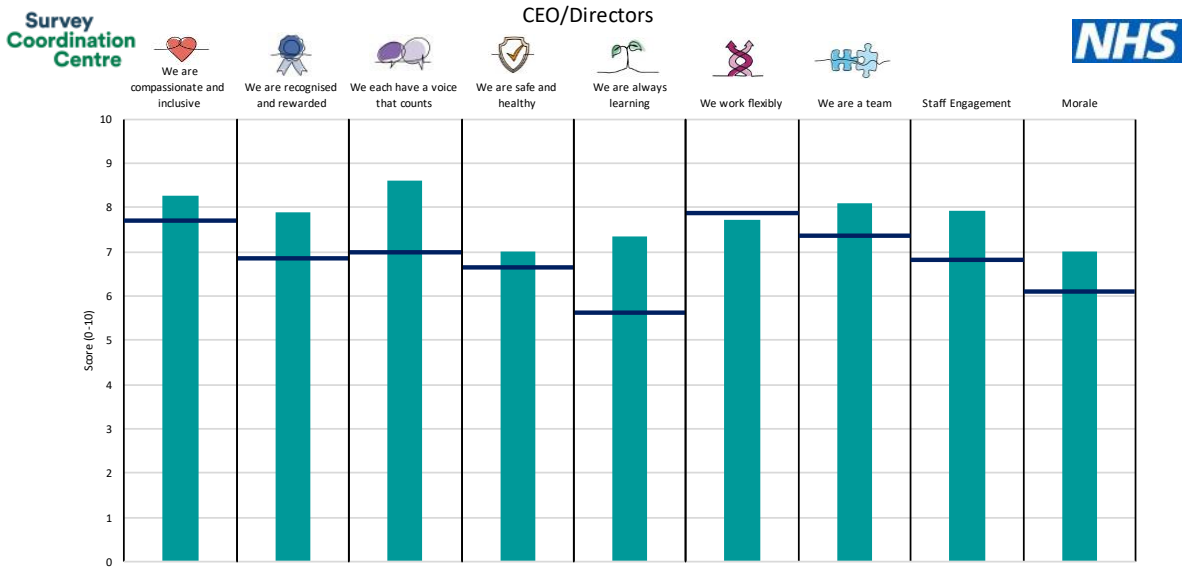
Directorate Level Data

The breakdown of the staff survey results for each Executive Director are shown below. These results are compared to the unweighted average for our organisation.

The directorate breakdowns used in this report reflect the structures within NHS Derby and Derbyshire ICB, as at the time of submission. In order to receive comparable data the participant threshold is 10 to ensure anonymity.

The CEO/Directors are above the average for the ICB in 8 / 9 categories, with We Work Flexibly scoring slightly below average. The Corporate Affairs directorate and Nursing and Quality directorate scored consistently above average in 9/9 categories.

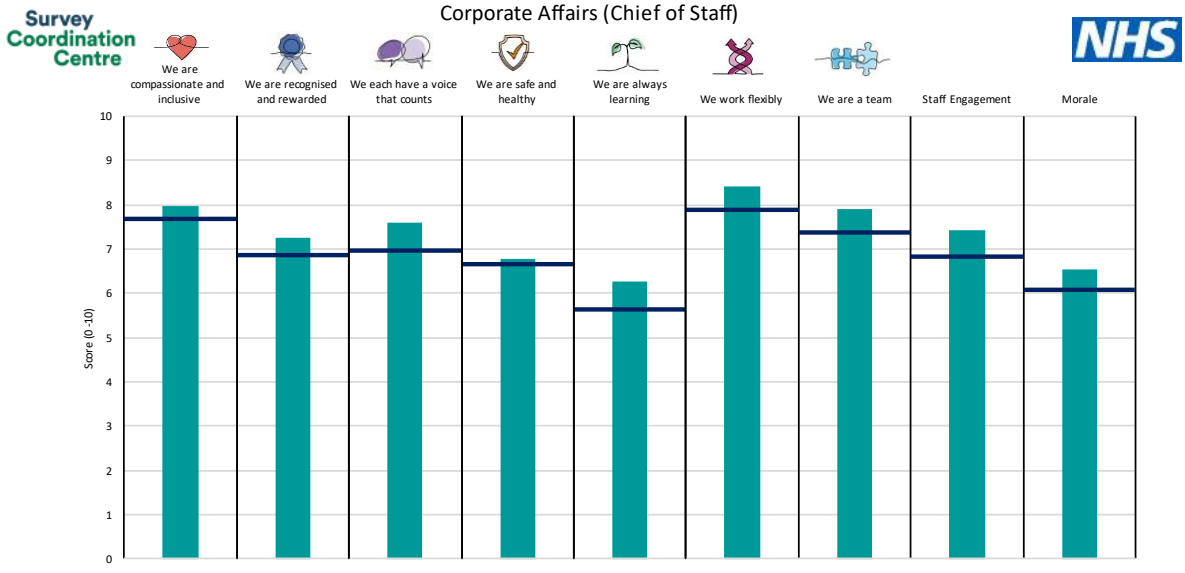
CEO/Directors



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	8.27	7.88	8.61	7.01	7.33	7.72	8.11	7.92	6.99
Your org	7.69	6.85	6.97	6.66	5.64	7.87	7.37	6.81	6.09
Responses	13	13	13	13	13	13	13	13	13

6

Corporate Affairs (Chief of Staff)

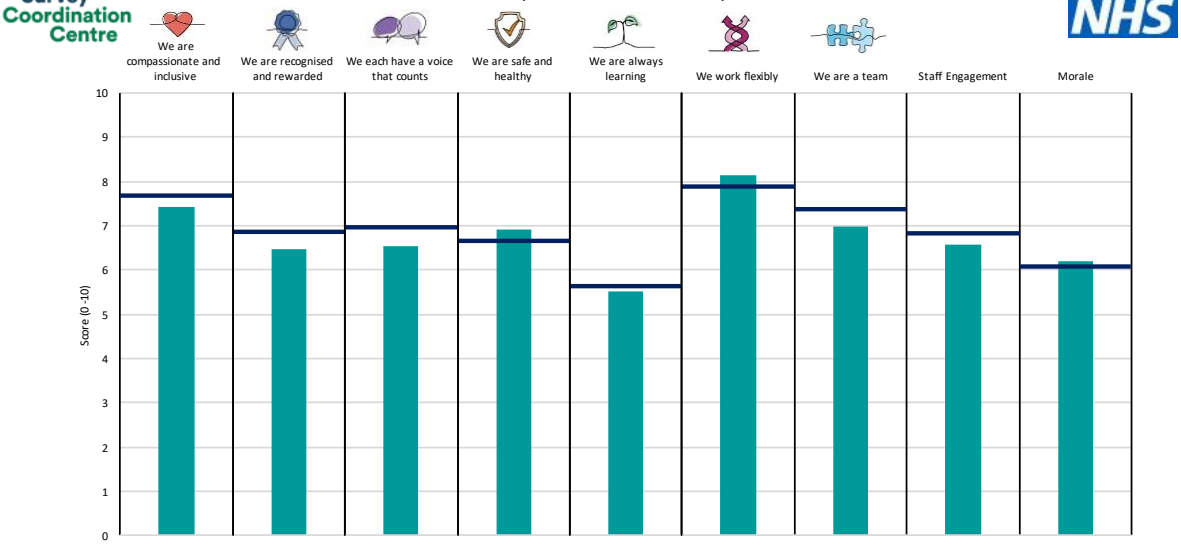


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.97	7.26	7.60	6.78	6.25	8.42	7.92	7.42	6.52
Your org	7.69	6.85	6.97	6.66	5.64	7.87	7.37	6.81	6.09
Responses	50	51	51	50	51	51	50	51	51

7

Finance (Chief Finance Officer)

Survey Coordination Centre



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.43	6.46	6.54	6.92	5.52	8.15	6.97	6.58	6.18
Your org	7.69	6.85	6.97	6.66	5.64	7.87	7.37	6.81	6.09
Responses	37	37	37	37	37	37	37	37	37

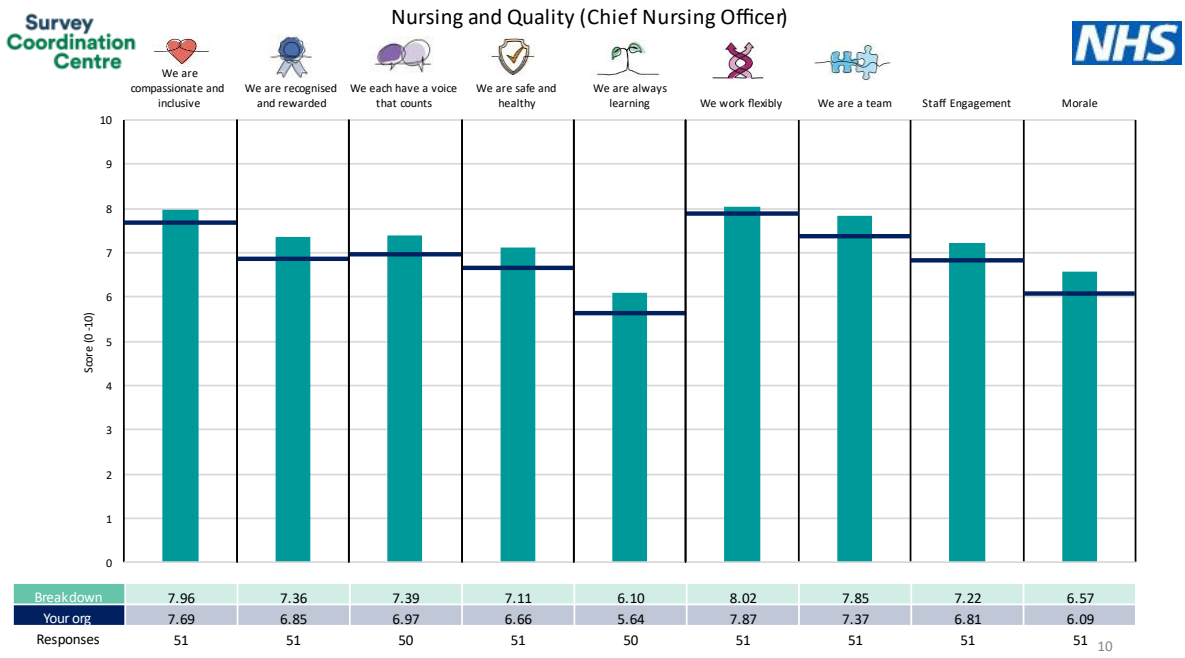
8

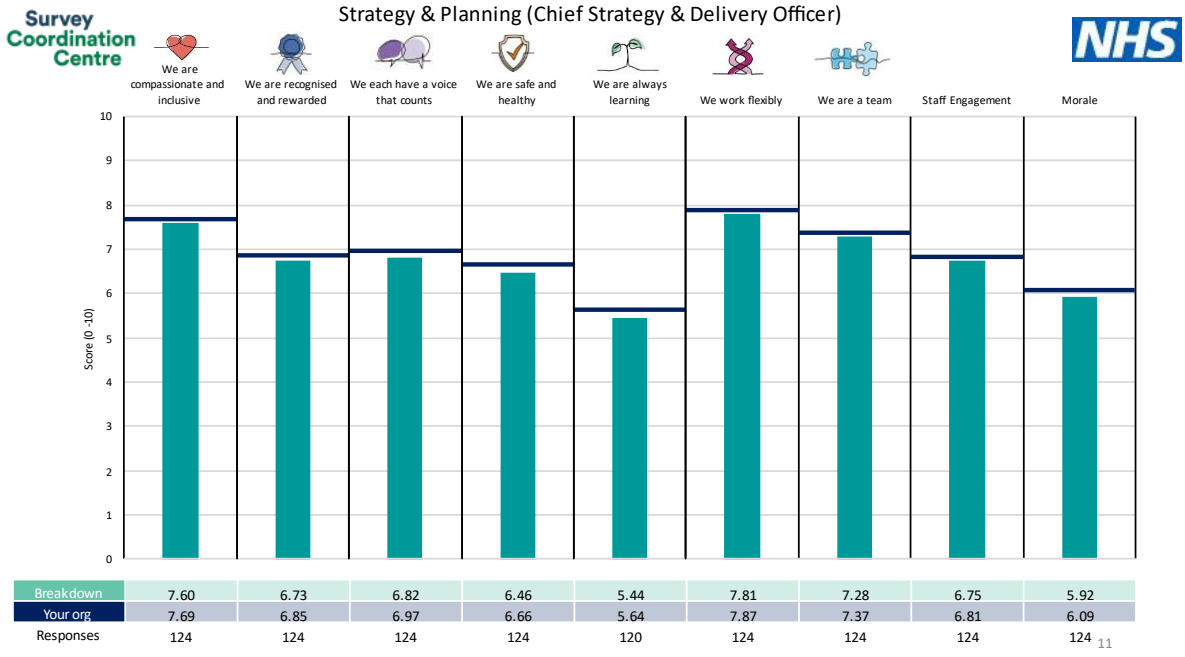
Medical (Chief Medical Officer)

Survey Coordination Centre

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.58	6.64	6.71	6.53	5.30	7.63	7.13	6.47	5.82
Your org	7.69	6.85	6.97	6.66	5.64	7.87	7.37	6.81	6.09
Responses	150	150	149	150	142	150	150	150	150

9





Actions taken to date

1. Staff Survey reports shared with Executive Team on 28th February 2024)
2. High level overview of the staff survey results communicated to all staff on 7th March 2024
3. Summary of the staff survey findings presented at Team Talk on 12th March 2024
4. Results shared with the Organisational Effectiveness and Improvement Group (OEIG) and the Diversity and Inclusion Network (DIN).
5. Joint OEIG and Diversity & Inclusion Network away day held on 16th May 2024 to discuss staff Survey and recommend actions for the ICB
6. Chief of Staff and Assistant Director of HR&OD met with Executive Directors to review the staff survey for their areas, discuss within their own teams and develop local plans:

Following consideration of the recommended Action Plan by the ICB Board, the action plan will be shared with all staff via Team Talk and reported to the Audit and Governance Committee for oversight and assurance.

The Action Plan will form part of the overall ICB Organisational Development Plan with updates being communicated to ICB colleagues on quarterly basis.

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.	☐

Staff experiences whilst working in the ICB can impact organisational performance and delivery. It is important to listen to and take action on the results of the survey to improve the experience of all staff working within the ICB.

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.

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.

Appendix 1 - Staff Survey Action Plan

Agreed Actions	Owner	Start Date	Due Date	RAG Status	Update	How Measured
We are compassionate & inclusive						
• **Board members to actively participate in the Building Leadership for Inclusion development programme** (include Delivery Group)	Chief of Staff	Sept 2023	Dec 2024	Green	Programme underway for Board. Initial session held with Delivery Group	Staff survey results Quarterly pulse checks
• **Implement the 6 High Impact Actions** (detailed in the nhs equality diversity and inclusion improvement plan published June 2023)	Chief of Staff/ICB CPO	June 2023	Jan 2026	Amber	An operational plan is in place, which identifies owners and timescales for each action	Reduction in disparity of staff with protected characteristics
• **Co-produce an Anti-Racism Strategy** (to include clear anti-racist commitments, commissioning the right development for leaders, managers and staff having practical tools to intervene – **Active Bystander Training**)	Director of Comms & Engagement/ Asst. Director of HR & OD	Sep 2024	Apr 2025	Amber	To commence in September	Proportionate success rate at each stage of the recruitment process
• **Wider roll out of Reverse/reciprocal mentoring for senior leaders/line managers**	Asst. Director of HR & OD	Apr 2024	Jan 2025	Green	Soft launch commenced – mentors received training. Wider roll out to commence Jan 2025	
• **Review of reasonable adjustment passport** (Managers to check colleagues have the necessary equipment/ adjustments)/**promotion of Access to Work**	Senior HR Business Partner	Sep 2024	Mar 2025	Amber	To commence in September	
• **Bitesize awareness training sessions** on protected characteristics at Team Talk (e.g. menopause, Neurodiversity awareness, hidden disabilities)	Asst. Director of HR & OD	Sep 2024	Mar 2025	Amber	Programme to be developed with D&IN	

We are recognised and rewarded • **Roll out a 360-degree appraisal process for manager**	Asst. Director of HR & OD	Jan 2025	July 2025	Red	Need to agree system and budget	Staff survey results
• I**mplement appraisal training for all staff** (*to address appraisal helped to do my job, clear objectives, extent ICB values work)*	HR Business Partner	July 2024	Mar 2025	Green	Training dates in place	100% Appraisals completed and on time
• **Objectives cascaded through Executives to their line managers for inclusion in individual appraisal objectives**	Chief of Staff	July 2024	Apr 2025	Amber	Currently being rolled out as part of appraisal and six monthly review process	
• **Promote the ICB values and behaviours – align with recognition of individuals and teams (**celebrate successes at Team Talk/ in Staff Bulletin**)**	Director of Comms & Engagement/ Asst. Director of HR & OD	Apr 2024	Mar 2025	Green	Staff stories being promoted at Team Talk	
We each have a voice that counts • **Continue to promote the FTSU Guardian role and culture of speaking up**	HR/ FTSU Guardian	Apr 2024	Mar 2025	Green	Promoted at Team Talk. Guardian report to ICB Committee.	Staff survey results Quarterly pulse checks
• **OEIG & D&IN representatives attend Delivery Group on a regular basis, feedback and provide input into organisational development** (e.g. to provide a formal update on activity current and planned)	Director of Comms & Engagement/ Asst. Director of HR & OD	Aug 2024	Mar 2025	Green	Review of Terms of reference underway and dates agreed	Increase in staff speaking up, feedback leading to change where needed

We are safe and healthy • **Leadership and Management development** (to include being a kind, compassionate and inclusive manager with a focus on wellbeing) • **Continued promotion of staff wellbeing offer**	ICB HR Director Senior HR Business Partner	June 2024 Apr 2024	Sep 2024 Mar 2025	Green Green	In progress Regular updates in People Matter and Team Talk communications	Staff survey results Quarterly pulse checks Number of formal complaints Sickness absence rates
We are always learning • **To ensure consistency across the ICB, HR to deliver line management briefings for new Policies including case studies to reinforce learning** • **Executive Director one to one meeting to review the staff Survey results for their directorate** (directorate action plans) • **Triangulation of staff survey results, sickness/ turnover/complaints/disputes data (**to identify specific areas of focus)	Senior HR Business Partner Chief of Staff/ Asst. Director of HR & OD Asst. Director of HR & OD	Apr 2024 Apr 2024 Aug 2024	Mar 2025 July 2024 Dec 2024	Green Green Amber	HR schedule in when new policy launched/ Action completed – each directorate to develop local plans To commence in August	Staff Survey results Quarterly pulse checks Learning & Development uptake
We work flexibly • **Promote all jobs/ career development opportunities as open to flexible working**	Senior HR Business Partner	Apr 2024	Mar 2025	Green	In place - Positive statement in all job adverts	Staff survey results Number of flexible working requests submitted/approved
We are a team • **Develop a revised staff communications, engagement and organisational development programme to support connectivity across the ICB, post-restructure, incorporating work on values, priorities, recognition and connectivity.**	Director of Comms & Engagement	Apr 2024	Mar 2025	Amber	In progress	Staff survey results Quarterly pulse checks

Staff Engagement • **Develop a revised staff communications, engagement and organisational development programme to support connectivity across the ICB, post-restructure, incorporating work on values, priorities, recognition and connectivity.**	Director of Comms & Engagement	Apr 2024	Mar 2025	Amber	In progress	Staff survey results Quarterly pulse checks Turnover/retention data

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th July 2024

Item: 041

Report Title	Audit and Governance Committee Assurance Report – June 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:	Not applicable.							
Which committee has the subject matter been through?	Not applicable.							

Recommendations
The ICB Board are recommended to **NOTE** the Audit & Governance Assurance Report.
Items to escalate to the ICB Board
There are no items to escalate to the Board. The issues raised last time regarding the completion of Internal Audit reviews have been addressed,
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Audit & Governance Committee on the 19th June 2024.
Background
The Audit & Governance Committee ensures that the ICB effectively delivers the statutory functions of the ICB. The June Committee has a particular focus on the completion and approval of the audited annual report and accounts. The Committee were able to approve these key documents for sign off and in doing so noted the hard work of both the finance and governance teams and the positive comments received from the External Auditors on the quality of the documents presented for audit. An unqualified opinion and value for money conclusion were given before the deadline.

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 to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Appendix 1

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Audit and Governance Committee on 19th June 2024

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	Approved the Annual Accounts for 2023/24 including the minor presentational changes since the draft in May Approved the Annual Report for 2023/24 including the minor presentational changes since the draft in May. Delegated responsibility for any subsequent minor changes to the Chief Executive Officer and Executive Director of Finance. In approving all three of the above the Committee noted the hard work that has gone into preparing these documents within a tight timeframe to such high quality. Positive comments were also received from the external auditors in support of the documents approved. Approved the DDICB New and Emerging Infectious Diseases and Pandemics Plan, DDICB On Call Policy and DDICB Evacuation and Shelter Policy.
Major actions commissioned or work underway	**Positive assurances received**
Noted that the review into learning from the major 111 procurement remains outstanding. Noted the progress being made to comply with the required Fit & Proper Person Test submission which satisfied us that the submission would be made as required.	Took positive assurance from the External Auditor's completion report which was positive about the quality of the financial statements and annual report presented for audit and the responsiveness of the finance and governance teams. The report identified that upon completion of the few outstanding elements the External Auditors would be giving an unqualified opinion and raising not significant issues on the value for money conclusion. Took positive assurance from Internal Audit's Head of Internal Audit Opinion of significant assurance which has been incorporated into the annual governance statement.

	Took positive assurance from the Emergency Preparedness, Resilience and Response update noting the increased national focus on cyber resilience following the recent issues in London. We noted the revised arrangements for the assurance group that will now support EPRR, business continuity and health and safety. Took positive assurance from the ICB Board Assurance Framework, Corporate Risk Register report and the risks responsible to the Audit and Governance Committee which confirmed that risks are being monitored and managed on an ongoing basis and that all committees are in the process of reviewing the underlying threats and associated actions. Took positive assurance from the procurement highlight report that most contracts were on track and compliant with the regulations. Took reasonable assurance from the conflicts of interest update which shows 72% compliance with the annual declaration process and noted the active chasing to be completed this month. Took reasonable assurance on the Month 1 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 positive assurance from the NHSE letter on delivering Net Zero which identified us as having a maturing programme which recognises the progress made to date. Took positive assurance from the committee annual report and self- assessment that the Committee is fulfilling it's role effectively and in particular that combining audit and governance has not impacted on the committee's ability to obtain sufficient assurance in both areas.
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

18th July 2024

Item: 042

Report Title	Public Partnership Committee Assurance Report – June 2024							
Author	Sean Thornton, Director of Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Richard Wright, Non-Executive Member and Chair of Public Partnership Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Richard Wright, Non-Executive Member and Chair of Public Partnership Committee							
Which committee has the subject matter been through?	Public Partnership Committee, 25th June 2024 (Extraordinary Meeting)							

Recommendations
The ICB Board are recommended to **NOTE** the Public Partnership Committee Assurance Report.
Items to escalate to the ICB Board
No matters of concern or key risks to escalate.
Purpose
This report provides the ICB Board with highlights from the extraordinary meeting of the Public Partnership Committee on the 25th June 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 June meeting was an extraordinary meeting to review time-sensitive schemes which required committee assurance. This report provides a summary of the items transacted.
Background
The Public Partnership Committee ensures that the ICB effectively delivers the statutory functions of the ICB in relation to patient and public involvement. The committee also seeks, through its terms of reference, to drive citizen engagement in all aspects of the ICB's work to ensure that local people are central to planning and decision-making processes.
Report Summary
The Derbyshire Public Partnership Committee Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made;

- major actions commissioned or work underway;
- positive assurances received; and
- comments on the effectiveness of the meeting.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	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.

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.

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

No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☐	Inclusive leadership	☐
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?			
None raised as a result of the items reviewed at these meetings.			

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

Appendix 1

NHS
Derby and Derbyshire
Integrated Care Board

Board Assurance Report

Public Partnership Committee on 25th June 2024 (Extraordinary Meeting)

Matters of concern or key risks to escalate	Decisions made
None recorded at this extraordinary meeting.	<u>Board Assurance Framework (BAF) & Corporate Risks</u> The Board Assurance Framework and Corporate Risks were not reviewed during this extraordinary meeting. <u>Learning Disability Short Breaks</u> The Committee supported the engagement approach being proposed to support the review of Learning Disability Short Breaks currently commissioned in north Derbyshire. The review would engage with stakeholders across Derby and Derbyshire to ensure equity of service provision in line with best practice and within the financial envelope available. <u>Howard Street GP Practice Merger</u> The Committee supported the engagement approach being taken to enable patients to comment on proposals to merge two closely-located GP practices in Glossop. The practices already benefit from single management and the practices' Patient Participation Group (PPG) has been fully involved in the planning and execution of the engagement.
Major actions commissioned or work underway	**Positive assurances received**

• Board Assurance Framework action plan – ongoing delivery of mitigating actions
• East Midlands Fertility Policy Review
• Recruitment to committee lay member vacancies
• Review of approach to committee/sub-group diversity.
• Establishment of Lay Reference Group.
• Ongoing development of engagement frameworks
  ○ Insight Framework
  ○ Governance Framework
  ○ Evaluation Framework
  ○ Co-production Framework
  ○ Engagement Framework
	The Committee did not review routine sources of assurance during this extraordinary meeting. These would ordinarily include the Patient and Public Involvement Log, progress on the committee performance report and other sources.
	
	<u>Engagement Model Implementation</u>
	Assurance was received on the examples of engagement planning being presented to the committee. These were evidence of the implementation of the approved engagement model, with the following highlights:
	
	Learning Disability Short Breaks – the scheme has embraced the ICB's engagement model in implementing engagement plans, with a comprehensive case for change, the collection of existing service insight and a demonstrable desire to engage patients and families in the review from the outset. This will be

	supported by commissioned advocacy services to ensure that families are able to engage with the review in their own way. Howard Street – the approach to engaging local patients is fully in line with the recently agreed approach to assurance on matters relating to general practice. The merging of practices brings this matter into the scope of the Public Partnership Committee work and assurance was received that an engagement approach built with and around the Practice Participation Group was the correct model.
Comments on the effectiveness of the meeting	
The committee reviewed a series of assurance questions and agreed that the meeting had been effective.	

NHS
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Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th July 2024

Item: 043

Report Title	Corporate Committees' Annual Reports 2023/24							
Author	Fran Palmer, Corporate Governance Manager							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Annual Reports							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Audit & Governance Committee – 19/06/24 Finance, Estates & Digital Committee – 25/06/24 People & Culture Committee – 27/06/24 Population Health & Strategic Commissioning Committee – 13/06/24 Public Partnership Committee – 30/04/24 Quality & Performance Committee – 27/06/24 Remuneration Committee – approved virtually							

Recommendations

The ICB Board are recommended to **NOTE** the Committee Annual Reports for 2023/24.

Purpose

It is a requirement for Committees of the ICB to produce an Annual Report each financial year, as set out in the Committee's Terms of Reference.

Background

As above.

Report Summary

Committee Annual Reports for 2023/24 (see Appendix 1) provides the ICB Board with a review of the work that each Committee has completed during the period 1st April 2023 to 31st March 2024 A conclusion has been provided by each Committee Chair.

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 further risks identified.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

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

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

Not applicable to this report.

Project Dependencies

Completion of Impact Assessments

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

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

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?					
None identified.					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable to this report.					

NHS
Derby and Derbyshire
Integrated Care Board

Audit & Governance Committee Annual Report 1st April 2023–31st March 2024

AUDIT & GOVERNANCE COMMITTEE ANNUAL REPORT

1st April 2023–31st March 2024

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Audit & Governance Committee and covers the period from 1st April 2023 to 31st March 2024.

1.2 The report provides the ICB Board and Accountable Officer with evidence relevant to their responsibilities in relation to the Assurance Framework and Governance Statement. The production of an annual report is recommended good practice for all UK based audit committees and is included in the NHS Audit Committee Handbook.

1.3 The operation of the Audit & Governance Committee is a central means by which the ICB Board ensures effective internal control arrangements are in place which comply with the principles of good governance, whilst effectively delivering the statutory functions of the ICB.

2. CONTEXT

2.1 The Audit & Governance Committee is accountable to the ICB Board and is constituted in line with the provisions of the NHS Audit Committee Handbook and the guidance issued by the UK Financial Reporting Council. It has overseen internal and external audit plans and the risk management and internal control processes (financial and quality), including control processes around counter fraud.

2.2 The work of the Audit & Governance Committee is driven by the strategic objectives identified by the ICB, and their associated risks. It operates a programme of audit assignments, agreed by the ICB, which is flexible to new and emerging priorities and risks. The Audit & Governance Committee also monitors the integrity of the financial and other disclosure statements of the ICB and any other formal reporting relating to the ICB's statutory performance.

3. MEMBERSHIP

3.1 The Audit & Governance Committee is constituted in accordance with statute, and membership comprised of Non-Executive Members of the ICB Board, in line with the Committee's terms of reference. A minimum benchmark of five meetings per year, at appropriate times in the reporting and audit cycle is suggested. The Committee met seven times during 2023/24, and all meetings were fully quorate. The quorum necessary for the transaction of business is two Non-Executive Members of the ICB Board, including the Chair or Vice Chair of the Committee. The full membership attendance can be found at Appendix 1.

3.2 Additionally, the Audit & Governance Committee held an extraordinary meeting to discuss a legal case.

4. INTERNAL AUDIT SERVICE

4.1 360 Assurance carry out a range of activities to provide an independent and objective opinion to the Accountable Officer, the ICB Board, and the Audit & Governance Committee on the degree to which risk management, control and governance support the achievement of the organisation's objectives. The activities are conducted against a work plan and in accordance with the 360 Assurance contract.

4.2 Following the conclusion of its 2023/24 work programme, 360 Assurance issued a Head of Internal Audit Opinion of 'significant assurance'. A summary of completed assignments is at paragraph 6.3.

5 EXTERNAL AUDIT SERVICE

The statutory external audit service is provided to the ICB by KPMG. The service has included the preparation of various reports, including a risk assessment, value for money conclusion, and planning in preparation for the year-end audit of financial statements. The end of year audit 2023/24 delivered an unqualified opinion that the financial statements:

5.1 gave a true and fair view of the state of the ICB's affairs as at 31st March 2024 and of its income and expenditure for the year then ended; and

5.2 had been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2023/24.

6. OUTPUTS OF THE AUDIT & GOVERNANCE COMMITTEE

The main outputs of the Audit & Governance Committee are summarised below:

6.1 Financial Reporting

During the year the Audit & Governance Committee has overseen the preparation and planning for the 2023/24 Annual Report and Accounts audit in accordance with the published NHS timetable.

This includes not only the specific year-end audit requirements but also in year review of the ICB's financial position and projections and mitigations in relation to the planned outturn. This year has been particularly difficult across the whole system and the ICB has played a fundamental role in leading and managing the system towards financial sustainability as well as managing its own finances.

6.2 Counter Fraud

6.2.1 The ICB engaged with the Counter Fraud Specialist via 360 Assurance and used their input to ensure that appropriate policies and procedures were in place to mitigate the risks posed by Fraud, Bribery and Corruption.

6.2.2 The Accredited Counter Fraud Specialist regularly attended the Committee meetings and provided comprehensive updates on progress towards completion of the Annual Work Plan and compliance with the Standards for Commissioners.

6.2.5 Any instances of fraud have been reported to the committee throughout the year, and the Counter Fraud Specialist has continued to brief ICB staff on developments in fraud prevention. At the 31st March 2024 there were no areas of concern to report to the ICB Board.

6.3. Internal Controls

The following Audit Reports from the 2023/24 programme were considered by the Committee, together with the Head of Internal Audit Opinion:

Audit Assignment	Assurance Level/Comments
Accounts payable, Treasury and Cash Management	Substantial
Data Quality and Performance Management Framework	Limited
Data Security and Protection Toolkit	Substantial – NHSE opinion level
Delegated Direct Commissioning	In progress
Financial Ledger and Reporting	Substantial
Health Inequalities	In progress
Mental Health Act Assessment Claims	Limited
Operational Planning	Limited
Personalised Care and Support: Section 117 payments	In progress
Risk Management Developmental Review	In progress
Safeguarding	Significant
System-Wide Discharge Management	In progress
Transformation and Efficiency Follow-Up	In progress

Any actions highlighted within the reports are managed by the corporate governance team and presented to the Audit & Governance Committee at each meeting for assurance.

6.4 Risk Management

The Committee has a specific role within the risk management framework of the ICB to not only oversee the mitigation and management of risks for which the Committee has specific oversight but also to review and assess the effectiveness of the wider risk management arrangements within the ICB. To that end the Committee receives regular reports throughout the year which outline significant changes relating to each of the strategic risk areas including proposed changes in risk scores, reviews of the underlying threats including any new or emerging threats as well as reviews of the impact of mitigating actions.

In order to add value to this process the Committee has also received a planned programme of deep dives into each of the strategic risk areas within the Board Assurance Framework. This enables the Committee to make a more focused assessment as to the way in which individual risks are being managed, During 2023/24 the following deep dives were presented:

- Finance
- Data and Digital Development
- Corporate Affairs
- Procurement

6.5 **Freedom to Speak Up**

The ICB has a Raising Concerns at Work (Whistleblowing) Policy and Freedom to Speak Up Policy, which supports employees in reporting genuine concerns about wrongdoing at work. The Freedom to Speak Up Guardian and Ambassadors support employees to speak up when they feel that they are unable to do so by any other means.

A Freedom to Speak Up report is presented to the Committee on a quarterly basis, to highlight any concerns that have been raised. During 2023/24 the ICB had 12 concerns raised through the freedom to speak up process.

6.5 **Corporate Governance**

The Committee discharged the ICB's responsibilities in respect of the following functions:

- Business Continuity;
- ICB Complaints and PALS;
- Business Continuity;
- ICB Complaints and PALS, including Pharmaceutical, Ophthalmic, Dental and General Practice Services;
- Digital Development and ICT Assurance, including Cyber Security;
- Emergency Preparedness Resilience and Response;
- ICB Estates;
- Fit and Proper Person Test;
- Freedom of Information;
- ICS Green Plan;
- Health, Safety, Fire and Security;
- Information Governance;
- Organisational Development including ICB Staff Survey;
- Procurement and assurance on compliance with procurement regulations; and
- Research Governance.

The Committee Chair provided a corporate assurance report to the ICB Board, following each meeting of the Audit & Governance Committee.

Procurement has been a particular focus of the Committee during 2023/24 and as a consequence improvements have been made in terms of the quality of reporting to

the Committee and also in the liaison between procurement teams within the ICB and CSU.

7. AUDIT COMMITTEE PERFORMANCE

7.1 The Audit & Governance Committee is committed to operating in a manner which is effective and efficient, continuing to provide best value return on time and resources invested in it. Specifically, its agenda has been designed to provide adequate consideration of the financial and other risks to the achievement of the ICB's strategic objectives whilst acknowledging the monthly operational cycle of other ICB Corporate Committees.

7.2 The Committee continues to monitor compliance with the requirements of the NHS Audit Committee Handbook and has reviewed its terms of reference within the constitution of the ICB.

8. ISSUES ARISING FROM THE COMMITTEE'S WORK

The end of year financial report preparation and audit certification was accomplished on time and the audit certification identified no issues of concern. Risks identified in the external audit plan have been satisfactorily mitigated.

9. ASSURANCE QUESTIONS

At the end of each agenda is a set of assurance questions, to ensure the committee reviews the performance of the meeting regarding attendance by Executive Directors/Senior Management, the quality and timing of the papers, risk management, future deep dives and escalations to the ICB Board. Analysis of these assurance questions for 2023/24 showed no indication of any issues the committee raised in regards to the performance of the meetings.

10. CONCLUSION

The Audit & Governance Committee has previously confirmed to the ICB Board, based on its work between the 1st April 2023 and 31st March 2024, that it considers the internal control framework to be appropriate and effective.

The Committee notes and commends the quality of the annual report and accounts, recognising the tight timescales for preparation.

The committee extends its appreciation to the Finance and Corporate Delivery teams for their hard work and support to the committee's agenda.

Sue Sunderland
Audit & Governance Committee Chair
May 2024

Appendix 1

Audit & Governance Committee Attendance Record 1st April 2023 to 31st March 2024

Audit and Governance Committee Member		4 May 2023	8 Jun 2023	10 Aug 2023	12 Oct 2023	14 Dec 2023	8 Feb 2024	14 Mar 2024
Sue Sunderland	Chair – Non-Executive Member (Audit & Governance)	✓	✓	✓	✓	✓	✓	✓
Richard Wright	Non-Executive Member (Finance, Estates & Digital) (up to 30th June 2023)	✓	✓					
Jill Dentith	Non-Executive Member (Finance, Estates & Digital) (from 1st July 2023)			✓	✓	✓	✓	✓
Margaret Gildea	Non-Executive Member (People & Culture) and Senior Independent Director	X	X	✓	✓	✓	✓	X

NHS
Derby and Derbyshire
Integrated Care Board

Finance, Estates & Digital Committee

Annual Report

1st April 2023–31st March 2024

FINANCE, ESTATES & DIGITAL COMMITTEE ANNUAL REPORT

1st April 2023–31st March 2024

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Finance, Estates & Digital Committee and covers the period from 1st April 2023 to 31st March 2024.

1.2 The report provides the ICB Board and Accountable Officer with evidence relevant to their delegated responsibilities of providing oversight and assurance to the ICB Board in the development and delivery of robust, viable and sustainable system financial, estates and digital plans and processes which meet the health and care needs of the citizens of Derby and Derbyshire, and aid the implementation of the Joined Up Care Derbyshire (JUCD) vision and strategy.

2. MEMBERSHIP AND QUORACY

2.1 In accordance with the terms of reference the membership of the committee during the reporting period comprised of:

Core Members

- ICB Non-Executive Member of Finance and Estates
- ICB Non-Executive Member of Audit and Governance
- ICB Chief Finance Officer
- ICB Operational Director of Finance
- ICB Chief Strategy and Delivery Officer
- ICB Chief People Officer
- Foundation Trust Non-Executive Director – Acute
- Foundation Trust Non-Executive Director – Community
- 5 x System Director of Finance
- 2 x Chief Operating Officers

System Members

- System Estates Officer
- System Digital Officer
- System Continuous Improvement Officer

Participant Members by invite only

- General Practice Representative
- Local Authority Representative Derby City
- Local Authority Representative Derby County
- Third Sector/Voluntary Sector Representative

2.2 The Committee met 12 times during 2023/24 and all meetings were fully quorate, except the meeting on the 26th September 2023. The quorum necessary for the transaction of business was one ICB Non Executive Member, one provider Non-Executive Director, and three Executive Directors, of which one should be the

ICB Chief Finance Director or nominated deputy and one a System Director of Finance or their nominated deputy. The full membership attendance can be found at Appendix 1.

2.3 The Committee also requested attendance by appropriate individuals to present relevant reports and/or advise the Committee.

3. KEY AREAS OF REVIEW

Throughout the reporting period, the Finance, Estates & Digital Committee reviewed, monitored and had oversight of finance in relation to work in the following areas:

Roles and Responsibilities	Reporting mechanism
Delivery	
Delivery of the single system-wide finance, digital and estates plan built around a re-defined way of delivering care.	• Monthly system financial position reports • Local Estates Strategy • Delivery of 5-Year Plan • JUCD Digital and Data Strategy • Productivity and Efficiency • Planning Priorities and Timetable • Financial Allocations, Planning and Sustainability • ICS Transformation Programme • Industrial Action • Population Health and Out of Hospital Funding • Workforce reports and the relationship between finance, efficiency and workforce
Providing oversight of the framework and strategy for finance, digital and estates planning to ensure that each of the system partners have plans which are compatible with and compliment the system approach.	
Oversight of the management of the system financial target.	
Overseeing development of a 5-year rolling system financial projection which demonstrates ongoing efficiency and value improvements/impacts of longer term investments.	
Overseeing development of the JUCD future financial regime and recovery to address our known financial pressures and to provide assurance to the ICB Board.	
Ensuring effective oversight of future prioritisation and capital funding bids.	
Oversight and monitoring of financial, digital, estates and continuous improvement performance and delivery in order to give the ICB Board confidence that JUCD is implementing its strategic outcomes.	
Statutory Oversight	
Considering full business cases for material service change or efficiency schemes.	• Financial Sustainability Board Governance Arrangements • National Oversight Framework • Pharmacy, Optometry and Dental Delegation • Shared Care Records Deep Dive • UHDBFT Productivity Deep Dive • Workforce Deep Dive
Reviewing exception reports on any material breaches of the delivery of agreed efficiency improvement plans including the adequacy of proposed remedial action plans.	
Reviewing exception reports on any material in-year overspends against delegated budgets, including the adequacy of proposed remedial action plans.	
Identifying and allocating resources where appropriate to improve performance of identified	

Roles and Responsibilities	Reporting mechanism
schemes or ad-hoc finance and performance related issues that may arise.	
Considering significant investment or disinvestment decisions.	
Ensuring that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements.	
Reviewing the adequacy and effectiveness of relevant policies and procedures for ensuring compliance and related reporting.	
Having oversight of the system Recovery and Restoration work related to finance and efficiency and receive assurance regarding progress.	
Corporate Assurance	
Agreeing and regularly reviewing the Risk Register and Board Assurance Framework for its area of remit, considering the adequacy of the submissions and whether new risks needed to be added to the Risk Register; or whether any risks required immediate escalation to the ICB Board.	• Board Assurance Framework • Risk Register • Finance, Estates & Digital Committee Assurance Report presented to ICB Board following each meeting • The Committee's register of interest was provided within the papers at each meeting
Producing and presenting to the ICB Board a Committee Assurance Report, following each meeting.	
Managing conflicts of interest.	

4. ASSURANCE QUESTIONS

At the end of each agenda is a set of assurance questions, to ensure the committee reviews the performance of the meeting regarding attendance by Executive Directors/Senior Management, the quality and timing of the papers, risk management, future deep dives and escalations to the ICB Board.

Analysis of these assurance questions for the year highlighted that papers were regularly sent to committee members less than five working days in advance of the meeting, as per the Terms of Reference. The delay was because of the timing of several reports which enable the Committee to have the most up to date information. It was therefore agreed by members that this was acceptable in these circumstances, noting that members would have a limited period within which to review the papers.

5. CONCLUSION

The Finance, Estates and Digital Committee has discharged its duties effectively during the year, in this most challenging of financial contexts. Attendance has been good, with ICB and System partners actively participating in the discussions and debates. The Committee has matured well as a "system" committee and has increasingly been able to provide assurance from that wider perspective which is testament to the skill of the membership.

The Committee has managed the balance of discussions between the shorter-term resource issues and the need to think about the longer-term actions to deal with an

aging population and increasing overall demand. There is a recognition of the need to shift the balance from non-recurrent to recurrent efficiencies, which is an ever-present topic for discussion.

Committee discussions are firmly based on timely committee papers, and supported by comprehensive attendance by skilled and experienced senior officers.

A higher standard, of report presentation was maintained. During the year ongoing cost improvements and productivity projects have been captured on a system wide ePMO tool and links with relevant workforce reports has enabled the Committee to consider the trinity of finance, efficiency and workforce. Reports relating to estates and digital issues have also been presented throughout the year. Following each meeting of the Committee the ICB Board has received a report highlighting any risks or assurances on the management of the ICB's resources.

My thanks go to all those who have been involved over the financial year.

Jill Dentith
Chair of Finance, Estates & Digital Committee
May 2024

APPENDIX ONE

Finance, Estates & Digital Committee Attendance Record 1st April 2023 to 31st March 2024

Finance, Estates and Digital Committee Member		25 April 2023	23 May 2023	27 Jun 2023	25 Jul 2023	22 Aug 2023	26 Sep 2023	24 Oct 2023	28 Nov 2023	19 Dec 2023	23 Jan 2024	27 Feb 2024	26 Mar 2024
Core NHS Members													
Richard Wright	Chair – Non-Executive Member (Finance, Estates & Digital) (up to 30th June 2023)	✓	✓	✓									
Jill Dentith	Chair – Non-Executive Member (Finance, Estates & Digital) (from 1st July 2023)				✓	✓	✓	✓	✓	✓	✓	✓	✓
Sue Sunderland	Non-Executive Member (Audit & Governance)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Keith Griffiths	Chief Finance Officer, ICB	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Darran Green	Acting Operational Director of Finance, ICB	✓	✓	✓	✓	✓*	✓	✓	✓	✓	✓*	✓	✓
Zara Jones	Executive Director of Strategy and Planning (up to 24th September 2023)	X	✓	X	✓*	X	X						
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive (from 2nd October 2023)							X	✓	X	✓	✓	X
Linda Garnett	Interim Chief People Officer, ICB	X	✓*	X	✓*	✓	✓	✓	✓	✓	✓	✓	✓
Stephen Jarratt	Non-Executive Director, UHDBFT (up to 31st August 2023)	X	X	X	X								
Ian Lichfield	Non-Executive Director, DCHSFT (up to 31st August 2023) Non-Executive Director, UHDBFT (from 1st September 2023)	✓	X	X	X	✓	X	✓	X	X	X	X	X
Stuart Proud	Non-Executive Director, DCHSFT (from 1st July 2023)				✓	✓	X	✓	✓	✓	✓	✓	✓
Steve Heppinstall	Executive Director of Finance, UHDBFT						✓*	✓	✓*	✓	✓	✓	✓
Simon Crowther	System Estates Lead/Executive Director Finance &	✓	X	✓	✓	✓	✓*	✓	✓*	✓	✓*	✓*	✓

* Indicates where a member was deputised.

Finance, Estates and Digital Committee Member		25 April 2023	23 May 2023	27 Jun 2023	25 Jul 2023	22 Aug 2023	26 Sep 2023	24 Oct 2023	28 Nov 2023	19 Dec 2023	23 Jan 2024	27 Feb 2024	26 Mar 2024
	Performance/Interim Deputy CEO, UHDBFT												
Peter Handford	Chief Finance Officer, DCHSFT	✓	✓	✓	✓	✓	✓	✓	✓	✓*	✓	X	X
Michelle Veitch	Chief Operating Officer, CRHFT	✓*	✓*	✓*	✓*	✓	✓	✓*	X	X	X	X	X
Ade Odunlade	Chief Operating Officer, DHcFT	✓	X	✓	X	✓*	X	✓	X	X	X	X	X
James Sabin	Director of Finance, DHcFT (from 1st November 2023)								✓*	X	X	✓	✓
Mike Naylor	Director of Finance, EMAS	✓	✓	✓	✓	✓	✓	✓	✓*	X	✓	✓	✓
System Members													
James Austin	Chief Digital Information Officer, ICB	✓	X	X	X	✓	✓	✓	✓	✓	✓	✓	✓
Maria Riley	JUCD Director of Transformation & PMO (up to 30th September 2023)	X	✓	✓	X	X	✓						
Susan Whale	JUCD Director of System PMO & Improvement (from 1st October 2023)							X	✓	✓	X	✓	X
Tamsin Hooton	JUCD Programme Director	✓	✓	X	✓	✓	X	X	✓	✓	✓	✓	✓

For those items with * above please note that a deputy was present to ensure quoracy.

NHS
Derby and Derbyshire
Integrated Care Board

People & Culture Committee Annual Report

1st April 2023–31st March 2024

PEOPLE & CULTURE COMMITTEE ANNUAL REPORT

1st April 2023–31st March 2024

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the People & Culture Committee and covers the period from 1st April 2023 to 31st March 2024.

1.2 The report provides the ICB Board and Accountable Officer with evidence relevant to their responsibilities of:

- promoting education and training of existing and future health care staff;
- delivering the commitments of the NHS People Plan across the system;
- overseeing plans to develop, support and retain the health and care workforce, adopting a "one workforce" approach with all partners across the ICS;
- ensuring the appropriate workforce capacity and capability to deliver the ICS objectives together with an organisational development plan; and
- overseeing the demonstration of equality, diversity and inclusion in its plans and their implementation.

2. MEMBERSHIP AND QUORACY

2.1 In accordance with the terms of reference the membership of the committee during the reporting period comprised of:

- Non-Executive Member for People and Culture;
- Non-Executive Member for Finance and Estates;
- ICB Chief People Officer;
- System Non-Executive Directors/Chairs of Trust People Committees;
- Chief People Officers/HRDs from Provider Trusts;
- Programme Director of the Provider Leadership Collaborative Board
- Chair of the Integrated Place Executive;
- Local Authorities HRD (or nominated Representative) and Service Lead;
- Independent Primary Care Provider leader.
- East Midlands Ambulance Service NHS Trust representation;
- Derbyshire Health United 111 (East Midlands) Community Interest Company representation.

2.2 The Committee met 4 times during the reporting period to ensure all people, culture and workforce information submitted to the Board was properly scrutinised and to develop an agreed view on any future issues arising. All meetings were fully quorate. The quorum necessary for the transaction of business is one ICB Non-Executive Member, one System Non-Executive Member, one ICB Executive Member and three other members. The full membership attendance can be found at Appendix 1.

3. KEY AREAS OF REVIEW

The People & Culture Committee ensured that arrangements were in place to deliver on their duties and achieve the expectations that are set for the ICB people function (as set out within NHS England guidance), which included the review and approval of work in the following areas:

Roles and Responsibilities	Reporting mechanism
One Workforce Plan	
Ensuring that the Derby and Derbyshire ICS has an ambitious Health and Care Workforce Strategy and overseeing the development and delivery of the work programme to grow our system leadership capacity, capability, talent, and culture across our ICS.	• Workforce Oversight, including annual plan and agency spend target • People Services Collaborative 7x5 Work Programme Updates • Workforce Priorities in Local Authorities / Social Care • Annual Workforce Plan Progress • Five-Year Workforce Plan • Agency Reduction Plan • Deep Dive: People Services Governance • Section 75 – Derby City Integration Work
Ensuring analysis and intelligence is used to coordinate our ICS workforce plan that integrates workforce, activity and finance planning where appropriate across health and care to meet current and future population, service and workforce needs, across programmes, pathways and Place.	
Overseeing the development and progress of a system wide approach to delivering People Services; ensuring the ten People Functions for the ICS are in place to make Derby and Derbyshire a better place to live and work for the ICS people.	
Promoting integrated system-working and to support collaborative working at scale.	
Anchor Institutions	
Ensuring the People and Culture strategy supports the ICS and its partners to achieve the ambition to be an Anchor Institution.	–
Workforce Health and Wellbeing	
Improving equality, diversity, and inclusion for our current and future workforce; maximising our potential as employers to reduce health inequalities and to improve the health and wellbeing of our communities.	• People Services Collaborative 7x5 Work Programme Updates • System WRES Report • Freedom to Speak Up
Ensuring there is a robust package of support and focus on the wellbeing of the workforce including health and safety, safeguarding and security management across our ICS.	
Recruitment and Retention	
Promoting a positive culture to enable the system to be an agile, inclusive, and modern employer to attract, recruit and retain the people we need to deliver our plans.	• Workforce Oversight, including annual plan and agency spend target • People Services Collaborative 7x5 Work Programme Updates • Workforce Priorities in Local Authorities / Social Care
Ensuring plans are in place to develop, support and retain the health and care workforce, adopting a "one workforce" approach with all	

Roles and Responsibilities	Reporting mechanism
partners across the ICS, promoting collaborative recruitment, education and training of existing and future health and care staff where appropriate.	• Agency Reduction Plan
Corporate Assurance	
Agreeing and regularly reviewing the Risk Register and Board Assurance Framework for its area of remit, considering the adequacy of the submissions and whether new risks needed to be added to the Risk Register; or whether any risks required immediate escalation to the ICB Board.	• Board Assurance Framework • Risk Register • People & Culture Committee Assurance Report presented to ICB Board following each meeting • The Committee's register of interest was not provided within the papers at each meeting • People Services Delivery Board Assurance Report
Producing and presenting to the ICB Board a Committee Assurance Report, following each meeting.	
Managing conflicts of interest.	

4. ASSURANCE QUESTIONS

At the end of each agenda is a set of assurance questions, to ensure the committee reviews the performance of the meeting regarding attendance by Executive Directors/Senior Management, the quality and timing of the papers, risk management, future deep dives and escalations to the ICB Board. Analysis of these assurance questions for 2023/24 showed no indication of any issues the committee raised in regards to the performance of the meetings.

5. CONCLUSION

During the year we concentrated on those key people and culture issues which affect the system as a whole, and it was very encouraging to see the level of input and engagement from all the various parts of the system.

I look forward to the continuing development of the committee as we work on behalf of the Board to be assured that the system is well placed to ensure the effective recruitment, retention, and health and wellbeing of our current and future workforce.

Margaret Gildea
Chair of People & Culture Committee
May 2024

APPENDIX ONE

People & Culture Committee Attendance Record 1st April 2023–31st March 2024

People and Culture Committee Member		7 Jun 2023	6 Sep 2023	6 Dec 2023	22 Feb 2024
Margaret Gildea	Chair – Non-Executive Member (People & Culture) and Senior Independent Director	✓	✓	✓	✓
Jill Dentith	Non-Executive Member (Finance, Estates & Digital) (from 1st July 2023)		X	✓	✓
Linda Garnett	Interim Chief People Officer (from 1st May 2023)	✓	✓	✓	✓
Janet Dawson	Non-Executive Member, DCHSFT	✓	X	✓	✓
Ralph Knibbs	Non-Executive Member, DHcFT	X	✓	X	✓
Joy Street	Non-Executive Member, UHDBFT (up to 31st August 2023)	X			
Billie Lam	Non-Executive Member, UHDBFT (from 1st September 2023)		X	✓	✓
Jeremy Wight	Non-Executive Member, CRHFT (up to 31st August 2023)	✓			
Atul Patel	Non-Executive Member, CRHFT (from 1st September 2023)		✓	✓	X
Vijay Sharma	Non-Executive Director, EMAS (up to 31st August 2023)	X			
Will Pope	Non-Executive Director, EMAS (from 1st September 2023)		X	X	X
Amanda Rawlings	Chief People Officer, ICB (up to 30th April 2023) and UHDBFT	✓	✓*	✓	✓
Darren Tidmarsh	Chief People Officer, DCHSFT	✓	✓	✓	✓
Rebecca Oakley	Deputy Director of People & Inclusion, DHcFT (from 1st May 2023)	✓	X	X	X
Kerry Gulliver	Director of HR & Organisational Development, EMAS	X	X	X	X
Caroline Wade	Director of HR & Organisational Development, CRHFT	✓	✓	✓	✓
Penelope Blackwell	Chair of Integrated Place Executive	X	X	X	X
Emma Crapper	HR Director, Derbyshire County Council (up to 31st December 2023)	X	✓*	X	
Liz Moore	Head of HR, Derby City Council	✓	✓	✓	✓
Susie Bayley	Medical Director, General Practice Taskforce Derbyshire	✓	✓	✓	X
Zahra Leggatt	Derbyshire Health United 111 (East Midlands) Community Interest Company representation	X	X	X	✓

* Indicates where a member was deputised.

Population Health & Strategic Commissioning Committee Annual Report

1st April 2023–31st March 2024

POPULATION HEALTH & STRATEGIC COMMISSIONING COMMITTEE ANNUAL REPORT

1st April 2023–31st March 2024

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Population Health & Strategic Commissioning Committee and covers the period from 1st April 2023 to 31st March 2024.

1.2 The report provides the ICB Board and Accountable Officer with evidence relevant to their delegated responsibilities of:

- ensuring that the ICB complies with the principles of good governance whilst effectively delivering the statutory functions of the ICB;
- overseeing the provision of health services in line with the allocated resources across the ICS through a range of activities; and
- in accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England has delegated the exercise of the following functions in the delegation agreement to the ICB relating to:
    - primary medical services;
    - primary dental services and prescribed dental services;
    - primary ophthalmic services;
    - pharmaceutical services and local pharmaceutical services.

2. MEMBERSHIP AND QUORACY

2.1 In accordance with the terms of reference the membership of the committee during the reporting period comprised of:

- ICB Non-Executive Member for Population Health and Strategic Commissioning and Public Partnerships
- ICB Board Clinical (Other) Member
- Two System Non-Executive Directors
- Representative for Provider Collaborative at Scale
- Representative for Provider Collaborative at Place
- Representative for Clinical and Professional Leadership Group – Clinician(s)
- GP Clinical Lead
- Secondary Care Doctor
- Allied Health Professional Representative
- Director of Public Health
- Chief Strategy and Delivery Officer
- Chief Nursing Officer
- Chief Medical Officer
- Chief Finance Officer
- Director of Primary Care
- Director of Medicines Management and Clinical Policies
- Chief People Officer

2.2 The Committee formally met seven times during the reporting period. All meetings were fully quorate, except the meeting on the 11th October. The quorum necessary for the transaction of business is one ICB Non-Executive Member, one System Non-Executive Director, one ICB Executive Director and four other members, including two clinical. The full membership attendance can be found at Appendix 1.

3. FREQUENCY OF MEETINGS

The Committee met before ICB Board meetings to ensure all information submitted to the ICB Board was properly scrutinised and to develop an agreed view on any future issues arising.

4. KEY AREAS OF REVIEW

The Population Health & Strategic Commissioning Committee ensured that arrangements were in place to deliver on their duties, which included the review and approval of work in the following areas:

Roles and Responsibilities	Reporting mechanism
Delegated Functions	
In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England has delegated the exercise of the following functions in the delegation agreement to the ICB relating to: • primary medical services; • primary dental services and prescribed dental services; • primary ophthalmic services; • pharmaceutical services and local pharmaceutical services.	• Primary Care Access Improvement Plan • Pharmacy, Optometry and Dental Services update
Strategic Commissioning & Transformation	
Ensuring strategic, long-term and outcome-based contracts and agreements are in place to secure the delivery of the ICB's commissioning strategy and associated operating plans.	• Cardiovascular Disease Prevention Plan • Clinical Policy Advisory Group updates • Clinical and Professional Leadership Group updates • Derbyshire Prescribing Group updates • Health Protection Board • Joint Area Prescribing Group updates • Mental Health Delivery Board updates • Primary Care Sub-Committee updates • Joint Forward Plan • Derbyshire Continuous Glucose Monitoring Policy • 5 Year Plan • NHS Operational Plan • Population Health Management • 2024/25 Strategic Planning • Glossop Transition
Overseeing the preparation and publication of the ICB's commissioning strategy and associated operating plans, aligned to the Health and Wellbeing Boards and Integrated Care Partnership strategies.	
Ensuring commissioning decisions are underpinned and informed by communications and engagement with the membership and local population as appropriate.	
Driving a focus on reducing health inequalities, improved outcomes and quality, and ensuring that the delivery of the ICB's strategic and operational plans are achieved within financial allocations.	
Supporting providers (working both within the Integrated Care System and Integrated Care	

Roles and Responsibilities	Reporting mechanism
Partnership) to lead major service transformation programmes to achieve agreed outcomes, including through joining-up health, care and wider support.	
Overseeing the implementation of ICB commissioning policies, within the financial envelope to help secure the continuous improvement of the quality of the services commissioning by the ICB.	
Working alongside councils to invest in local community organisations and infrastructure and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in social and economic development and environmental sustainability.	
Operational Planning	
Overseeing the development of savings plans and services as detailed in the ICB's Operational Plan, approving the appropriate business cases and mobilisation plans, subject to appropriate evidence being provided (with particular reference to statutory equality and engagement duties) to support the decisions made.	<u>Business Cases</u> • Children & Young People Mental Health: Young Adults' Service • Community Musculoskeletal • Long-Covid-19 <u>Procurements</u> • General Practice Out of Hours • Derby Urgent Treatment Centre • Cataract Surgery • Derbyshire Wheelchair Services <u>Contract Awards</u> • AQP Community Audiology • Derby and Derbyshire Integrated Community Equipment Service • Non-Emergency Patient Transport <u>Contract Extensions/Arrangements</u> • Voluntary, Community and Social Enterprises
Prioritising service investments/disinvestments arising from strategic and operational plans, underpinned by value-based decisions and against available resources, and ensuring that appropriate evaluation is in place for new and existing investments.	
Corporate Assurance	
Agreeing and regularly reviewing the Risk Register and Board Assurance Framework for its area of remit, considering the adequacy of the submissions and whether new risks needed to be added to the Risk Register; or whether any risks required immediate escalation to the ICB Board.	• Board Assurance Framework • Ethical Framework for Decision Making Policy • Risk Register • Population Health & Strategic Commissioning Committee Assurance Report presented to ICB Board following each meeting • The Committee's register of interest was provided within the papers at each meeting
Producing and presenting to the ICB Board a Committee Assurance Report, following each meeting.	
Managing conflicts of interest.	

5. ASSURANCE QUESTIONS

At the end of each agenda is a set of assurance questions, to ensure the committee reviews the performance of the meeting in regards to attendance by Executive Directors/Senior Management, the quality of the papers, risk management, future deep dives and escalations to the ICB Board. Analysis of these assurance questions for 2023/24 showed no indication of any issues the committee raised in regards to the performance of the meetings.

6. CONCLUSION

I have only assumed responsibility as Chair since January so my thanks to Julian Corner who fulfilled this role during the first 18 months of the ICB. Inevitably that was a developing situation as the ICB came to grips with its wider responsibilities and particularly its need to deliver, through strategic commissioning and an enhanced focus on prevention, improved health and wellbeing in the population of Derbyshire.

Overall the committee has performed well, people have engaged and we have generally fulfilled our statutory responsibilities under the current scheme of delegation. That said, we have probably been too short-term driven, too process and probably not got the demarcations between ourselves, executive committees and the responsibilities of our providers and contractors quite right.

During the last two months we have reviewed our progress as a committee and our Terms of Reference and whether, in the way we construct our agendas and the information/papers we review, we are getting good assurance that the system is moving in the right direction at an acceptable speed, and will deliver on its strategic intentions. Consequently we have reviewed membership, planned development meetings on the correct risks for the committee and the type of performance reporting we want to see. Our focus will be to move the committee into a more forward thinking mode but with equal emphasis on short term activity levels across the system, and longer term investment in prevention and hence better public health performance.

We hope that this is the committee where the operational plan as a triangulation of activity, workforce and finance truly comes together and we get assurance that the operational plan will deliver better performance in the future.

Richard Wright
Chair of Population Health & Strategic Commissioning Committee
June 2024

APPENDIX ONE

Population Health & Strategic Commissioning Committee Attendance Record 1st April 2023–31st March 2024

Population Health and Strategic Commissioning Committee Member		11 May 2023	13 Jul 2023	14 Sep 2023	12 Oct 2023	9 Nov 2023	11 Jan 2024	14 Mar 2024
Julian Corner	Chair – Non-Executive Member (Population Health & Strategic Commissioning), ICB (up to 30th November 2023)	X	✓	✓	✓	X		
Richard Wright	Non-Executive Member (Finance, Estates & Digital), ICB (from 1st April to 30th June 2023, membership reinstated from 1st December 2023)	✓					✓	✓
Dr Adedeji Okubadejo	Clinical Lead Member and Vice ICB Board Chair, ICB (from 1st April 2023)	X	✓	✓	X	✓	X	✓
James Reilly	Non-Executive Director, DCHSFT (from 1st November 2023)					✓	✓	✓
Sardip Sandhu	Non-Executive Director, UHDBFT (from 1st January 2024)						✓	✓
Dr Penny Blackwell	Representative for Provider Collaborative at Place	X	X	✓	X	X	X	X
Dr Avi Bhatia	Representative for Clinical & Professional Leadership Group	✓	X	✓	✓	✓	✓	✓
Dr Emma Pizzey	GP Clinical Lead	✓	✓	✓	✓	✓	✓	✓
Dr Suneeta Teckchandani	Secondary Care Doctor	✓	X	✓	✓	✓	✓	✓
Dominic Fackler	Allied Health Professional Representative (up to 30th April 2023)							
Robyn Dewis	Director of Public Health, Derby City Council	✓	✓	✓	✓	✓	✓	✓
Mark Powell	Chief Executive Officer, DHcFT (from 1st April 2023)	X	X	✓	X	X	X	X
Zara Jones	Executive Director of Strategy and Planning, ICB (up to 24th September 2023)	✓	✓	✓				
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive, ICB (from 2nd October 2023)				✓	✓	✓	✓
Brigid Stacey	Executive Director of Nursing & Quality, and Deputy Chief Executive Officer, ICB (up to 4th July 2023)	✓						
Paul Lumsdon	Interim Chief Nurse Officer, ICB (from 1st July 2023 to 31st August 2023) Executive Director of Operations, ICB (from 1st September 2023 to 31st December 2023)		✓	X	✓	✓		
Prof Dean Howells	Chief Nurse Officer, ICB (from 1st September 2023)			X	✓	✓	✓	✓

Population Health and Strategic Commissioning Committee Member		11 May 2023	13 Jul 2023	14 Sep 2023	12 Oct 2023	9 Nov 2023	11 Jan 2024	14 Mar 2024
Dr Chris Weiner	Chief Medical Officer, ICB	✓	✓	✓	X	✓	✓	✓
Keith Griffiths	Chief Finance Officer, ICB	✓	X	✓	X	X	✓	✓
Clive Newman	Director of GP development, ICB	✓	✓	✓	✓*	✓	✓	✓
Steve Hulme	Director of Medicines Management & Clinical Policies, ICB	✓	✓	✓	✓	✓*	✓	✓
Amanda Rawlings	Chief People Officer, ICB (up to 30th April 2023)							
Linda Garnett	Interim Chief People Officer, ICB (from 1st May 2023)	X	X	X	X	X	✓	✓

For those items with * above please note that a deputy was present to ensure quoracy.

* Indicates where a member was deputised.

Joined Up Care Derbyshire

NHS
Derby and Derbyshire
Integrated Care Board

Public Partnership Committee Annual Report

1st April 2023–31st March 2024

PUBLIC PARTNERSHIP COMMITTEE ANNUAL REPORT

1st April 2023–31st March 2024

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Public Partnership Committee and covers the period from 1st April 2023 to 31st March 2024.

1.2 The report provides the ICB Board and Accountable Officer with evidence relevant to their delegated responsibilities of:

- ensuring appropriate engagement and consultation with patients and the public for new or changing services;
- assessing levels of assurance and risk in relation to the delivery of statutory duties in public and patient involvement and consultation, as defined within the Health & Social Care Act 2012;
- retaining a focus on the need for engagement in strategic priorities and programmes, to ensure the local health system is developing robust processes in the discharging of duties relating to involvement and consultation; and
- seeking assurance that the Derbyshire system is following defined processes to take due regard when considering and implementing service changes as defined by the Equality Act 2010 and delivered through targeted engagement.

2. MEMBERSHIP AND QUORACY

2.1 In accordance with the terms of reference the membership of the committee during the reporting period comprised of:

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

- <u>Non-voting Members</u>
  - Chief Executive, Healthwatch Derby/Healthwatch Derbyshire
  - ICB Chief of Staff
  - ICB Deputy Director of Communications and Engagement
  - Community engagement representative, Derbyshire County Council
  - Community engagement representative, Derby City Council
  - ICB Head of Engagement

2.2 The Committee met 9 times during the reporting period. All meetings were fully quorate. The quorum necessary for the transaction of business was 1 ICB Non-Executive Member, to include the Chair or Vice Chair, plus at least 2 representatives drawn from the lay members and FT Governors, and 1 Executive Director or Deputy. The full membership attendance can be found at Appendix One.

3. FREQUENCY OF MEETINGS

The Committee met bi-monthly before every ICB Board meeting to ensure all information submitted to the ICB Board was properly scrutinised and to develop an agreed view on any future issues arising. Development sessions also took place throughout the course of the year as agreed.

4. KEY AREAS OF REVIEW

The Public Partnership Committee ensured that arrangements were in place to deliver on their duties, which included the review and approval of work in the following areas:

Roles and Responsibilities	Reporting mechanism
Patient and Public Engagement	
Champion patient and public engagement across the Derbyshire health and care system, providing a watchful eye in scrutinising service developments.	• Citizen's Panel • Fertility • Glossop Services Engagement Approach • LD Short Breaks • Living Well • Long-Covid-19 • GP Access • Patient Participation Groups
Champion the routine principles of continuous engagement and co-production when assessing all public engagement activity, challenging and escalating findings where standards and principles have not been met.	
Seek assurance that the ICB and wider system are meeting statutory duties relating to Patient and Public Engagement, as laid out in the Health & Care Act 2022, including those relating to Local Authority Scrutiny.	
Seek assurance, through reports, reviews and presentations that the public are an integral part of designing, commissioning, transforming and monitoring services.	
Oversee the development and delivery of a robust infrastructure of engagement mechanisms including, but not limited to, place-level engagement, reference groups to provide insight on emerging issues, a citizen's panel from which can be drawn individuals across a matrix of geography/conditions/protected characteristics, project-specific lay representation and other mechanisms as required.	
Seek assurance that the system has robust mechanisms for training relevant staff on statutory duties relating to Patient and Public Engagement, as laid out in the Health & Care Act 2022.	

Roles and Responsibilities	Reporting mechanism
Ensure due process and appropriate methodologies have been followed in terms of involving the public in system projects, including providing constructive advice and challenge on proposed methods.	
Transformation, innovation and improvement	
Ensure that the development and delivery of the Derby and Derbyshire Integrated Care Strategy is driven by the insight and opinions gathered from local people.	• Engagement Strategy and Framework • Evaluation Framework • Insight Framework • Joint Forward Plan • New Powers for Secretary of State in Service Reconfiguration • System Insight Group
Make recommendations for improvements and innovations in the way the system works with patients and the public.	
Respond to external reviews and National Lessons Learnt reviews and bulletins especially with regards to the way patients and the public are engaged	
Act as an advocate for the engagement work being carried out for the future of health and social care in Derbyshire through appropriate networks.	
Equality and Diversity	
Seek assurance of work to reach seldom-heard groups and that this is being coordinated across partners and agencies, ensuring that all voices are being heard.	• The Committee ensures that due regard is given to Equality & Diversity throughout all reports and work carried out • Equality Delivery System
Seek assurance that the system has processes to ensure that adherence to the Equality Act duties of due regard is informing engagement programmes accordingly.	
Ensure that all voices are heard at committee and programme meetings and that all groups are given appropriate opportunity to shape local services.	
Corporate Assurance	
Make recommendations on the 'phase 2' responsibilities of the Committee, likely from autumn 2022, concurrent with the confirmation of the scope of the Integrated Care Partnership, specifically relating to the scope, reporting arrangements and membership of this committee.	• PPI Assessment Log • Board Assurance Framework • Risk Register • Public Partnership Committee Assurance Report presented to ICB Board following each meeting • The Committee's register of interest was provided within the papers at each meeting
Sign off the approach to all formal consultation programmes, either with delegated authority from the ICB Board or prior to their final sign off at those meetings.	
Agreeing and regularly reviewing the Risk Register and Board Assurance Framework for its area of remit, considering the adequacy of the submissions and whether new risks needed to be added to the Risk Register; or whether any risks required immediate escalation to the ICB Board.	

Roles and Responsibilities	Reporting mechanism
Producing and presenting to the ICB Board a Committee Assurance Report, following each meeting.	
Managing conflicts of interest.	
Oversee the development, completion and action planning of any internal or external audits relating to public engagement.	

5. ASSURANCE QUESTIONS

At the end of each agenda is a set of assurance questions, to ensure the committee reviews the performance of the meeting in regards to attendance by Executive Directors/Senior Management, the quality of the papers, risk management, future deep dives and escalations to the ICB Board.

As there were a number of development session throughout the year, this was only done at the meetings in May, August, September and October. Although included within the agendas for January and February, the questions were not included within the minutes for these meetings. However, analysis of these assurance questions for the preceding months showed no indication of any issues the committee raised in regards to the performance of the meetings.

6. CONCLUSION

For most of the year this Committee was chaired by Julian Corner who left the ICB at the end of November so I have only been involved more latterly. I am pleased with the levels of commitment and engagement by all the members of the committee and feel that in broad terms it has made a great start to fulfilling its objectives in the new ICP/ICB system environment. The committee particularly put significant effort into developing the engagement strategy which forms a very important foundation on which future assurance can be gained. Input from members in this was vital.

That said we have had a review and evaluation over the last couple of months and refocused our direction and priorities going forward. We want to really assure ourselves that the opinion and priorities of the whole population (including some of the diverse groups) are being properly captured, that they are being properly evaluated and that they are being used to build the short and long-term plans and priorities of the ICB and wider system. The focus must be on ensuring that the process is happening correctly and not on individual messages that are being heard.

I am impressed by the wish from all the members of the committee into making this happen.

Richard Wright
Chair of Public Partnership Committee
17 April 2024

APPENDIX ONE

Public Partnership Committee Attendance Record 1st April 2023–31st March 2024

Public Partnership Committee Member		25 Apr 2023	30 May 2023	27 Jun 2023	29 Aug 2023	26 Sep 2023	31 Oct 2023	28 Nov 2023	30 Jan 2024	27 Feb 2024
Voting Members										
Julian Corner	Chair – Non-Executive Member (Population Health and Strategic Commissioning) (up to 30th November 2023)	✓	✓	✓	✓	✓	✓	✓		
Richard Wright	Chair – ICB Chair (from 1st December 2023)								✓	✓
Sue Sunderland	Non-Executive Member (Audit & Governance)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Steven Bramley	Lay Representative	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tim Peacock	Lay Representative	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jocelyn Street	Lay Representative	✓	✓	X	✓	X	✓	✓	✓	✓
Patricia Coleman	Lay Representative (from 1st January 2024)								✓	X
Carol Warren	Lead Governor, CRHFT (from 1st January 2023)	X	✓	✓	✓	✓	✓	✓	X	✓
Maura Teager	Lead Governor, UHDBFT (up to 30th September 2023)	X	✓*	X	✓*	✓*				
Val Haylett	Public Governor (from 1st October 2023)						✓	✓	X	X
Lynn Walshaw	Deputy Lead Governor, DCHSFT	✓	X	✓	✓	X	✓*	✓	✓	✓
Christopher Mitchell	Public Governor, DHcFT (up to 31st May 2023)	X	X							
Hazel Parkyn	Public Governor, DHcFT (from 1st June 2023)			✓	X	✓	✓	✓	X	✓
Sam Dennis	Director of Communities, Derby City Council (from 2nd October 2023)						X	✓*	X	X
Kim Harper	Chief Officer, Community Action Derby	X	XX	X	X	X	X	X	X	X

Public Partnership Committee Member		25 Apr 2023	30 May 2023	27 Jun 2023	29 Aug 2023	26 Sep 2023	31 Oct 2023	28 Nov 2023	30 Jan 2024	27 Feb 2024
Non-Voting Members										
Helen Henderson	Chief Executive Officer, Healthwatch Derbyshire (up to 29th May 2023)	x							X	
Amy Salt	Engagement and Involvement Manager (from 30th May 2023)		✓	✓	✓	✓	✓	✓	✓	✓
Helen Dillistone	Executive Director of Corporate Affairs, ICB	✓	X	✓	X	✓	✓*	✓	✓	✓
Sean Thornton	Deputy Director Communications & Engagement, ICB/JUCD	✓	✓	✓	✓	✓	✓	X	✓	✓
Karen Lloyd	Head of Engagement, ICB/JUCD	✓	✓	✓	✓	✓	✓	✓	✓*	✓

For those items with * above please note that a deputy was present to ensure quoracy.

NHS
Derby and Derbyshire
Integrated Care Board

Quality & Performance Committee Annual Report

1st April 2023–31st March 2024

QUALITY & PERFORMANCE COMMITTEE ANNUAL REPORT

1st April 2023–31st March 2024

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Quality & Performance Committee and covers the period from 1st April 2023 to 31st March 2024.

1.2 The report provides the ICB Board and Accountable Officer with evidence relevant to their delegated responsibilities of ensuring:

- the system organisations discharge their statutory duties in relation to the achievement of continuous quality improvement;
- quality and outcome information against key performance trajectories is received and quality issues identified, ensuring they are acted upon;
- delivery against of the Constitution, NHS Long Term Plan, Public Health Outcomes Framework, and associated NHS performance regimes, agreeing any action plans or recommendations as appropriate;
- continuous improvements in quality and outcomes of clinical effectiveness, safety and patient experience are secured;
- processes are in place to interpret and implement local, regional and national policy (e.g. Quality Accounts, Safeguarding etc.) and provide assurance that policy requirements are embedded in services; and
- considerations relating to safeguarding children and adults are integral to services and robust processes are in place to deliver statutory functions of all Health and Social Care Organisations within the ICS.

2. MEMBERSHIP AND QUORACY

2.1 In accordance with the terms of reference the membership of the committee during the reporting period comprised of:

- ICB Board Clinical (Other) Member;
- ICB Non-Executive Member for Finance and Estates;
- ICB Chief Nursing Officer;
- ICB Chief Medical Officer;
- ICB Chief Strategy and Delivery Officer;
- Provider Non-Executive Directors, with responsibility for Quality; and
- Primary Care Representative.

2.2 The Committee formally met 11 times during 2023/24 and meetings were fully quorate. except the meetings on the 29th June, 27th July, 31st August, 28th September, 2nd November and 21st December 2023. The quorum necessary for the transaction of business is one ICB Non Executive Member, to include the Chair or Vice Chair, plus at least the Chief Nurse Officer, or Chief Medical Officer from the ICB (or deputy), and two provider representatives (to include one provider Non-Executive Director, with responsibility for Quality).

3. FREQUENCY OF MEETINGS

The Committee met monthly before every ICB Board meeting to ensure all quality and performance information submitted to the ICB Board had been properly scrutinised and to develop an agreed view on any future issues arising.

4. KEY AREAS OF REVIEW

The Quality & Performance Committee ensured that arrangements were in place to deliver on their duties, which included the review and approval of work in the following areas:

Roles and Responsibilities	Reporting mechanism
Collaboration	
Ensuring a collaborative approach to promote multi-professional leadership and a shared vision for quality and performance within the System.	• System Integrated Performance Report • Risk Stratification and Harm Review update
Ensuring a culture of learning and improvement to ensure provision of high-quality sustainable services.	
Quality oversight is maintained in relation to public health outcomes and the wider determinants of health; and take appropriate action as required to support the reduction in health inequalities.	
Quality and performance oversight is maintained in relation to the performance of Health and Social Care organisations within the ICS in terms of the Care Quality Commission (CQC) and any other relevant regulatory bodies.	
Systems	
Ensuring clear roles and accountabilities in relation to quality and performance oversight	• Monitoring maternity and neonatal services and issues • Primary Care quality oversight • Quality Framework • Safeguarding Adults and Children • Delegation of Pharmacy Optometry and Dental services • Risk Escalation from the Health Protection Board • Quality Accounts • Serious Violence Strategy • LeDeR Annual Report • Early Warning System in Primary Care • Public Health Inequalities
Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place	
Ensuring effective improvement mechanisms are in place, including peer review and external support.	
Ensuring there are processes to effectively identify early warning signs that there is a quality or performance issue.	
Processes are established to identify, resolve and escalate risk emerging from poor quality as a result of poor performance against performance indicators.	
Implementation of the Patient Safety Strategy, including process and compliance in relation to PSIRF; being informed of all Never Events and informing the key partners of any escalation or sensitive issues.	
Processes are in place to interpret and implement local, regional and national policy (e.g. quality	

Roles and Responsibilities	Reporting mechanism
accounts, safeguarding, infection control etc.) and provide assurance that policy requirements are embedded in services.	
Receiving assurance from the System Quality Group on the approval of nursing and quality policies.	
Considerations relating to safeguarding children and adults are integral to services and robust processes are in place to deliver statutory functions of all Health and Social Care Organisations within the ICS.	
Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD report);	
Equality Impact Assessments are undertaken and reviewed by System Quality Group for proposed service changes using the established mechanisms with any matters of concern escalated.	
Learning and Insight	
Establishing systems to draw from intelligence in order to inform quality and performance improvement, and to act on early warning signs.	• Lessons learned from learning reviews • Care Quality Commission – General Practice • Neuro Developmental Assessment Waiting Times and Pathway
Maintaining oversight in terms of variation and risk across clinical pathways and to provide a view on the quality aspects of clinical pathways, care journeys and Transformation Programmes.	
Ensuring that quality and performance assurance data is used to inform commissioning decisions and drive improvements.	
Ensuring that processes are in place to provide assurance and oversight that services are high quality; meaning that they are safe, effective, caring, responsive and well-led and provide patients, service users and carers with positive experiences of care.	
Liaising with appropriate external bodies such as the CQC or professional regulatory bodies.	
Improvement	
Scrutinise structures in place to support quality, performance, planning, control and improvement, to be assured that the structures operate effectively and timely action is taken to address areas of concern.	
Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes.	
At every service level there is a consistent set of meaningful “measures that matter” which can be used to inform improvement.	

Roles and Responsibilities	Reporting mechanism
Data and intelligence are effectively utilised in order to identify and prioritise the most important quality and performance issues, enabling corrective action to be taken.	Deep Dives into: • Infection, Prevention, Control and C. Difficile • Making Room for Dignity Programme • Children and Young People's Eating Disorders • LeDeR Review Process • Role of the LMNS • Cancer 62-day waits • Safeguarding Adults and Children • Discharge and Flow • Stroke Services • Personal Health Budgets
Action is taken where required to investigate any quality, safety or patient experience concerns, noting action is taken to ensure that improvements in quality are implemented where necessary.	
Corporate Assurance	
Agree and put forward the key quality priorities that are included within the ICB strategy/annual plan, including priorities to address variation/inequalities in care.	• System Quality Group Assurance Report • Board Assurance Framework • Risk Register • Quality & Performance Committee Assurance Report presented to ICB Board following each meeting • The Committee's register of interest was provided within the papers at each meeting
Oversee and monitor the delivery of the ICB key statutory requirements.	
Oversee and scrutinise the ICB's response to all relevant Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health and Social Care, NHSEI and other regulatory bodies/external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.	
Agreeing and regularly reviewing the Risk Register and Board Assurance Framework for its area of remit, considering the adequacy of the submissions and whether new risks needed to be added to the Risk Register; or whether any risks required immediate escalation to the ICB Board.	
Producing and presenting to the ICB Board a Committee Assurance Report, following each meeting.	
Managing conflicts of interest.	

5. ASSURANCE QUESTIONS

At the end of each agenda is a set of assurance questions, to ensure the committee reviews the performance of the meeting in regards to attendance by Executive Directors/Senior Management, the quality of the papers, risk management, future deep dives and escalations to the ICB Board. Analysis of these assurance questions for 2023/24 showed no indication of any issues the committee raised in regards to the performance of the meetings.

6. CONCLUSION

The ICB Quality and Performance committee has had a busy year and we have seen increasing collaboration in the work to monitor and improve quality across partners in the Derby and Derbyshire Integrated Care System. The focus on processes and outcomes has also included the consideration of patient experience. A number of significant concerns have emerged during the year including those about our local maternity and neonatal services, infection prevention and control, and stroke service. Deep dives are instigated in order to gain further understanding and this report presents a list of deep dives during the year. The strength of collaboration is very obvious in the partnership approach that has been taken in dealing with these difficulties.

Looking into the future, the committee intends to move from a position of looking back and reviewing what happened to one of predicting and proactively dealing with unexpected and sustained variation to prevent deterioration in the quality of services provided to our population. We also plan to place more emphasis on quality improvement rather than just the monitoring of quality as a core of our routine business.

Dr Adedeji Okubadejo
Chair of Quality & Performance Committee
14 June 2024

APPENDIX ONE

Quality & Performance Committee Attendance Record 2023/24

Quality and Performance Committee Member		27 Apr 2023	25 May 2023	29 Jun 2023	27 Jul 2023	31 Aug 2023	28 Sep 2023	2 Nov 2023	30 Nov 2023	21 Dec 2023	25 Jan 2024	28 Mar 2024
Dr Adedeji Okubadejo	Chair – Clinical Lead Member and Vice ICB Board Chair (from 1st April 2023)	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
Margaret Gildea	Non-Executive Member (People and Culture) and Senior Independent Director (up to 30th June 2023)	✓	✓	X								
Richard Wright	Non-Executive Member (Finance, Estates & Digital) (up to 30th June 2023)	✓	✓	X								
Jill Dentith	Non-Executive Member (Finance, Estates & Digital) (from 1st July 2023)				✓	✓	✓	✓	✓	✓	✓	✓
Brigid Stacey	Chief Nurse Officer and Deputy Chief Executive Officer (up to 4th July 2023)	✓	✓	✓								
Paul Lumsdon	Interim Chief Nurse Officer (from 1st July 2023 to 31st August 2023) Executive Director of Operations (from 1st September 2023 to 31st December 2023)				✓	✓						
Prof Dean Howells	Chief Nurse Officer (from 1st September 2023)						✓*	✓*	✓	✓	✓	✓
Dr Chris Weiner	Chief Medical Officer	X	✓	✓	X	✓	X	✓	✓	✓	✓	✓
Zara Jones	Executive Director of Strategy & Planning (up to 24th September 2023)	✓*	✓	✓	✓*	✓*						
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive (from 2nd October 2023)							✓	✓*	✓*	✓	✓*

* Indicates where a member was deputised.

Quality and Performance Committee Member		27 Apr 2023	25 May 2023	29 Jun 2023	27 Jul 2023	31 Aug 2023	28 Sep 2023	2 Nov 2023	30 Nov 2023	21 Dec 2023	25 Jan 2024	28 Mar 2024
Christine Fearns	Non-Executive Director, UHDBFT (up to 28th April 2023)	X										
Chris Harrison	Non-Executive Director, UHDBFT (from 1st October 2023)						X	X	✓	✓	X	X
Jayne Stringfellow	Non-Executive Director, CRHFT (up to 31st August 2023)	X	X	X	✓	X						
Nora Senior	Non-Executive Director, CRHFT (from 1st September 2023)						X	X	✓	X	X	X
Lynn Andrews	Non-Executive Director, DHcFT	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓
Kay Fawcett	Non-Executive Director, DCHSFT	✓	✓	✓	X	✓	X	X	✓	X	✓	✓
Robyn Dewis	Director of Public Health, Derby City Council	✓	✓	X	X	X	✓	X	✓	✓	✓	✓
Gemma Poulter	Assistant Director Adult Social Care, Derbyshire County Council	X	X	X	X	X	X	X	X	X	X	X

For those items with * above please note that a deputy was present to ensure quoracy.

NHS
Derby and Derbyshire
Integrated Care Board

Remuneration Committee Annual Report 1st April 2023–31st March 2024

REMUNERATION COMMITTEE ANNUAL REPORT

1st April 2023–31st March 2024

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Remuneration Committee and covers the period from 1st April 2023 to 31st March 2024.

1.2 The report provides the ICB Board and Accountable Officer with evidence relevant to their responsibilities of:

- determining and approving:
  - all aspects of remuneration, including but not limited to salary;
  - arrangements for termination of employment and other contractual terms and non-contractual terms;
  - arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate;
  - the ICB pay policy;
- overseeing contractual arrangements;
- the nomination and appointment of ICB Board members;
- performance review/oversight for directors/senior managers;
- succession planning for the ICB Board;
- assurance in relation to ICB statutory duties.

2. MEMBERSHIP AND QUORACY

2.1 In accordance with the terms of reference the membership of the committee during the reporting period comprised of:

- Non-Executive Member of Remuneration;
- Non-Executive Member of Population Health and Strategic Commissioning;
- ICB Board Clinical (Other) Member.

2.2 The Committee met 10 times during the reporting period and all meetings were fully quorate. The quorum necessary for the transaction of business is two of the members. The full membership attendance can be found at Appendix 1.

3. KEY AREAS OF REVIEW

Throughout the reporting period, the Remuneration Committee reviewed, monitored and had oversight of the following areas:

Roles and Responsibilities	Reporting mechanism
Salary (including any performance-related elements) bonuses, pensions and cars for Chief Executive, Directors and other Very Senior Managers.	• Executive Director Appointments, Structure and Remuneration • Functional Director Pay Progression • General Practice Place Lead Remuneration • ICB Board – Clinical (Other) Member Role • ICB Chair Appointment Arrangements • Non-Executive Members' Review of Pay • Relocation Policy and Hybrid Working • Running Cost Reduction and ICB Restructure • Staff Consultation Process and Restructure • Very Senior Manager Pay Award and Structure
Termination of employment and other contractual matters for Chief Executive, Directors and other Very Senior Managers, and all staff.	
ICB pay policy (including the adoption of pay frameworks such as Agenda for Change), contractual and termination arrangements for all staff.	
Arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.	
Nomination and appointment of (some or all) ICB Board members.	
Performance review/ oversight for directors/senior managers.	
Succession planning for the ICB Board.	
Assurance in relation to ICB statutory duties.	
Corporate Assurance	
Producing and presenting to the ICB Board a Committee Assurance Report, following each meeting.	• Remuneration Committee Assurance Report verbally presented to ICB Board following each meeting • The Committee's register of interest was provided within the papers at each meeting.
Managing conflicts of interest.	

4. CONCLUSION

The Remuneration Committee has met more regularly than normal to oversee a number of changes in the Executive Team and the recent cost reduction and restructuring exercise. It ensured that partners were consulted about the future shape of the organisation and key roles within it, and also that the restructuring was carried out fairly and with an emphasis on staff wellbeing.

It has been a challenging but successful year with a strengthened Executive Team and an organisation reshaped to meet the requirements of the System at a reduced cost.

Margaret Gildea
Chair of Remuneration Committee
9 July 2024

APPENDIX ONE

Remuneration Committee Attendance Record

1st April 2023–31st March 2024

Remuneration Committee Member		28 Apr 2023	11 May 2023	24 May 2023	21 Jul 2023	1 Aug 2023	14 Sep 2023	16 Oct 2023	12 Dec 2023	26 Jan 2024	25 Mar 2024
Margaret Gildea	Chair – Non-Executive Member (People & Culture) and Senior Independent Director	✓	✓	✓	✓	X	✓	✓	✓	✓	✓
Julian Corner	Non-Executive Member (Population Health & Strategic Commissioning) (up to 30th November 2023)	X	X	✓	✓	X	✓	X			
Dr Adedeji Okubadejo	Clinical Lead Member and Vice ICB Board Chair (member from 1st July 2023)	X	X	✓	✓	✓	✓	X	X	✓*	✓*
Richard Wright	Non-Executive Member (Finance, Estates & Digital) (member until 30th June 2023)	✓	✓	✓							

* Indicates where a member was deputised.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th July 2024

Item: 044

Report Title	ICB Board Assurance Framework – Quarter 1 2024/25							
Author	Rosalie Whitehead, Risk Management & Legal Assurance Manager							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – ICB Board BAF Strategic Risk Report							
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 Quality and Performance Committee People and Culture Committee Public Partnership Committee							

Recommendations
The ICB Board are recommended to: • **RECEIVE** the final Quarter 1 24/25 BAF strategic risks 1 to 10; • **NOTE** the revised risk description for Strategic Risks 3 and 5; and • **NOTE** the revised threats 3 and 4 in respect of Strategic Risk 3.
Purpose
The purpose of this report is to present to the ICB Board the final Quarter 1 2024/25 BAF strategic risks 1 to 10. The full Quarter 1 BAF can be found here.
Background
A fundamental aspect of the ICB's governance structure is the establishment and implementation of sound risk management arrangements. The effective design and embedment of these arrangements will ensure that the Board is kept informed of the key risks facing the ICB and the wider system and is assured that robust processes are in place to manage and mitigate them. The Board Assurance Framework (BAF) is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's aims and objectives. The BAF provides the Board with a framework to support identification of key areas of focus for the system and updates as to how those key areas are being addressed. The strategic risks are the risks that face the system, not just the ICB. The ICB however will take a system coordination role to develop the framework that underpins the delivery and will require

system partners input to mitigate complex risks. It will require strong alignment with system partner BAFs and assurance will be drawn from a range of internal and external sources.
System organisations have a duty to support the ICB in the management of the BAF and the achievement of the ICB's objectives.

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.	☒

The report covers each strategic risk.

Financial impact on the ICB or wider Integrated Care System

Yes ☒	No☐	N/A☐

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

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

No conflicts of interest have been identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

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

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

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

APPENDIX 1

Derby and Derbyshire Integrated Care Board

Board Assurance Framework Strategic Risk Report Quarter 1 – 2024/25

This report provides a description of the strategic risks currently facing the Derbyshire system and provides the final position for each at quarter 1 2024/25 including the decisions of the relevant committees with regard to any changes in scoring, risk description, threats etc since quarter 4 2023/24.

The ICB has nine strategic risks in total (noting Strategic Risk (SR) 5 was closed and merged with SR 6 in quarter 4 2023/24). Four strategic risks are scored very high and five scored high.

As demonstrated in the table below, there has been no movement in risk score since Q4, however there are new risk descriptions for risks 3 and 5, with updated threat descriptions for risks 1 and 3.

Risk No	Description	Q4 2023/24 closing risk score	Q1 2024/25 closing risk score	Risk Movement	Rationale	Additional Comments
SR1 *Quality and Performance Committee*	There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and both upper tier Councils to deliver consistently safe services with appropriate standards of care.	**12**	**12**	⟺	The risk score remains at 12. An increase to 16 was proposed due to the challenging financial constraints across the system. However, the Quality and Performance Committee meeting was not quorate.	A new threat 4 has been added namely "Risk to clinical quality and safety due to the significant financial constraints across all partners within Joined Up Care Derbyshire". The impact of this threat is the inability to deliver safe services and appropriate standards of care within organisations or across Joined Up Care Derbyshire. Further work will now be undertaken to identify the gaps and actions.

SR2 *Quality and Performance Committee*	There is a risk that short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	**16**	**16**	⟷	This risk remains scored at 16. A decrease to 12 was proposed, recognising that there is more embedment now within the system. However, the Quality and Performance Committee meeting was not quorate and members also required further assurance regarding system embedment.	
SR3 *Public Partnerships Committee*	*New risk description*: 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.	**12**	**12**	⟷	The risk score has been discussed and remains at a high 12.	Additional detail has been added to Threat 3 (in bold text) "The complexity of change required, and the speed of transformation, **potential decommissioning and other cost improvement programmes** required leads to patients and public being engaged too late in the planning stage, or not at all leading to legal challenge where due process is not being appropriately followed". Additional wording that in the event of the ICB having to de-commission services to meet financial pressures, then there is a risk that due process may not be

						followed due to speed of action required. A new, replacement threat 4, namely "The system does not adopt the ethos of the Insight or Co-Production Frameworks, public views do not routinely influence decisions and the power balance across the NHS system resides with decision-makers". A refresh of all gaps has been undertaken to reflect the team's workplan for 24/25, including necessary carry over of activity form the 23/24 BAF. The mitigating actions are currently being populated.
SR4 *Finance, Estates and Digital Committee*	There is a risk that the NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	**20**	**20**	⟺	It was agreed that strategic risk 4 would remain scored at a very high 20.	
SR5 *People and Culture Committee*	*New risk description*: 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.	**20**	**20**	⟺	The risk score was agreed to remain at a very high score of 20.	System Gap in Control reference 5T1.2C *System level control total* and the corresponding action have been removed due to this not having been agreed by the System.

SR7 *Population Health and Strategic Commissioning Committee*	There is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	**12**	**12**	⟷	The risk profile for this risk remains at a high 12.	Actions are progressing in respect of this strategic risk and the refreshed Joint Forward Plan will be presented at the July ICB Board meeting.
SR8 *Population Health and Strategic Commissioning Committee*	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	**12**	**12**	⟷	The risk profile for this risk remains at a high 12.	The recruitment of the analytics team is complete for all roles other than the Associate Director of Business Intelligence. Interviews are planned in respect of this post for early July.
SR9 *Population Health and Strategic Commissioning Committee*	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.	**16**	**16**	⟷	The risk profile remains scored at a very high 16.	One action has been completed during quarter 1 relating to action reference: 9T2.1A: "The Prevention and Health Inequalities Board was established in April 2024 and the Terms of Reference were approved".
SR10 *Finance, Estates and Digital Committee*	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	**12**	**12**	⟷	The current risk score of a high 12 remains appropriate as the quarter 1 closing position.	

Each responsible Executive and the Committee reviewed and approved their final Quarter 1 2024/25 strategic risks at the Committee meetings held during June 2024.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

18th July 2024

Item: 045

Report Title	Risk Register Report – June 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 – Movement in risk summary – June 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 summarises the movement of all risks in June 2024.

and to **APPROVE** closure of**:**

- Risk 03 relating to the sustainability of individual GP practices. The reason for the closure of this risk is that four new risks have been proposed and approved at PHSCC and the new risks are a cluster of risks which come together to form a structure rather than individual risks which sit isolated from one another.
- Risk 16 relating to the ICB staff re-structure. This risk is now recommended to be closed as the restructure has been completed, vacancies are being recruited to and the vast majority of staff (98.5%) have secured a role in the new ICB structure. The support for the relatively small number of individuals 'at risk' will continue to be provided by the HR team as part of their normal day to day work.

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.
Please find the ICB corporate risk register here for information.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☒
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	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	**Has this been signed off by a finance team member?**
Strategic risk SR4 describe the system's financial risk. *There is a risk that the NHS in Derby and Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move to a sustainable financial position and achieve best value from the £3.4billion available funding.*	Keith Griffiths, Chief Finance Officer

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

No conflicts of interest have been identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

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

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

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

CORPORATE RISK REGISTER REPORT

INTRODUCTION

The purpose of this report is to present the ICB Board with 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 nine very high risks, seven high and four moderate scoring risks on the corporate risk register.

RISK MOVEMENT

Decreased risks

One risk was decreased in score in May 2024:

1. 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.*

   This risk was proposed to be decreased in risk score from a very high score of 16 (probability 4 x impact 4) to a high score of 12 (probability 3 x impact 4).

   The reason for the proposed decrease in risk score was that although there is still a live issue around the eligibility for funding, this is now against a reduced number of providers resulting in lower financial risk.

One risk was decreased in score in June 2024:

1. Risk 15: *(Audit and Governance Committee) The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI.*

   This risk was proposed to be decreased in risk score from a high score of 9 (probability 3 x impact 3) to a moderate score of 6 (probability 3 x impact 2).

   The reason for the risk impact to be decreased to 2 is that there have been no impacts to date. The risk score will be increased again should the situation change. The oversight of these services has been included in the new structures where appropriate and this risk will be reviewed throughout the year particularly as and when further delegations come into the ICB to ensure the correct capacity and staffing arrangements are in place.

Increased risks

No risks were increased in score in May or June 2024.

CLOSED RISKS

One risk was proposed for closure in May:

1. Risk 03: *(Population Health and Strategic Commissioning Committee) There is a risk to the sustainability of individual GP practices (due to key areas detailed) across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.*

- Following the Population Health and Strategic Commissioning Committee (PHSCC) Development Session Risk Workshop held on 9th May 2024, four new risks were discussed. These new risks are a cluster of risks which come together to form a structure rather than individual risks which sit isolated from one another.

One risk was proposed for closure in June:

1. Risk 16: *(Audit and Governance Committee) With the review of ICB structures there is a risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.*

- This risk is now recommended to be closed as the restructure has been completed, vacancies are being recruited to and the vast majority of staff (98.5%) have secured a role in the new ICB structure. Support for the relatively small number of individuals 'at risk' will continue to be provided by the HR team as part of their normal day to day work.

NEW RISKS

Four new risks were proposed in May:

1. Risk 28**:** *(PHSCC) There is a risk that the ICB does not systematically review historically agreed resource utilisation within contracts and care pathways, resulting in the lost opportunity to redeploy wasteful and inefficiently used resources to better improve health outcomes for the residents of Derby City & Derbyshire.*

2. Risk 29: *(PHSCC) There is a risk that the ICB does not deliver the strategic ambitions and priorities within the 5 Year Forward View.*

3. Risk 30: *(PHSCC) There is a risk that the local health and care economy is unsustainable because of a failure to reduce 'failure demand' by effectively reducing health inequalities and delivering primary and secondary prevention.*

4. Risk 31: *(PHSCC) There is a risk that key healthcare services cannot be maintained due to fragility caused by availability of staff, insufficient capital investment or inadequate outcomes for Derby City and Derbyshire community.*

Further work is currently being undertaken to populate the proposed new risks including the initial, current and target risk scores, actions and mitigations along with assigning a risk owner for each of the four new risks.

Two new risks were proposed in June:

1. Risk 06B: *(Finance, Estates and Digital Committee) 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).*

   This new risk was proposed to be scored at a very high 20 (probability 4 x impact 5).

   This risk was proposed as a result of risk 06 being split into two separate risks, 06A (relating to delivery of the 24/25 financial plan) and 06B relating to delivery of 2 year break even.

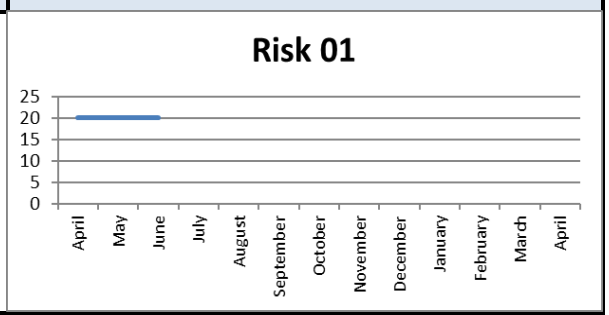
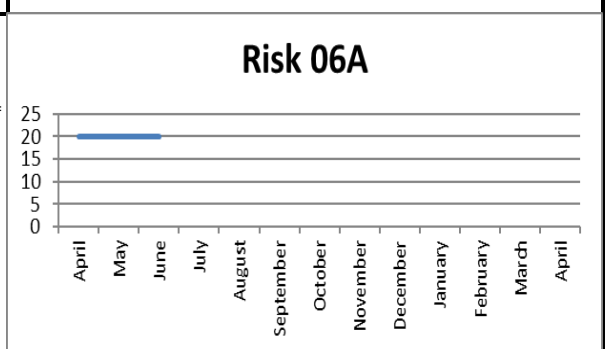
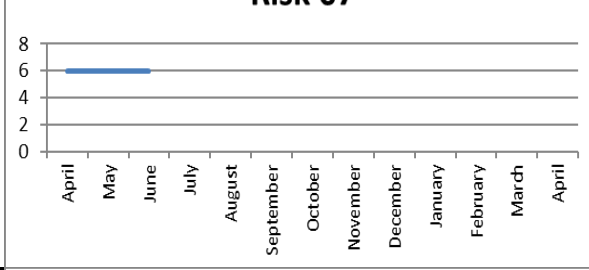
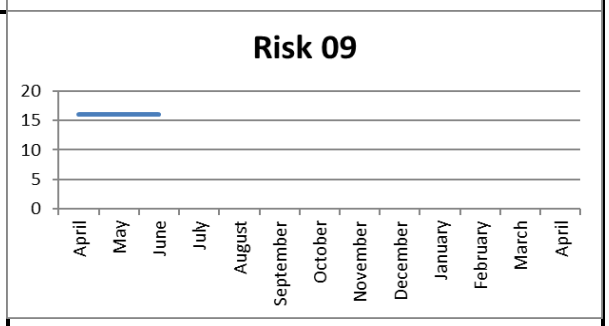
   As this is a 'new' risk, work will continue on refinement for future months.

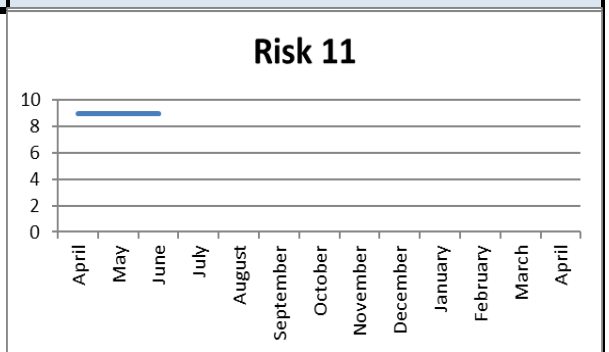
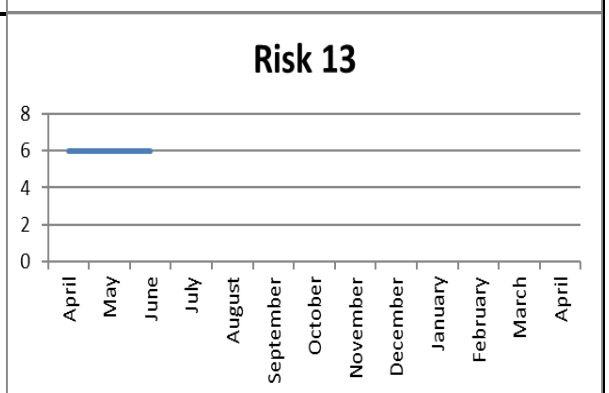
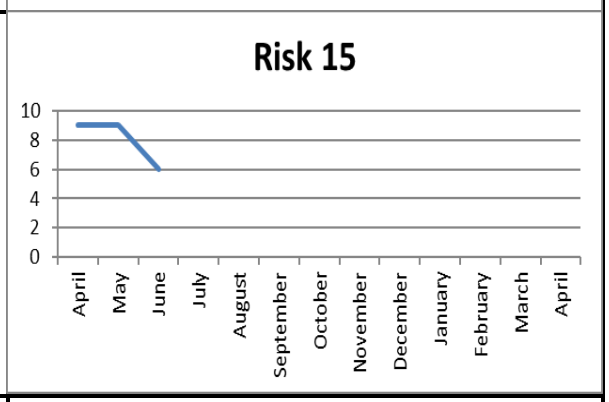
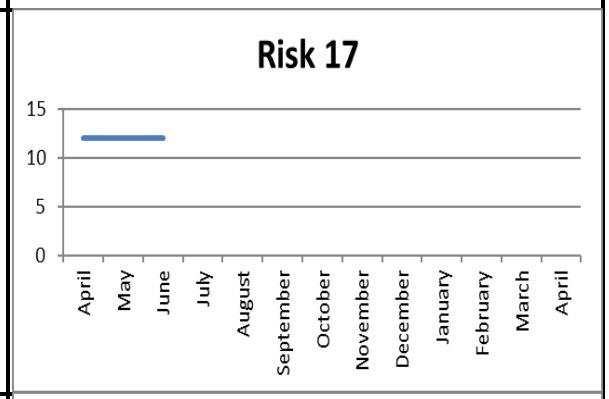
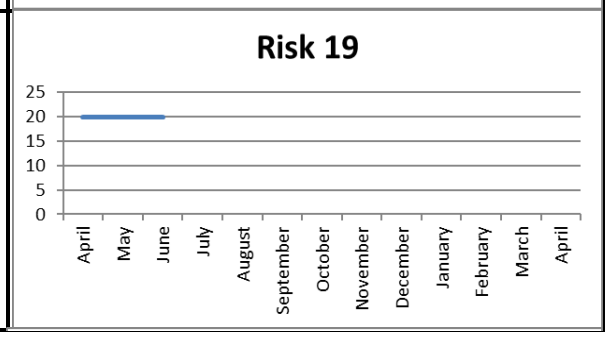
2. Risk 33: *(System Quality Group) There is a risk of significant increased length of stay to hospital patients due to the inability to source appropriate support for discharges across Discharge Pathways 1, 2 and 3 (leading to medically fit patients with no right to reside, remaining in hospital for more than 7 days).*

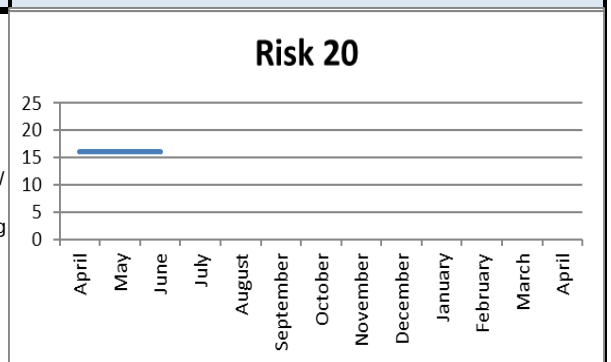
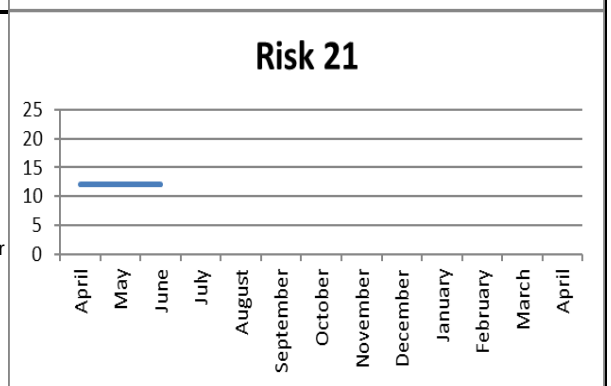
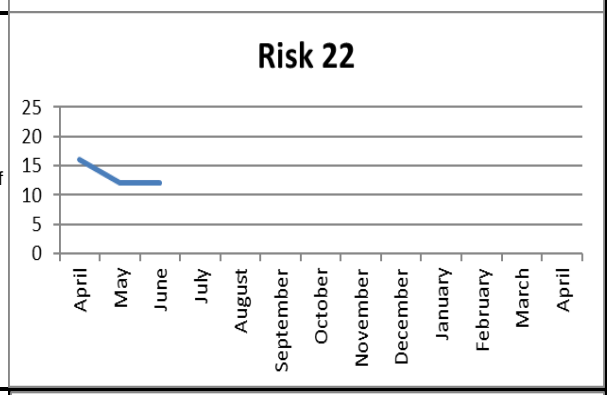
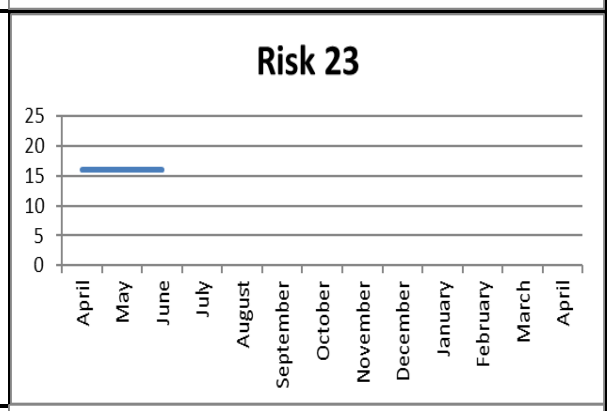
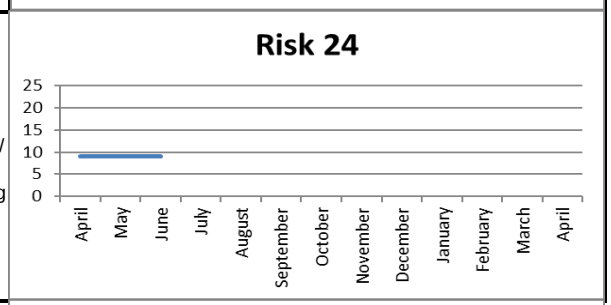
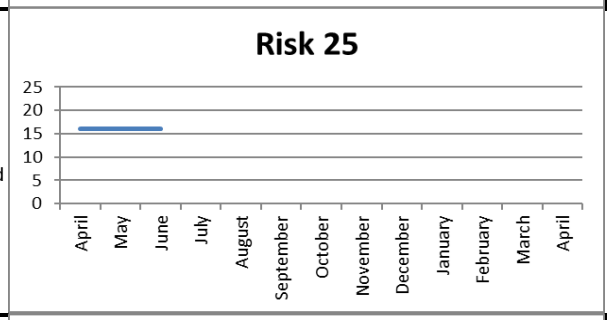
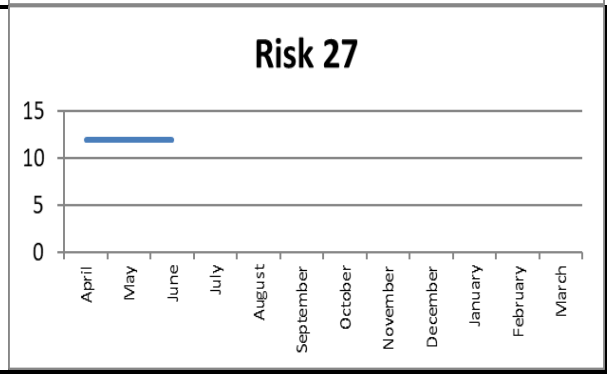
   This proposed, new risk is scored at a high 12 (probability 3 x impact 4).

Appendix 2 - ICB Risk Register - Movement - June 2024

Derby and Derbyshire Integrated Care Board

Risk Reference	Risk Description	Previous Rating (May)			Residual / Current Risk Rating (June)			Movement - June	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 volume of attendances remains high.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager	
03	There is a risk to the sustainability of the individual GP practices across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.	4	4	16	4	4	16	**RISK PROPOSED FOR CLOSURE**	Four new risks have been approved to replace former PHSCC risks.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care	**RISK PROPOSED FOR CLOSURE**
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**	5	4	20	4	5	20	⇔	The System submitted a revised deficit plan of £50.0m for 24/25	Keith Griffiths, Chief Financial Officer	Jason Burn, Operational Director of Finance Derby and Derbyshire ICB Tamsin Hooton, Programme Director, Provider Collaborative	
06B	New risk: 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	**NEW RISK**	Risk 06 has been split into two separate risks, 06A (relating to delivery of the 24/25 financial plan) and 06B relating to delivery of 2 year break even.	Keith Griffiths, Chief Financial Officer	Jason Burn, Operational Director of Finance Derby and Derbyshire ICB Tamsin Hooton, Programme Director, Provider Collaborative	**NEW RISK**
07	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to the former Derby and Derbyshire CCG this data is not held consistently across the sites.	2	3	6	2	3	6	⇔	Scanning of HR files to be scheduled over the next 12 months.	Helen Dillistone Chief of Staff	James Lunn, Assistant Director of Human Resources and Organisational Development	
09	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	4	4	16	4	4	16	⇔	At the Quality and Performance Committee meeting held on 28th March 2024, the Chair and Committee members asked for a further paper to be to be submitted outlining further detailed evidence to support the recommendation to decrease the risk score. This paper has now been deferred until June 2024.	Prof Dean Howells Chief Nursing Officer	Letitia Harris Assistant Director of Clinical Quality	

Risk Reference	Risk Description	Previous Rating (May)			Residual / Current Risk Rating (June)			Movement - June	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
11	If the ICB does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	3	3	9	3	3	9	⇔	ICS to consider the impact of the ICS financial sustainability and the delivery of the Green Net Zero targets across the system.	Helen Dillistone Chief of Staff	Suzanne Pickering Head of Governance	
13	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.	2	3	6	2	3	6	⇔	Ongoing work to map priorities through ICB Delivery Group.	Helen Dillistone Chief of Staff	Sean Thornton - Director of Communications and Engagement	
15	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	3	3	9	3	2	6	↓	No impacts to date. The risk score will be increased again should the situation change.	Helen Dillistone Chief of Staff	Chrissy Tucker - Director of Corporate Delivery	
16	Risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.	2	3	6	2	3	6	**RISK PROPOSED FOR CLOSURE**	Re-structure has been completed.	Helen Dillistone Chief of Staff	James Lunn, Assistant Director of Human Resources and Organisational Development	**RISK PROPOSED FOR CLOSURE**
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	⇔	Planning continues for public information programme, linked to 24/25 operational planning and submission of revised JFP on 30 June.	Helen Dillistone Chief of Staff	Sean Thornton - Director of Communications and Engagement	
19	New risk description May: 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	⇔	Due to the recognised pressures and delays of hospital discharges through several factors, there has been a request to separate and develop a new risk from Risk 19 to ensure that ongoing discharge work is captured as its own risk with ownership from system partners.	Dr Chris Weiner Chief Medical Officer	Jo Warburton Dan Webster	

Risk Reference	Risk Description	Previous Rating (May)			Residual / Current Risk Rating (June)			Movement - June	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
20	Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.	4	4	16	4	4	16	⇔	Concerns of asylum seekers placed within Hotels for lengthy period of time remains a concern/risk.	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children	
21	There is a risk that contractors may not be able to fulfil their obligations in the current financial climate. The ICB may then have to find alternative providers, in some cases at short notice, which may have significant financial impact.	3	4	12	3	4	12	⇔	The risk level has not changed because GP providers are still reporting financial and workforce challenges to maintain safe and effective services for our population.	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	New risk description May: 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	⇔	The recommendation is to roll this risk over into 2024/25.	Keith Griffiths, Chief Financial Officer	Jason Burn, Operational Director of Finance Derby and Derbyshire ICB	
23	New risk description June: 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	⇔	Direct Access (DA) gynaecology pathway now in place and work is developing to fully implement FIT pathway.	Prof Dean Howells Chief Nursing Officer	Monica McAllindon	
24	There is a risk that the ICB is non-compliant with the requirement to commission and have in place a Designated Doctor for looked after children as this is a statutory role.	3	3	9	3	3	9	⇔	Advert for the post is out again - there is some potential that internal interest within the Trust is being expressed.	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children	
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	⇔	The pathway redesign is still in the planning stage and the risk will not be reduced until implementation commences.	Dr Chris Weiner Chief Medical Officer	Scott Webster Head of Strategic Clinical Conditions and Pathways	
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	4	12	3	4	12	⇔	ICB Commissioning and Procurement Group meeting and identifying opportunities to strengthen processes. Communications and Engagement Team represented on the group and able to play advisory role to embed PPI and equality good practice. Expected that this risk can reduce by end of Q2.	Helen Dillistone - Chief of Staff	Sean Thornton - Director of Communications and Engagement	

Risk Reference	Risk Description	Previous Rating (May)			Residual / Current Risk Rating (June)			Movement - June	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
NEW RISK 28	There is a risk that the ICB does not systematically review historically agreed resource utilisation within contracts and care pathways resulting in the lost opportunity to redeploy wasteful and inefficiently used resources to better improve health outcomes for the residents of Derby City & Derbyshire.							NEW RISK	NEW RISK	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	TBC	NEW RISK
NEW RISK 29	There is a risk that the ICB does not deliver the strategic ambitions and priorities within the 5 Year Forward View.							NEW RISK	NEW RISK	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	TBC	NEW RISK
NEW RISK 30	There is a risk that the local health and care economy is unsustainable because of a failure to reduce 'failure demand' by effectively reducing health inequalities and delivering primary and secondary prevention.							NEW RISK	NEW RISK	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	TBC	NEW RISK
NEW RISK 31	There is a risk that key healthcare services cannot be maintained due to fragility caused by availability of staff, insufficient capital investment or inadequate outcomes for Derby City and Derbyshire community.							NEW RISK	NEW RISK	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	TBC	NEW RISK
NEW RISK 33	There is a risk of significant increased length of stay to hospital patients due to the inability to source appropriate support for discharges across Discharge Pathways 1, 2 and 3 (leading to medically fit patients with no right to reside, remaining in hospital for more than 7 days).				3	4	12	NEW RISK	NEW RISK	Dr Chris Weiner Chief Medical Officer	Jo Warburton Kirsty McMillan	NEW RISK

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				
Strategic Update from Place			X			
Strategic Update from Provider Collaborative				X		
Opportunities for Delegated Services			X			
Research Strategy		X				
ICB Strategic Objectives Refresh				X		
Primary Care Strategy	X					
Digital Development Update						X
Green NHS Strategy and Progress					X	
Delivery and Performance						
Performance Report • Quality • Performance • Workforce • Finance		X	X	X	X	X
Primary Care Access Recovery Plan	X					
NHS Impact	X					
Operational Plan and Financial Plan 24/25 and 25/26		X				X

ICB Key Areas	16 May	18 Jul	19 Sept	21 Nov	16 Jan	20 Mar
Winter Plan			X			
People and Culture						
ICB Staff Survey		x				
NHS Workforce Strategy and Plan Update					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

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