**MINUTES OF NHS DERBY AND DERBYSHIRE ICB BOARD MEETING IN PUBLIC**

**Thursday, 16th November 2023**

**via Microsoft Teams**

**Unconfirmed Minutes**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Present:** | | | | |
| Richard Wright | | RW | ICB Chair (Meeting Chair) | |
| Michelle Arrowsmith | | MA | ICB Chief Strategy and Delivery Officer / Deputy CEO | |
| Jim Austin | | JA | ICB Chief Digital and Information Officer | |
| Dr Avi Bhatia | | AB | Participant to the Board for the Clinical & Professional Leadership Group | |
| Dr Chris Clayton | | CC | ICB Chief Executive Officer | |
| Jill Dentith | | JED | ICB Interim Non-Executive Member | |
| Helen Dillistone | | HD | ICB Chief of Staff | |
| Linda Garnett | | LG | ICB Interim Chief People Officer | |
| Margaret Gildea | | MG | ICB Non-Executive Member / Senior Independent Director | |
| Keith Griffiths | | KG | ICB Chief Finance Officer | |
| Ellie Houlston | | EH | Director of Public Health – Derbyshire County Council  (Local Authority Partner Member) | |
| Prof Dean Howells | | DH | ICB Chief Nurse | |
| Paul Lumsdon | | PL | ICB Executive Director of Operations | |
| Dr Andrew Mott | | AM | GP Amber Valley (Partner Member for Primary Care Services) | |
| Dr Deji Okubadejo | | DO | ICB Board Clinical Other Member | |
| Stephen Posey | | SPo | Chief Executive UHDBFT / Chair of the Provider Collaborative Leadership Board (NHS Trust and FT Partner Member) | |
| Mark Powell | | MP | Chief Executive DHcFT (NHS Trust and FT Partner Member) | |
| Sue Sunderland | | SS | ICB Non-Executive Member | |
| Dr Chris Weiner | | CW | ICB Chief Medical Officer | |
| **In Attendance:** | | | | |
| Dr Duncan Gooch | | DG | GP, Derbyshire GP Provider Board (Item ICBP/2324/100) | |
| Tiffany Hey | | TH | 360o Assurance | |
| Dawn Litchfield | | DL | ICB Board Secretary | |
| Fran Palmer | | FP | ICB Corporate Governance Manager | |
| Ian Potter | | IP | Managing Director, GP Provider Board (Item ICBP/2324/100) | |
| Victoria Searby | | VS | Finance Director, DHU Health Care CIC | |
| Sean Thornton | | ST | ICB Deputy Director Communications and Engagement | |
| **Apologies:** | | | | |
| Tracy Allen | | TA | Chief Executive DCHSFT / Participant to the Board for Place | |
| Stephen Bateman | | SB | CEO, DHU Health Care CIC | |
| Julian Corner | | JC | ICB Non-Executive Member | |
| Suzanne Pickering | | SP | ICB Head of Governance | |
| Andy Smith | | AS | Strategic Director of People Services – Derby City Council  (Local Authority Partner Member) | |
|  | | | | |
| **Item No.** | **Item** | | | **Action** |
| **ICBP/2324/**  **091** | **Welcome and apologies**  Richard Wright (RW) welcomed everyone to the meeting.  Today's meeting has been extended to allow more time for consideration of the Primary Care / General Practice items on the agenda, with a subsequent time reduction made to the confidential meeting.  The winter period is a busy time of the year for the NHS. It is also a time when it takes stock of the last 6 months, and starts to look at the next 12 months, as the start of the next 5 years, and the longer-term plans; it seems increasingly difficult to balance the shorter and longer term.  RW urged everyone to get their covid, flu and MMR vaccinations. Prevention is so important to the smooth running of the system and helps reduce the load in the winter period. He appealed to NHS staff, and those of partner organisations, to support each other at this tough time, when they are already tired. Taking time to reflect on the good things being done is important; our staff are there for people when they are at their most vulnerable. Testament to this, today's news highlights how the NHS has developed treatments and will be tackling some of the blood disorders that have plagued us for years. RW thanked everyone, on behalf of the Board, for doing such good work - it is much appreciated.  Julian Corner (JC) is leaving the ICB at the end of this month. He has been with the ICB since its inception and has brought with him a very different way of thinking about things; he will be missed. RW thanked JC for his input and wished him well for the future.  Jill Dentith (JD) was congratulated on being appointed from an interim to permanent Non-Executive Member (NEM) role, as JC's replacement; the NEM roles may however be revised going forward. RW thanked JD for stepping in on an interim basis.  This time last meeting we said goodbye to Zara Jones; today we are welcoming Michelle Arrowsmith (MA) who has joined us as the Chief Delivery and Strategy Officer and Deputy CEO; this stresses the delivery mode of the system. MA has a very interesting and diverse background which was welcomed.  Apologies for absence were noted as above. | | |  |
| **ICBP/2324/**  **092** | **Confirmation of quoracy**  It was confirmed that the meeting was quorate. | | |  |
| **ICBP/2324/**  **093** | **Declarations of Interest**  The Chair reminded Committee Members of their obligation to declare any interests they may have on issues arising at Committee meetings which might conflict with the business of the ICB.  Declarations made by members of the Board are listed in the ICB’s Register of Interests and included with the meeting papers. The Register is also available either via the ICB Board Secretary or the ICB website, using the following link: <https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/integrated-care-board-meetings/>  Items ICBP/2324/100 and ICBP/324/101 – Dr Andy Mott (AM) and Dr Avi Bhatia (AB) declared a conflict of interest in these items as working GPs in Derbyshire. It was agreed that they would both remain in the meeting to inform the discussions on these items.  No further declarations of interest were made. | | |  |
| **ICBP/2324/**  **094** | **Minutes of the meeting held on 21st September 2023**  **The Board APPROVED the minutes of the above meeting as a true and accurate record of the discussions held** | | |  |
| **ICBP/2324/**  **095** | **Action Log – September 2023**  ICBP/2324/051 – Integrated Assurance and Performance Report – This report now includes much more information to demonstrate system working and is an ongoing process.  ICBP/2324/075 – Integrated Assurance and Performance Report – Staffordshire residents – A briefing note was circulated around the system after the last Finance, Estates and Digital Committee. This is an ongoing theme in conversations with regional and national colleagues.  **The Board NOTED the Action Log** | | |  |
| **ICBP/2324/**  **096** | **Chair's Report**  RW presented his report, a copy of which was circulated with the meeting papers; the report was taken as read and the following points of note were made:   * RW and Dr Chris Clayton (CC) are engaging with Local Authorities, District Councils and MPs on a routine basis. A constructive visit was undertaken yesterday to Northeast Derbyshire District Council, with mature discussions held on the wider determinants of health, the different roles around them, and what can be done to support each other; this was also the case at Derbyshire Dales District Council. Great discussions were held at the Integrated Care Partnership Board and the Health and Wellbeing Boards; there is a maturing position on rationalising and understanding the golden thread of what we all do and how we can support each other. CC concurred with this understanding. * The Board has started a development programme around inclusion (as opposed to equality of access), geared around what inclusion means in the future world, how to make it part of our psyche and strongly build it into the wider system.   **The Board NOTED the Chair's report** | | |  |
| **ICBP/2324/**  **097** | **Chief Executive's Report**  CC presented his report, a copy of which was circulated with the meeting papers; the report was taken as read and the following points of note were made:   * We are heading into winter, with an important year ahead in 2024/25, whilst closing 2023/24 in the best way; we have a huge job collectively in the NHS family to focus on NHS delivery, ensuring safety and quality of Urgent and Emergency Care (UEC) services whilst maintaining a focus on planned and cancer care. At the same time, we are focusing on strategic direction over the next 5 years. The purpose of the important conversations with system partners is to maintain focus and influence across a broad stream of networks in terms of the wider determinants of health. A real purpose of strategic intent is being taken going forward. * The ICB commences a staff consultation tomorrow. Staff will be supported through this challenging time. There is no good time to do this necessary work, however this is the best time. Talking to colleagues, their views are to move forward and work through it; the Board is sensitive to this. Signalled in the intent are the 3 roles of the ICB; it has an important role in its statutory duties to ensure there are good quality, safe services to meet the population's need, with that comes an increasing oversight role, alongside NHSE, around growing expertise, and to support the NHS family to become more integrated and effective in the manner in which it delivers health and care. A mind's eye will be kept on how the ICB undertakes a facilitatory and supportive role whilst Provider Collaboratives and Places become more self-sustaining, recognising this is a journey that will need to be fine-tuned; during the consultation, CC will be having conversations with system leads to consider the role they play in this. * Working with others on the wider determinants of health, the ICB will become a more influential partner in the broader regard; there is a commitment to the work being done with others. * A new Secretary of State was appointed this week. CC will update the Board further once more is known about their views and the direction of health and care governance. * CC thanked colleagues working inside and outside the health service who supported collective efforts to work through and recover from storm Babet. The ICB's administrative base at Cardinal Square was disrupted by flooding. * Patient choice, and information and data elements, are described within the report, as are awards received by staff during these challenging times. Derby and Derbyshire continue to make progress.   Questions / comments   * Concern was expressed around the staff consultation, as many staff have been through this process many times before; it is a traumatic time for them. Thought needs to be given to the whole system approach, and perhaps whether there may be suitable alternative employment opportunities in the wider system. Colleagues will be working hard to ensure people are safe and supported. The staff work really hard, and nothing would be possible without them (JED). * Congratulations were given to everyone who has won an award, particularly when they are working under such pressure; this is an excellent acknowledgement of the work going on in the system (JED) * It was enquired whether the travel to treat arrangements are having an impact; people can opt to travel to different locations for treatment, presumably in and out of Derby and Derbyshire; it was asked how this might impact on efficiency arrangements in diverting staff away from the Derby and Derbyshire agenda towards the wider picture (JED). CC responded that it is too early to take a sense on this, however any impact on operational delivery will be assessed by the ICB's corporate committees and reported to the Board. Choice is not a new concept, it has been offered for some time, with different leanings towards it over the years, however, historically Derby and Derbyshire have worked with other partners to transfer care; it is not a new phenomenon. JED added that this has been a recent national advertising campaign. * A high-level summary from the virtual wards summit was requested as this is something that the Quality and Performance Committee is particularly interested in (DO). Dr Chris Weiner (CW) advised that a virtual ward summit was held in September with broad engagement from across the system to look at the virtual wards process. There is enthusiasm to move forward and process development within the shared clinical environment. There is a broad base of clinical support for the development of virtual wards. It is a long-term development journey, which is being pushed hard this winter, recognising that it is a national priority to transform the way in which health care is delivered. This journey will take us through the next few years with commitment from the national team. The impact of the development session has resulted in an increase in the number of the virtual ward bed spaces available and utilisation of these bed spaces. There was 20% bed utilisation at the start of this year; it is now consistently running at over 50%, with a change being seen in clinical practice. There is still a long way to go. Greater usage of these beds is hoped for this winter to take pressure off Acute Trusts' front doors and manage people who could be better treated in the virtual ward space. RW was pleased to see the progress being made to embed this change.   The Board NOTED the Chief Executive's report | | |  |
| **ICBP/2324/**  **098** | **Corporate Risk Register – October 2023**  Helen Dillistone (HD) presented the Risk Register as at 31st October 2023, which provided assurance to the Board on the operational risks faced by the organisation. Each risk is allocated, actively monitored, and managed by one of the ICB's Corporate Committees.  During October, two new risks were proposed:  Risk 22: National policy not to fund the agenda for change pay award for bank staff or staff currently not on the payroll of NHS statutory bodies. The Finance, Estates and Digital Committee (FEDC) considered, at its meeting on 24.10.2023, that there is a risk in terms of being able to locally fund the pay awards, and also on staff morale. This could leave the Derbyshire system with a potential £13m recurrent liability. As this is a national decision the ICB has no mitigations. This risk is rated at a very high 25.  Risk 23: There is a risk to Joined Up Care Derbyshire (JUCD) performance against the Cancer Standards, including 28 Day Faster Diagnosis Standard, 62 Day Waits and 104+ days due to an increase in referrals from Staffordshire into UHDBFT resulting in significant capacity challenges to meet increased demand for diagnostic investigations, diagnosis, and treatment. The System Quality Group approved this new risk at its meeting on 7.11.2023. This risk is rated at a very high 16.  It is proposed that the following risk be closed:  Risk 02: Changes to the interpretation of the Mental Capacity Act and Deprivation of Liberty Safeguards, results in a greater likelihood of challenge from third parties, which will have an effect on clinical, financial, and reputational risks of the ICB. It is recommended that this risk be closed due to the work being done with Midlands and Lancashire Commissioning Support Unit to process the applications.  Questions / comments   * Risk 22 – Following consideration at FEDC, the resource and staff morale elements were highlighted. A process is being done to reword this risk to cover both of these points; it was requested that this risk be held in abeyance until this conversation has been held before being added to the Risk Register (JED). This rewording was welcomed, as it materially affects General Practice (GP); the quantum of this impact will be managed in a different way as it will fall on individual partnerships to fund. It was requested that GP also be built into this risk (AM). RW thanked Keith Griffiths for raising this issue at a national level. * Risk 02 – Mark Powell (MP) considered that if the Midlands and Lancashire Commissioning Support Unit are taking a hold on this, it will present less of a challenge. It does not specifically relate to DHcFt, although the Mental Capacity Act is on DHcFT's Risk Register. Paul Lumsdon (PL) supported the removal of this risk that was not mentioned in the King's Speech which could cause further delay; a watchful eye will be kept on this. * Risk 23 – This risk specifically refers to cancer, however it also affects the elective pathway; it was enquired whether this is covered elsewhere (DO). HD responded that, in terms of meeting the performance standards, there is a more general risk; this new risk relates to the increased referrals from Staffordshire and recognises the work underway on the pathway with Staffordshire colleagues. Stephen Posey (SPo) supported this risk being added to the register.   **The Board RECEIVED and NOTED:**   * **The Risk Register Report**   **• Appendix 1, as a reflection of the risks facing the organisation as at 31st October 2023**  **• Appendix 2, which summarises the movement of all risks in October 2023**  **• APPROVED the CLOSURE of risk 02 relating to changes to the interpretation of the Mental Capacity Act and Deprivation of Liberty Safeguards** | | |  |
| **ICBP/2324/**  **099** | **Board Assurance Framework (BAF) Quarter 2 - 2023/24**  HD presented the Quarter 2 BAF which covers the work undertaken by the ICB's Corporate Committees on the strategic risks identified. A significant review has been undertaken by Internal Audit on the controls and assurances being undertaken to ensure risk areas are being addressed and work is being done to close any gaps. The report demonstrated greater maturity, both in discussions and ownership.  Decreases were recommended in the following risks:   * Risks 1 and 2 – The Quality and Performance Task and Finish Working Group recommended these risks be reduced from 20 to 16 as a result of maturity in the system and work being done to support these areas. * Risks 7 and 9 – A thorough review of both risks was undertaken during Quarter 2, with several system gaps being removed. The description of Risk 9 has been reworded as follows: '*There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.'* * Risk 8 – This risk was previously separated into two elements; however, it is now recommended that it be separated into two separate risks which would sit better in the Population Health and Strategic Commissioning Committee (PHSCC) and FEDC.   Questions / comments   * Sue Sunderland (SS) echoed how much this has developed over the last six months; it now feels like there are targeted actions to address the gaps in place. It was requested that Committees, in the next quarter, focus on looking at how assured they are on the threats, particularly when actions have been completed; it was asked if those actions could be revisited to check why some are only partially assured and decide whether more work needs to be done. * RW considered that great progress has been made. It is worth reminding ourselves that changing the way we do things in order to improve our performance naturally increases risk during that change. Having no risk is almost impossible; however, the risk of not doing something is higher. These documents show how the risk of change is being managed; it is worth looking at them as a dynamic organisation rather than as a static system.   **The Board:**   * **APPROVED the Quarter 2 BAF strategic risks 1 to 10** * **NOTED the decrease in risk scores for Strategic Risk 1 and 2 from a very high score of 20 to a very high score of 16** * **NOTED the split of Strategic Risk 8 into two separate risks and the transfer of ownership of Strategic Risk 8 from the Finance, Estates and Digital Committee to the Population Health and Strategic Commissioning Committee** | | |  |
| **ICBP/2324/**  **100** | **Primary Care Model for Derby and Derbyshire**  *AM and AB declared a conflict of interest in this item*  Dr Andy Mott (AM) presented this item in his role as Medical Director for the GP Provider Board (GPPB). One of the prime outcomes from the May Board Development session was to develop the emerging model into something more tangible; this is one of the key functions of the Derby and Derbyshire GPPB. The model describes a potential way forward and distils the key benefits of GP within the constraints of the environment, including workforce. Engagement has been undertaken through many partner Boards and Committees. It is presented for discussion, endorsement, and consideration of next steps toward implementation.  Dr Duncan Gooch (DG) highlighted the work done by the GPPB to make this a great document. CC has described the ICB as having a statutory duty to ensure there are good quality services which meet the needs of the population; this is also the driver behind this model. The NHS is not good enough at describing what the high-quality services are that meet the needs of the population from a primary care perspective. DG provided examples of how this proposed model will work for different patient cohorts and conditions. These examples demonstrated how the totality of provision remains within the scope of existing primary care services. By prescribing care in the way set out, there is a collective opportunity to build, create and deliver services to ensure services meet the needs of our population.  Ian Potter (IP) stated that, subject to today's discussions and feedback, the next stage is to work up a detailed implementation plan and business case for this model, that will be fed into the annual planning process. IP advised this is a large, complex project which will be delivered over a period of time; there are clear alignments to work taking place in the community setting. There is a link to the community transformational work and the opportunity to learn from and align resources to the delivery of the model. In order to make it work, support is required from the system to implement it; data and digital are key to these processes and are not within the gift of the GPPB to deliver. System working will be required to unlock efficiencies to help deliver this model going forward.  RW acknowledged the amount of work that has gone into producing this.  Questions / comments   * This is a brilliant strategy document which answers a lot of questions on health and care for the population; if properly resourced and supported it will help to reduce the current problems. The idea of local interpretation and adaptation of the model to reflect local needs was supported; it was enquired how local success will be fed back up and shared across the system for consideration to improve care (DO). DG responded that this is about how transformation is delivered within PC; there are lots of organisations, both large and small, using distributed leadership to achieve change. This will not be a top-down approach as, as soon as an organisation is told what to do, it will give resistance. The description of the gap tells of the importance in using the right techniques to deliver transformation. * Primary Care is a key component of our system and crucial to the delivery of workforce, finance, and efficiencies. Good examples were provided of how this is working in practice which is positive to see. From the perspective of the FEDC chair, JED wanted to ensure that these elements are being capitalised on; it is key to getting this up front and central to utilise what already exists or what needs to be changed. The governance arrangements appear to be complicated; it needs to be ensured that it supports and facilitates achievements rather than hindering them, providing a smooth process to ensure that everyone is safe in the governance forum (JED). DG considered that the reason this point was collectively reached and articulated was to provide a backup. If the public were asked what GP is, many different descriptions would be given that did not reflect reality. Being able to demonstrate what it means is important, as is the communication of it to the public. This model is an ongoing process through the life course which will help people understand what PC is and how they can best interact with it. * This is an exciting proposal, from which benefits for patients will be seen. It was enquired how broadly this had been tested with GPs; there are multiple providers involved and it was asked how they will be managed. It was also asked whether there is learning from the practicalities of people receiving services from different teams (SS). DG confirmed that this has come from GP, and has been through many iterations, and discussed at the GP Conference and by the LMC, where it was widely supported. * PC / GP are the bedrock of the NHS, with everything else building from them; this approach was welcomed. A way through the issues faced in terms of managing complex patients in a world with people are living longer with long term condition's, can be seen, and will be strengthened by this. It is all too easy to see this as a PC/GP led approach, delivered entirely by them. There are partners on our Board from acute, mental health and community trusts for whom there will be implications on future ways of working; it needs to be recognised upfront how we come together as a system to support the bedrock of GP (CW). DG considered that it is easy to think PC is GP. Every organisation is already delivering PC and first contact care. There is a need to discuss and organise the services together to provide a PC offering within the system. * This is excellent and will come as a relief to communities who are unsure how PC works. The system needs to come together and not just rely on the GPPB and colleagues. It will be a relief to communities to know this work is taking place. Effective communication is important, to prevent people with nostalgia for a family doctor who does everything, to see this as a powerful way forward (MG). * CC added that the Board has previously accepted the bedrock nature of GP in the health and care model and has actively supported to commit to it. There is a need to confirm our view; as planning is undertaken for 2024/25 and beyond, this will need to be put at the heart of what we do. * CC is grateful to GP leaders. The ICB has supported the development of a Derby and Derbyshire GP voice and now needs to get leverage out of it. On the Board's behalf, CC meets 2 to 3 times a year with all Primary Care Network (PCN) leads, both clinical and managerial. Some of the emerging themes from the conversations include the serious structural challenges faced by GP. It is clear that PC is broader than GP, however both are important. A significant shift in the workload and type of GP and General Practitioners has been seen, as well as a shift in the complexity in a surgery and consultation lists in the last 5 to 10 years; colleagues have very few simple cases. Strategically, the ICB has increased the complexity of the GP consultation list through supporting additional roles. A shift of funding is being seen; as more money is put into PCN's, a consequential challenge is seen to individual practices' financial sustainability; strategic thought needs to be given to this. There are challenges in terms of the individual supervisory requirements for ARRS. A new GP team is being created which needs to be supervised, developed, and trained. Linked to this is the financial security upon which we want GPs to build; there is uncertainty around the contractual framework. PC / GP estate is a real concern to colleagues; there is a mixed environment of estate, and thinking forward there is a need to increase our view on GP in the capital conversation. DG agreed that the role of General Practitioner has substantially changed; this model requires further change in the role of professional who have their own development needs. * CC supported the document which well described a functional model of care; however, there is still a need to see a structural response to the challenges being faced. This urgently needs strong engagement and membership conversations on the view of the structural model that supports the functional model. CC would like to know the views of the senior GP leaders in Derby and Derbyshire on the partnership and independent contractor models. DG has been deliberately evasive in talking about structural change in order to make progress, as this is a fundamental change in the delivery of PC. Historically the PC model was based on universal access; this model will articulate that a universal access system exacerbates health inequalities which is not the best way to deliver high quality services that meet the needs of the population. Services that are appropriate to the needs of the population need to be delivered. This model is a fundamental shift in thinking in terms of access to GP; if we distracted this by asking whether the partnership model exists and what structurally changes, we would not be able to move away from this. In terms of partnership model, there is commonality on GPs leading PC in local communities; the current infrastructure is the partnership model within the independent contractor, although there are other models which are successful. The function of having local GPs who support and supervise across a whole group of people and can carry risk and make difficult decisions around people's health and care, is very important. The future still has this function whatever it might be and will be part of the next stage. AM added that engagement has been undertaken as wide as possible, however this is about sequencing; there would be no point in going to the harder to reach practices unless the ICB agreed it. Communication will be a significant part of the implementation plan; it was raised at the Healthwatch Derbyshire AGM. System support will be required with communication. The partnership structure requires consideration as it will have implications on what the GPPB's role is in future; it is currently established to deliver and drive this model as a collective representative voice. The GP provider ask at a scale is mentioned in the fuller stocktake and needs to be led by GPs. * CC fully understood the process undertaken to date, however there are structural challenges. The GPPB was requested to actively engage in conversations with practitioners on the structural questions. CC has asked PCNs to consider questions in preparation for his next visit, including clarity of the functional role at an individual GP, PCN and Place / Place Alliance level from a GP perspective; the GPPB was requested to actively support these conversations and return to the ICB Board in 3-6 months with thoughts that supports those functions. DG took CC's challenge on and challenged back that in order to do this the Board needs to commit to this model; structural change cannot be supported in a context of uncertainty, as it would become reductionist. There is a need to be ambitious about what we want to achieve for PC in Derby and Derbyshire. * PL echoed his support for the functional proposal and how the structure under that will come into play. The focus should be on the resilience of PC/GPs. The outcomes need to pick up the workforce indicators and build on existing expertise. * RW highlighted that the system is currently looking at the vision of where it wants to be in 5 years' time. He fully backed this model of care, and concurred with the point made that GP/PC has an effect on other parts of the system; there is a need to pull together localised care. GP is a big part of this system therefore needs to be considered when doing this. He agreed that one size does not fit all.   **The Board:**   * **ENDORSED the new Primary Care Model for Derby and Derbyshire** * **APPROVED the Primary Care Model for Derby and Derbyshire** * **SUPPORTED the proposed approach to implementation, and the need to ensure governance and architecture arrangements reflect the central role that Primary Care will play in the development and delivery of integrated care in Derby and Derbyshire** * **DISCUSSED the approach by which the GPPB will discuss and access support for implementation** | | | **AM/DG/**  **IP** |
| **ICBP/2324/**  **101** | **System Level Primary Care Access Improvement Plan**  *AM and AB declared a conflict of interest in this item*  Michelle Arrowsmith (MA) advised this is about the here and now of PC, as opposed to its future as discussed in the previous item. It is a national piece of work which the Board is required to approve.  Clive Newman (CN) stated that this national plan has two main goals:  1. To tackle the 8am rush and reduce the number of people struggling to contact their practice. End to patients being requested to call back another day to book an appointment  2. For patients to know on the day they contact their practice how their request will be managed  CN provided an overview of the measures being taken to reach these goals, details of which were included in the meeting papers. This work is necessary but insufficient and sits within a broader long-term vision. An access working group is overseeing the implementation of this plan, for which progress is being tracked.  A year-end report will be presented to a future Board in March 2024.  Questions / comments   * It was enquired whether Urgent Treatment Centres (UTCs) play a role in this. A recent visit to Whitworth Hospital, highlighted a lack of PC presence. It was enquired whether there will be a return on these proposals in terms of a reduced load on acute hospitals or other parts of the system. In order to know where best to invest, given the limited resources available, there is a need to demonstrate the positives and negatives from a system perspective (RW). * More detail was requested around the primary/secondary interface that reduces bureaucracy in response to the Academy of Royal College's report in order to provide assurance on where outputs will be seen (CC). CW outlined the asks in terms of cutting bureaucracy. It was recognised that these requests were reasonable and longstanding, however they will present implications. Behavioural changes will be required of a large number of clinicians and services across Derby and Derbyshire. A process is required to get this change into the system. PC colleagues are involved and CPLG assistance will be required. Agreement is required on the standards we need to hold ourselves to, as a group of clinical services, in terms of enacting change. As a last resort, there may be a need to use the levers within the commissioning structures. Although these are simple requests, the amount of change, and number of people needing to change their practice in order to make it work effectively, is significant. It is hoped to see some progress in the next three months. * The interface is only one small part of this, there is a lot more to be discussed. It is not unreasonable to be asking for these measures to be implemented; it is nobody's fault that they have not been actioned already – it is an outturn of the complex ecosystem we work in. GPs spend a lot of time dealing with administration; not doing this would give them more time to do other things. It would be unfair to say this only comes from secondary care, as it comes from various organisations; other aspects also require consideration. Discussions will take place at CPLG to reach a clinical agreement and find a sensible way forward, looking at how it is implemented as a system to ensure ever changing staff and organisations are made aware of it. GP cannot be unilateral, it will work through it; however, in order to do so an agreement is needed that it is the right way for all. GP/PC has to be able to utilise resources as they see fit; ARRS is an example of where they are not allowed to do that. The system can help to take the population on this journey (AB). * As PCLB chair, time will be spent time on this as a collaborative. There is a need to understand whether reducing the demand on PC will help with the U&EC flow across the system; there is commitment by the system to do better on this.   **The Board APPROVED the System-Level Access Improvement Plan** | | | **MA/CN** |
| **ICBP/2324/**  **102** | **Integrated Assurance and Performance Report**  CC highlighted that this report is about the concept of balancing operations with finance and people, underpinned by quality and safety; going forward, this will be the approach built on.  Performance – Michelle Arrowsmith (MA) outlined the key messages from a performance perspective, as described in the meeting papers. It was highlighted that the performance data has been validated. A lot of the metrics are considered on an hourly/daily/weekly basis and there is significant scrutiny on performance and what is underlying its delivery. Weekly system meetings are held on elective and cancer care, to scrutinise any issues and ascertain what needs be done to improve the situation. There are vulnerabilities around performance in some areas as we start to go into the winter pressures period; reassurance was provided that these are being scrutinised.  Workforce – Linda Garnett (LG) outlined the key messages from a workforce perspective, as described in the meeting papers. The Board were asked to take confidence from the numbers, as the People's Services teams have undertaken a huge amount of work on them. The plan demonstrates a slight overspend, however there is a downward trend in terms of growth and workforce numbers against the pay bill and establishment. Attention was drawn to agency usage; NHSE requires the plan to reduce the agency staffing spend to be reported formally to the Board; it will be interesting to understand what is driving agency spend. All providers have strengthened the processes to sign off agency expenditure. Some of the services driving the use of agency have deep seated supply issues; the teams are working hard to make progress.  Quality – Professor Dean Howells (DH) outlined the key messages from a quality perspective, as described in the meeting papers. Maternity services, local and nationally, were highlighted. The Section 29 improvements required by mid-December are being worked on. When the Board meets in January, the full published report into UHDBFT will be available. There will be an opportunity to look at it and the broader cultural elements being worked through. The PC interface with the CQC continues at pace; there will be a focus on this over the next 3 months. A discussion around sustainability of improvement is required; the work will flow through in the next few months as the activity continues. The time is now right for us to reconsider an extension of Strategic Risk 2 on short term operational needs, not just having an impact on health outcomes, but also on sustained quality compliance, taking note of the increasing pressure on compliance. DH has completed his front-line visits and it is evident that there is a strong culture on quality compliance and quality reporting however there is less focus on quality improvement as a system. DH has walked through the whole quality improvement journey at CRHFT and will be asking the Board to more systematically consider the Derby and Derbyshire improvement methodology. DH was impressed by the ICB's contribution to the safeguarding approach and the way Local Authorities respond to safeguarding referrals and high-profile cases.  Finance – Keith Griffiths (KG) outlined the key messages from a finance perspective, as described in the meeting papers. KG noted that, dependent upon industrial action, there is a potential £60-70m overspend at yearend, as things currently stand; this is driven by changes since the formal plan was submitted. This will be influenced by productivity delivered over the winter and the costs of U&EC. The national press has announced additional resources for the NHS; our share, against a £60-70 potential problem, will be £12.2m. There is a lot of work to do to square off the financials, against the workforce and operational challenges. Financial pressures are now being felt in all areas of the system, including PC, mental health, community services, Continuing Health Care and Out of Area Sector placements. Work is being done to triangulate performance expectations, workforce, and finances under the auspice of maintaining safe care over the winter period. This is the end of the first half year, with six more months to go. CC added that the letter was received this time last week. Assurance was provided to the Board that expert colleagues are working across the system on the individual components and will bring a view to the confidential Board planned for next week.  Questions / comments   * It was helpful to receive the extra information on agency use. It is pleasing that admin and estates has been investigated. It was enquired what measures were being taken to reduce/eliminate off framework agency usage (which is more expensive). One trust outside Derbyshire has stopped using off framework agency staff completely: it was asked how far this is being pushed (SS). LG responded that the plan is to eradicate off framework usage, this is linked to the controls providers are implementing to manage it. It is a difficult one; many providers will say it is in their process, as when faced with a difficult decision in the middle of the night, there is a need to do this. LG is unsure whether this can be totally eradicated. KG added that, in reality, it is about keeping patients safe therefore sometimes appropriate actions need to be taken. * KG advised that it is important to recognise that the Derbyshire system is one of best performing financially in the Midlands. Some big issues are being dealt with which are manifesting themselves in the financials. * RW felt that it would be good to have a better period of stability without any strikes in order to get control of this work; it has not been an easy year up to now.   RW thanked colleagues for this report, which contained a lot of information. Further work is required to streamline it, whilst highlighting the issues that really need to be looked at from a system level. Balancing the short / long term with inclusion, prevention, and healthy life expectancy, would be welcomed. It was confirmed that the whole system is now being covered.  **The Board NOTED the Month 6 Operational Plan performance update against the planned commitments and targets** | | |  |
| **ICBP/2324/**  **113** | **NHS Operational Plan** **– October 2023 to March 2024**  MA presented a refresh of the Operational Plan for the final 6 months of the year, with a particular focus on winter. The report was taken as read. The volatile performance on U&EC in October was highlighted. This is a good plan, however there are still some gaps, including acute respiratory hubs, a single point of access and virtual wards; all three of these areas will come into the forefront as to how they can help across the system during the winter period.  The Plan is live and dynamic, and it is now about delivering, enacting, and monitoring against it to deal with any potential risks. MA will be leading this from a system perspective.  **The Board NOTED the Derby and Derbyshire NHS' Operational Plan for October 2023 – March 2024** | | |  |
| **ICBP/2324/**  **114** | **Audit and Governance Assurance Report – September/October 2023 / 2022-23 Annual Report**  Sue Sunderland (SS) presented these reports which were taken as read. It is hoped that people would find the Annual Report useful. Although the Board is well sighted on the financial position, the Committee benefited from a deep dive on the underlying issues and constraints that impact how well the ICB is able to mitigate the pressures it is facing; this was summarised in the assurance report. There is a need to keep this in mind, as some pressures are more difficult to address than others. There are ongoing issues regarding procurement.    **The Board RECEIVED and NOTED the reports for assurance purposes** | | |  |
| **ICBP/2324/**  **115** | **Finance, Estates and Digital Committee Assurance Report – September/October 2023**  Jill Dentith (JED) presented this report which was taken as read. A presentation was given on workforce that provided assurance on the more detailed aspects. Efficiencies link closely to transformation; there is a need to ensure that transformations are being embedded. Although savings are currently £2m over plan, this is due to non-recurrent aspects rather than recurrent; this has to be turned around to secure a better financial position. The National funding letter was received after the Committee meeting and will be picked up at the next meeting. The wider role of the Committee, how it fits in with other committees and the value it can add to the Board discussions, is being considered. CC/HD will discuss the roles of all committees to prevent overlap.  RW noted that PC estates will be a big issue going forward, and so much relies on having a Shared Care Record (SCR) to be able to operate as a system. JA stated that the SCR is well established and rolled out in Derby and Derbyshire and work is now being done to enhance it; however, there are brakes being put on digital funding which we need to be mindful of. A deep dive will be taken to the committee in December. JED added that an estates strategy is being developed, of which PC is a key part.  **The Board RECEIVED and NOTED the report for assurance purposes** | | |  |
| **ICBP/2324/**  **106** | **Derbyshire Public Partnership Assurance Report – September / October 2023 / 2022-23 Annual Report**  SS presented these reports which were taken as read; no questions were raised.  **The Board RECEIVED and NOTED the reports for assurance purposes** | | |  |
| **ICBP/2324/**  **107** | **Population Health and Strategic Commissioning Committee Assurance Report – October 2023 / 2022/23 Annual Report**  DO presented these reports which were taken as read. No major concerns were reported and no questions were raised.  **The Board RECEIVED and NOTED the reports for assurance purposes** | | |  |
| **ICBP/2324/**  **108** | **Quality and Performance Committee Assurance Report – September 2023 / 2022-23 Annual Report**  DO presented these reports which was taken as read. There are ongoing concerns on quality and performance as outlined in the IAPR. The Committee has invited a PC representative to attend its meetings; AM is currently fulfilling this role. The Committee will be receiving a deep dive on maternity at its November meeting. No questions were raised.  **The Board RECEIVED and NOTED the reports for assurance purposes** | | |  |
| **ICBP/2324/**  **109** | **People and Culture Committee Annual Report 2022/23**  Margaret Gildea (MG) presented the Annual Report. It was noted that the Committee is working on key issues around workforce. A development session is scheduled for next week to look at how the Committee is performing and whether it is fulfilling its obligations.  **The Board RECEIVED and NOTED the report for assurance purposes** | | |  |
| **ICBP/2324/**  **110** | **Freedom to Speak Up Update**  MG presented the report which was taken as read. Following the Lucy Letby letter, discussions were held as a system to ensure that Freedom to Speak Up systems and processes were working everywhere to provide people with freedom. MG has agreed to take on the role of ensuring that all systems and processes are in place and working effectively; this will be discussed at the P&CC on 6.12.2023.  RW added that the Freedom to Speak up role has now been taken on for Primary Care. An update was requested at the next meeting.  **The Board RECEIVED and NOTED the verbal update for assurance purposes** | | | **MG** |
| **ICBP/2324/**  **111** | **Derbyshire County Council Director of Public Health Annual Report 2022/23**  Ellie Houlston (EH) presented this report which was taken as read. It has been taken to various Boards across the system. It sets out statistics for mental health across the county, building on the 'Let's Chat Campaign' to promote good mental health. RW added that this report should be read under the context of the current financial pressures the Local Authority finds itself under.  **The Board RECEIVED and NOTED the report for assurance purposes** | | |  |
| **ICBP/2324/**  **112** | **Ratified minutes of the Derby and Derbyshire Health and Wellbeing Boards**   * Derby City Health & Wellbeing Board – 7.9.2023 * Derbyshire County Health & Wellbeing Board – 5.10.2023   **The Board RECEIVED and NOTED the above minutes for information** | | |  |
| **ICBP/2324/**  **112** | **Ratified Minutes of ICB Corporate Committees**   * Audit & Governance Committee – 10.8.2023 * Public Partnership Committee – 29.8.2023 / 26.9.2023 * Quality & Performance Committee – 31.8.2023/ 28.9.2023   **The Board RECEIVED and NOTED the above minutes for information** | | |  |
| **ICBP/2324/**  **113** | **Forward Planner**  **The Board NOTED the forward planner for information** | | |  |
| **ICBP/2324/**  **114.1** | Did the items on the agenda address the risks in a way that we feel will mitigate them over the short and medium term. If not, do we want to consider a deep dive on any items in a future agenda. No | | |  |
| **ICBP/2324/**  **114.2** | Did any of the discussions prompt us to want to change any of the risk ratings up or down? No | | |  |
| **ICBP/2324/**  **115** | **Any Other Business**  None raised. | | |  |
| **ICBP/2324/**  **116** | **Questions received from members of the public**  No questions were received from members of the public. | | |  |
| **Date and Time of Next Meetings** | | | | |
| **Date**: Thursday, 18th January 2024  **Time**: 9am to 10.45am  **Venue:** via MS Team | | | | |