NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC AGENDA

Thursday 16th November 2023 at 9am to 11.30am

Via MST

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

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

Time	Reference	Item	Presenter	Delivery
09:00	**Introductory Items**			
	ICBP/2324/091	Welcome, introductions and apologies: Tracy Allen, Suzanne Pickering, Stephen Bateman, Julian Corner	Richard Wright	Verbal
	ICBP/2324/092	Confirmation of quoracy	Richard Wright	Verbal
	ICBP/2324/093	Declarations of Interest • Register of Interests • Summary register for recording interests during the meeting • Glossary	Richard Wright	Papers
09:05	**Minutes and Matters Arising**			
	ICBP/2324/094	Minutes from the meeting held on 21st September 2023	Richard Wright	Paper
	ICBP/2324/095	Action Log – September 2023	Richard Wright	Paper
09:10	**Strategy and Leadership**			
	ICBP/2324/096	Chair's Report – October 2023	Richard Wright	Paper
	ICBP/2324/097	Chief Executive Officer's Report – October 2023	Dr Chris Clayton	Paper
09:20	**Risk Management**			
	ICBP/2324/098	ICB Risk Register – October 2023	Helen Dillistone	Paper
	ICBP/2324/099	Board Assurance Framework Quarter 2 2023/24	Helen Dillistone	Paper

Time	Reference	Item	Presenter	Delivery
09:30	**For Decision**			
	ICBP/2324/100	Primary Care Model for Derby and Derbyshire	Dr Andy Mott / Dr Duncan Gooch / Ian Potter	Paper
	ICBP/2324/101	System-level Primary Care Access Improvement Plan	Michelle Arrowsmith / Clive Newman	Paper
10:15	**Integrated Assurance & Performance**			
	ICBP/2324/102	Integrated Assurance and Performance Report • Quality • Performance • Workforce • Finance	Dr Chris Clayton Dr Deji Okubadejo/ Dean Howells Dr Deji Okubadejo/ Michelle Arrowsmith Margaret Gildea/ Linda Garnett Jill Dentith/ Keith Griffiths	Paper
10:45	**For Discussion**			
	ICBP/2324/103	Operational Plan – October 2023 to March 2024	Michelle Arrowsmith	Paper
11:00	**Corporate Assurance**			
	ICBP/2324/104	Audit and Governance Committee Assurance Report – October 2023 and 2022/23 Annual Report	Sue Sunderland	Paper
	ICBP/2324/105	Finance, Estates and Digital Committee Assurance Report – September / October 2023	Jill Dentith	Paper
	ICBP/2324/106	Derbyshire Public Partnership Committee Assurance Report – October 2023 and 2022/23 Annual Report	Sue Sunderland	Paper
	ICBP/2324/107	Population Health and Strategic Commissioning Committee Assurance Report – October / November 2023 and 2022/23 Annual Report	Dr Deji Okubadejo	Paper
	ICBP/2324/108	Quality and Performance Committee Assurance Report – September 2023 and 2022/23 Annual Report	Dr Deji Okubadejo	Paper
	ICBP/2324/109	People and Culture Committee 2022/23 Annual Report	Margaret Gildea	Paper
	ICBP/2324/110	'Freedom To Speak Up' – Update on arrangements	Margaret Gildea	Paper

Time	Reference	Item	Presenter	Delivery
11:20	**Items for Information**			
	The following items are for information and will not be individually presented			
	ICBP/2324/111	Derbyshire County Council Director of Public Health Annual Report 2023	Ellie Houlston	Paper
	ICBP/2324/112	Ratified minutes of Health and Wellbeing Boards • Derby City Council – 7.9.2023 • Derbyshire County Council – 5.10.2023	Richard Wright	Papers
	ICBP/2324/113	Ratified minutes of ICB Committee Meetings • Audit & Governance Committee – 10.8.2023 • Public Partnership Committee – 29.8.2023 / 26.9.2023 • Quality & Performance Committee – 31.8.2023 / 28.9.2023	Richard Wright	Papers
11:25	**Closing Items**			
	ICBP/2324/114	Forward Planner	Richard Wright	Paper
	ICBP/2324/115	1. Did the items on the agenda address the risks in a way that we feel will mitigate them over the short and medium term. If not, do we want to consider a deep dive on any items in a future agenda? 2. Did any of the discussions prompt us to want to change any of the risk ratings up or down?	Richard Wright	
	ICBP/2324/116	Any Other Business	Richard Wright	Verbal
	ICBP/2324/117	Questions received from members of the public	Richard Wright	Verbal

Date and time of next Meeting in Public:

Date: Thursday, 18th January 2024
Time: 9am to 10.45am
Venue: via MS Teams

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

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Allen	Tracy	Participant to the Board for Place	Primary & Community Care Delivery Board Chair of Digital and Data Delivery Board Integrated Place Executive Meeting	CEO of Derbyshire Community Health Services NHS Foundation Trust	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Partner is a Director (not Board Member) for NHS Derby and Derbyshire ICB				✓	01/07/22	Ongoing	
				Trustee for NHS Providers Board		✓			01/07/22	30/06/23	
				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 Committee Population Health & Strategic Commissioning Committee Quality & Performance Committee	Director of husband's company - Woodford Woodworking Tooling Ltd				✓	01/11/14	Ongoing	No action required as not relevant to any ICB business
Austin	Jim	Chief Digital & Information Officer	Finance & Estates Committee	Employed jointly between NHS Derby and Derbyshire Integrated Care Board and Derbyshire Community Health Services NHS Foundation Trust	✓				01/11/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Spouse is a locum GP and the Local Place Alliance lead for High Peak (8 hours per week)				✓	01/11/22	Ongoing	
Bhatia	Avi	Participant to the Board for the Clinical & Professional Leadership Group	Chair - Clinical and Professional Leadership Group, Derbyshire ICS Population Health & Strategic Commissioning Committee	GP partner at Moir Medical Centre	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				GP partner at Erewash Health Partnership	✓				01/07/22	Ongoing	
				Part landlord / owner of premises at College Street Medical Practice, Long Eaton, Nottingham	✓				01/07/22	Ongoing	
				Spouse works for Nottingham University Hospitals in Gynaecology				✓	01/07/22	Ongoing	
Clayton	Chris	Chief Executive Officer	ICS Executive Team Meeting	Spouse is a partner in PWC				✓	01/07/22	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Corner	Julian	ICB Non-Executive Member	Public Partnership Committee Population Health & Strategic Commissioning Committee Remuneration Committee	As the CEO of Lankelly Chase Foundation, I may have an interest in organisations being commissioned by the JUCD if that would support a grant funding relationship that Lankelly Chase has with them.		✓			01/03/22	30/06/25	Not aware of any grant relationships between Lankelly Chase and Derbyshire based organisations, or organisations that might stand to benefit from JUCD commissioning decisions. If that were to happen I would alert the JUCD chair and excuse myself from decisions both at Lankelly Chase and JUCD.
Dentith	Jill	Interim Non-Exective Member	Audit & Governance Committee Finance & Estates 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, short term corporate governance support to Shaping Health International Ltd (UK)	✓				09/03/23	30/09/23	
				Providing part-time, short term corporate governance support to Conexus	✓				01/06/23	Ongoing	
Dillistone	Helen	Chief of Staff	Audit & Governance Committee Public Partnership Committee	Nil							No action required
Garnett	Linda	Interim Chief People Officer	People & Culture Committee Population Health & Strategic Commissioning Committee Finance & Estates Committee ICS Executive Team Meeting	Husband, Wynne Garnett is providing services to the ICB via 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 Limited	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Coaching and organisation development with First Steps Eating Disorders	✓				01/07/22	Ongoing	
				Director, Melbourne Assembly Rooms		✓			01/07/22	Ongoing	
Griffiths	Keith	Chief Finance Officer	Finance & Estates Committee Population Health & Strategic Commissioning Committee Integrated Place Executive ICS Executive Team Meeting	Nil							No action required
Houlston	Ellie	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)	System Quality Group Integrated Care Partnership Health and Wellbeing Board - Derbyshire County Council	Director of Public Health, Derbyshire County Council	✓				01/09/22	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair. Sheffield based - unlikely to bid in work in Derbyshire
				Director and Trustee of SOAR Community			✓		01/09/22	Ongoing	

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					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Howells	Dean	Chief Nurse Officer	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee Local Maternity and Neonatal System Board Clinical and Professional Leadership Group Information Governance Assurance Forum ICS Executive Team Meeting	Honorary Professor, University of Wolverhampton	✓				13/09/23	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair.
Jones*	Zara	Executive Director of Strategy & Planning	Finance & Estates Committee Population Health & Strategic Commissioning Committee Quality & Performance Committee	Nil							No action required
Lumsdon	Paul	Executive Director of Operations	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee Local Maternity and Neonatal System Board Clinical and Professional Leadership Board	Nil							No action required
MacDonald*	John	ICB Chair	Derby and Derbyshire Integrated Care Partnership Board	Chair at University Hospitals of Leicester NHS Trust	✓				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
Mott	Andrew	GP Amber Valley (Primary Medical Services Partner Member)	System Quality Group Joint Area Prescribing Committee Derbyshire Prescribing Group Clinical and Professional Leadership Group Primary Care Network Delivery & Assurance Group End of Life Programme Board	GP Partner of Jessop Medical Practice	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Practice is shareholder in Amber Valley Health Ltd (provides services to our PCN)	✓				01/07/22	Ongoing	
				Medical Director, Derbyshire GP Provider Board	✓				01/07/22	Ongoing	
				Wife is Consultant Paediatrician at UHDBFT				✓	01/07/22	Ongoing	
Okubadejo	Adedeji	Clinical Lead Member	Population Health & Strategic Commissioning Committee Quality & Performance Committee Remuneration Committee	Director, Carwis Consulting Ltd – Provision of clinical anaesthetic services as well as management consulting services to organisations in the independent healthcare sector	✓				01/04/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Consultant Anaesthetist, University Hospitals Birmingham NHS Foundation Trust	✓				01/04/23	30/04/23	
				Provision of private clinical anaesthetic services in the West Midlands area	✓				01/04/23	Ongoing	
				Director & Chairman OBIC UK – Working to improve educational attainment of BAME children in the UK			✓		01/04/23	Ongoing	
Posey	Stephen	CEO UHDBFT / Chair of the Provider Collaborative Leadership Board (NHS Trust & FT Partner Member)	UEC Delivery Board (Chair) Provider Collaborative Leadership Board (Chair)	Chief Executive of UHDBFT	✓				01/08/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Board Trustee of the Intensive Care Society (ICS)		✓			01/08/23	Ongoing	
				Executive Well-Led Reviewer for the Care Quality Commission (CQC)		✓			01/08/23	Ongoing	
				Chief Executive Member of the National Organ Utilisation Group (OUG)		✓			01/08/23	Ongoing	
				Partner is Chief Executive Officer of the Royal College of Obstetricians and Gynaecologists				✓	01/08/23	Ongoing	
				Partner is a Non-Executive Director for the Kent, Surrey & Sussex (KSS) AHSN				✓	01/08/23	Ongoing	
				Partner is Trustee of Magpas Charity				✓	01/08/23	Ongoing	
				Partner is a Non-Executive Director for Manx Care				✓	17/05/23	Ongoing	
Powell	Mark	CEO DHcFT (NHS Trust & FT Partner Member)	People & Culture Committee Population Health & Strategic Commissioning Committee	CEO of Derbyshire Healthcare NHS Foundation Trust	✓				01/04/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Treasurer of Derby Athletic Club			✓		01/03/22	Ongoing	
Rawlings*	Amanda	Chief People Officer	People & Culture Committee Population Health & Strategic Commissioning Committee	Employed jointly between NHS Derby and Derbyshire Integrated Care Board and University Hospitals of Derby and Burton NHS Foundation Trust, as Chief People Officer	✓				01/07/22	30/04/23	This position was agreed by both the ICB and UHDB. Declare interest when relevant and withdraw from all discussion and voting if UHDB is potential provider, unless otherwise agreed by the meeting chair
Smith	Andy	Strategic Director of People Services - Derbyshire County Council (Local Authority Partner Member)	Clinical and Professional Leadership Group	Director of Adult Social Care and Director of Children's Services, Derby City Council	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Member of Regional ADASS and ADCS Groups		✓			01/07/22	Ongoing	

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					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Stacey*	Brigid	Chief Nurse Officer and Deputy Chief Executive Officer	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee	Nil							No action required
Sunderland	Sue	Non-Executive Member - Audit & Governance	Audit and Governance Committee Finance and Estates Committee Public Partnership Committee IFR Panels CFI Panels	Audit Chair NED, Nottinghamshire Healthcare Trust Audit Chair of Joint Audit Risk & Assurance Committee for the Office of the Police & Crime Commissioner and Chief Constable of Derbyshire Husband is an independent person sitting on Derby City Audit Committee		✓ ✓		 ✓	01/07/22 01/07/22 01/07/22	Ongoing Ongoing Ongoing	The interests should be kept under review and specific actions determined as required - declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair Unlikely for there to be any conflicts to manage
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	Chair	N/A	Nil							No action required

SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

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

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

Abbreviations & Glossary of Terms

A&E	Accident and Emergency
AfC	Agenda for Change
AGM	Annual General Meeting
AHP	Allied Health Professional
AQP	Any Qualified Provider
Arden & GEM CSU	Arden & Greater East Midlands Commissioning Support Unit
ARP	Ambulance Response Programme
ASD	Autistic Spectrum Disorder
BAF	Board Assurance Framework
BAME	Black Asian and Minority Ethnic
BCCTH	Better Care Closer to Home
BCF	Better Care Fund
BMI	Body Mass Index
bn	Billion
BPPC	Better Payment Practice Code
BSL	British Sign Language
CAMHS	Child and Adolescent Mental Health Services
CATS	Clinical Assessment and Treatment Service
CBT	Cognitive Behaviour Therapy
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile
CEO (s)	Chief Executive Officer (s)

CfV	Commissioning for Value
CHC	Continuing Health Care
CHP	Community Health Partnership
CMHT	Community Mental Health Team
CMP	Capacity Management Plan
CNO	Chief Nursing Officer
COO	Chief Operating Officer (s)
COP	Court of Protection
COPD	Chronic Obstructive Pulmonary Disorder
CPD	Continuing Professional Development
CPN	Contract Performance Notice
CPRG	Clinical & Professional Reference Group
CQC	Care Quality Commission
CQN	Contract Query Notice
CQUIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CSE	Child Sexual Exploitation
CSF	Commissioner Sustainability Funding
CSU	Commissioning Support Unit
CTR	Care and Treatment Reviews

CVD	Chronic Vascular Disorder
CYP	Children and Young People
D2AM	Discharge to Assess and Manage
DAAT	Drug and Alcohol Action Teams
DCC	Derbyshire County Council or Derby City Council
DCHSFT	Derbyshire Community Health Services NHS Foundation Trust
DCO	Designated Clinical Officer
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHSC	Department of Health and Social Care
DHU	Derbyshire Health United
DNA	Did not attend
DoF(s)	Director(s) of Finance
DoH	Department of Health
DOI	Declaration of Interests
DoLS	Deprivation of Liberty Safeguards
DPH	Director of Public Health
DRRT	Dementia Rapid Response Team
DSN	Diabetic Specialist Nurse
DTOC	Delayed Transfers of Care
ED	Emergency Department
EDS2	Equality Delivery System 2
EDS3	Equality Delivery System 3

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

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

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

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

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

MINUTES OF NHS DERBY AND DERBYSHIRE ICB BOARD MEETING IN PUBLIC

Thursday, 21st September 2023

via Microsoft Teams

Unconfirmed Minutes

Present:		
Richard Wright	RW	ICB Chair (Meeting Chair)
Tracy Allen	TA	Chief Executive DCHSFT / Participant to the Board for Place
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
Zara Jones	ZJ	ICB Executive Director of Strategy and Planning
Prof Dean Howells	DH	ICB Chief Nurse
Dr Andrew Mott	AM	GP Amber Valley (Partner Member for Primary Care Services)
Dr Deji Okubadejo	DO	ICB Board Clinical Other Member
Stephen Posey	SPo	Chief Executive UHDBFT / Chair of the Provider Collaborative Leadership Board (NHS Trust and FT Partner Member)
Mark Powell	MP	Chief Executive DHcFT (NHS Trust and FT Partner Member)
Andy Smith	AS	Strategic Director of People Services – Derby City Council (Local Authority Partner Member)
Sue Sunderland	SS	ICB Non-Executive Member
Dr Chris Weiner	CW	ICB Chief Medical Officer
In Attendance:		
Stephen Bateman	SB	CEO, Derbyshire Health United
Jacinta Bowen-Byrne	JBB	Interpreter
Fraser Holmes	FH	Interpreter
Dawn Litchfield	DL	ICB Board Secretary
Fran Palmer	FP	ICB Corporate Governance Manager
Suzanne Pickering	SP	ICB Head of Governance
Sean Thornton	ST	ICB Deputy Director Communications and Engagement
Apologies:		
Julian Corner	JC	ICB Non-Executive Member
Ellie Houlston	EH	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)

ICBP/2324/064	**Welcome and apologies** Richard Wright (RW) welcomed everyone to the meeting. RW apologised to any patients affected by the current industrial action, and acknowledged and thanked staff for the work they are undertaking to minimise the effects. Since the last meeting, two disturbing issues relating to the NHS have been raised: the Lucy Letby verdict and the accusations on alleged sexual harassment. These issues are not something that any decent person can relate to; they are unbelievable and cannot be condoned. It is just awful for	

	many staff in the NHS who just want to do the right thing and provide a great service to support patients. Assurance was given that steps are in hand to try to ensure this does not happen again. One of the most disturbing aspects of this is that allegedly warnings were raised and potentially ignored. Margaret Gildea (MG), as Chair of the People and Culture Committee (P&CC), has agreed to work with the Executive Team to re-assess the 'Freedom to Speak Up' arrangements across the system to confirm they are fit and proper, providing people with confidence to speak up and assurance that any 0020concerns raised will be dealt with correctly. Work is being undertaken around the 'fit and proper person' assessments and procedures to ensure that assessments are undertaken before people are employed by the NHS and before they move to other areas within the NHS. RW welcomed Stephen Posey (SPo), CEO of UHDBFT, to his first ICB Board meeting. The Board now has Senior Executive representation from the Acute sector through SPo, Community and Place through Tracy Allen (TA) and Mental Health through Mark Powell (MP); this representation will be important going forward in improving the patient experience and joining up the system. Professor Dean Howells (DH) was welcomed as the Chief Nurse. DH's portfolio includes quality and safety, which in these turbulent times is a massive issue. To ensure, during the disruption from industrial action, that safe operations are maintained is one of the core objectives. Today is Zara Jones's (ZJ) last meeting. Although sad because ZJ is leaving, RW is happy as where she is going is great for her career. ZJ has done an amazing job over the last few years, especially during the transition period. ZJ is amazing in the amount of detail she can retain; she works incredibly hard to be on top of all the knowledge. RW thanked ZJ for everything she has done and wished her all the best for the future. Apologies for absence were noted as above.	
Item No.	**Item**	**Action**
ICBP/2324/065	**Confirmation of quoracy** It was confirmed that the meeting was quorate.	
ICBP/2324/066	**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 at the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/integrated-care-board-meetings/ No further declarations of interest were made.	
ICBP/2324/067	**Minutes of the meeting held on 20th July 2023** **The Board APPROVED the minutes of the above meeting as a true and accurate record of the discussions held**	

ICBP/2324/068	**Action Log – July 2023** There were no outstanding items on the action log. **The Board NOTED the Action Log**	
ICBP/2324/069	**Chair's Report** RW presented his report, a copy of which was circulated with the meeting papers; the report was taken as read and no questions were raised. RW highlighted his recent visit to the Urgent Treatment Centre (UTC) at Whitworth Hospital with some of the System Chairs. This was an excellent visit, with brilliant staff operating a one-stop-shop for patients. The visit demonstrated the best bits and the further potential of the service. A discussion held around wound dressings highlighted that as we introduce and grow facilities like the UTC's we need to agree collectively the right procedures and places for things to be done to fully join up services and maximise the systems potential. It provided assurance on the amount of work being taken away from the Acute Trusts and GP surgeries. There are 5 UTCs across the system, however these have not been fully mainstreamed into the whole system. **The Board NOTED the Chair's report**	
ICBP/2324/070	**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: • For years now, the Derbyshire Chief Executives' meeting, which includes Local Authorities, himself on behalf of the NHS, the fire service, education, and police leaders, have met monthly to review developments across the whole public sector. This forum picks up areas of importance and common interest and the report highlighted some of the matters being worked through. The report predominantly highlights NHS and care services, however there is a broader conversation in which the NHS is connected and plays a full part. Linked to this is how it translates into Places, and the work on the ground. • Sections 2,3 and 4 highlight areas of local and national interest. • CC gave his own personal thanks to ZJ for all great work she has done. The next item is the Annual Reports for the CCG and ICB; ZJ was instrumental in driving forward the work of the CCG and its transition into an ICB. ZJs ability to capture complexity is exemplary; CC spotted her talent in 2018 and appointed her into an Executive role; ZJ has more than fulfilled her talent. ZJ was wished all the best for the future. She will be missed, and her career will continue to be watched with pride. **The Board NOTED the Chief Executive's report**	
ICBP/2324/071	**NHS Derby and Derbyshire Clinical Commissioning Group Annual Report and Accounts - April to June 2022 / NHS Derby and Derbyshire Integrated Care Board Annual Report and Accounts - July 2022 to March 2023** CC recognised that colleagues already have access to the full Annual Report and Accounts for 2022/23 and presentation. A summary of the pertinent points was provided for information.	

	Keith Griffiths (KG) reported that the ICB ended 2022/23 with a £14.8m deficit, and a whole System deficit of £31.6m. It is important to recognise that at the start of the year a £60m system deficit was expected, therefore significant progress was made to reduce it. Two sets of accounts were produced in 2022/23. The CCG formally closed on 30th June 2022, at which point it reported breakeven. The National finance team wanted to see the year in its entirety until 31st March 2023. Both sets of accounts were given a clean bill of health by the External Auditors. KG appreciated and acknowledged the quality of the work of the finance team in managing the transition from CCG to ICB. Dr Avi Bhatia (AB) stated that the CCGs went from four into one, and then from one CCG into an ICB; this was a high degree of change which was well managed. Putting clinicians and professionals at the heart of decision making was done well. The support of Primary Care Networks (PCNs) helped to put General Practice (GP) around the table in the system. Covid was a defining area in the CCG, particularly the vaccination programme and its aftermath. A lot of work was done on the wider determinants of health. During this period a lot of people were working in isolation, at home on their own. The time of the system has now come, which is appropriate. The main thing is that nothing can be done in isolation, everything is everybody's issue, problem, and success. AB is happy to provide support from a clinical and professional perspective and thanked everyone involved in the CCG during this period. RW thanked both AB and John MacDonald (the previous ICB Chair), and everybody who pulled the reports together. From an assurance perspective, Sue Sunderland (SS), Chair of the Audit and Governance Committee, echoed her appreciation of the work done to prepare these reports within such a short time frame. Positive feedback was provided by the Auditors on how well everything had been prepared and how well the staff could answer questions on the content; it is a success story in how smoothly the process went. **The Board RECEIVED the formal presentation of NHS Derby and Derbyshire Clinical Commissioning Group Annual Report and Accounts - April to June 2022 and the NHS Derby and Derbyshire Integrated Care Board Annual Report and Accounts - July 2022 to March 2023**	
ICBP/2324/072	**ICB Annual Assessment and Development** CC thanked colleagues behind the scenes who made this happen. As in previous iterations of NHS architecture, self-assessment assurance continues. A version was introduced to think about how to do this from an individual organisational perspective, the duties of the ICB and the wider purpose and partnership actions. Helen Dillistone (HD) acknowledged that this is an important piece of feedback from the Regulator. Given that the ICB is only a little over 12 months old, this report reflects the first 9 months of its existence; it provides feedback on where further development work is required and highlights areas of good practice. An annual rating was not provided this year; this will follow for year 2 and beyond. This work will be built into the broader Organisational Development Plan for the ICB, to continuously improve and develop as an organisation, taking feedback from the Regulator, the Staff Survey, and areas of performance to continually work on with partner	

	organisations. In terms of ongoing governance, it will be taken through the Audit and Governance Committee and fed back to the Board. Questions / comments: • One of the items to be looked at is how to ensure system wide transformation schemes can be fully realised; this is important in terms of operational and financial efficiency, but also a system wide approach to good patient care. It was asked how this will be taken forward in the next year (MG). HD considered this to be an important part of the letter and overarching strategy across the system which plays into the priorities collectively described in the Joint Forward Plan, and the pace and scale of the delivery needed. It will feature as part of the overall System Improvement Plan underpinning the work required to address the operational and financial challenges. • One of the eight specific duties is to involve patients and the public. RW would like to have seen one of the duties to be staff involvement, which is just as important. • The letter was deemed to be positive and gives a strong picture of where the ICB is within such a short time. It has to be ensured that areas of improvement are picked up in an orderly fashion and actioned going forward, building on the work done and taking it into the next chapter (JED). • This is a great summary of the considerable progress made. A real focus is needed on how to achieve system wide transformation through the triangulation of finance, activity, and workforce, and understand how they will change linked to outcomes for citizens. RW's report provided an update on the community transformation programme and the diagnostics; this is how to go forward and build the capability to deliver whole system transformation and understand the links between outcomes, the operational KPIs that impact them, and the resources used across the different system partners. An options appraisal has been completed to take this forward; details will be brought back on how people might feel about 'investing to save' to build capacity and capability and pick up on the challenge in section 4 over the next few months. RW is keen to look at the proposals in the context of the whole system, as opposed to looking at things in isolation. • CC considered the question about improvement to be fundamental. This is a highly complex system. It was asked how this Board, the ICP and H&WBs assure themselves that they are making improvements. A significant piece of work on ensuring that the various committees, looking at different aspects, come together to present a whole picture to the Board and take a collective view of improvement will commence at the 19th October system-wide event. Improvement at a system level is a key function of the ICB's role; this is different to the CCG's statutory role. The ICB is not fully active in all spaces yet, it is still developing; Dr Chris Weiner (CW) has a building role, thinking through the theme of improvement and how to do it. Linked to the national impact work across the NHS, this theme will be brought back to the Board in due course. RW added that thinking in outcomes prevents thinking becoming siloed. • DO highlighted the work on reducing health inequalities and the importance of using local data and allowing Place to flourish. **The Board NOTED the contents of this report**	
ICBP/2324/073	**Corporate Risk Register – August 2023** Helen Dillistone (HD) presented the Risk Register as at 31st August 2023,	

which provides assurance to the Board on the operational risks faced by the organisation. The report highlights changes to the 6 very high risks and provides details of the actions implemented to mitigate them. The Chairs of the ICB's Corporate Committees are familiar with the risks assigned to them; it is an important feature of the Committees to report up to the Board accordingly. The risks relate to operational, financial and performance challenges across the system.

A new risk has been identified relating to contracts, and providers not being able to fulfil some of their contractual obligations and duties, partially those driven by additional costs. This risk was raised by the Audit and Governance Committee and taken to the Finance and Estates Committee where it was recommended that a new risk be added to the Risk Register with a risk score of 12. The report demonstrates risk movement during August; no changes have been made to risk scores. Further scrutiny will be given to each risk during the autumn months to implement mitigations and controls that will actively manage the risks.

Questions / comments

- Risk 21 – KG and JED were actioned to clarify the wording. It was agreed that the wording of this risk would be amended to make it stronger: 'There is a risk that contractors may not be able to fulfil their obligations in the current financial climate. The ICB may have to find alternative providers in some cases at short notice which may have a significant financial impact'. (JED)
- Risk 6 – It is important that the first bullet point is clarified to demonstrate the level of the risk. It reads that there was a £12.9m deficit against a £12.6m planned when it is a £25.5m deficit against £12.6m planned (SS).
- Risk 9 – It may be helpful to refer to the impact of strikes on the waiting list, as this is a factor not planned for beforehand. Relating to the targets, both Trusts have confirmed that processes will be in place for the standards by the end of Quarter 4, however the target was to achieve the KPIs by the end of Quarter 4, which is not the same as delivering them; clarification was requested on the where Trusts are on the delivery of this (SS).
- Risk 9 – Consideration of the risk that delays are having an adverse effect on system workload and sustainability was suggested. For example, the increase in General Practice workload as patients are seeking places to go with their issues whilst waiting. Community service colleagues report the delays are not only risking harm but generating churn and non-value-added demand from all parts of the system at the same time. This is a significant risk from a different aspect (TA).
- CC noted that it is not easy to create a succinct Risk Register when things are multi-faceted and complicated. It is harder to do, but important to try to delineate and separate out the impacts of industrial action from the general position of operational challenges. On that basis, a separate piece of work will be commenced, linking with other ICBs, on the impacts of the industrial action. CW will help with this, and the findings brought to Board on the different impacts, from those that are directly operational in the immediacy to those that are longer term. It is an important point around the issue of knock implications of waiting times on other areas. This is an area of work that needs to be better understood, often we focus on the waiting list itself, whilst the Risk Register looks at the broader impacts.

	HD noted the comments and will request the amendments to be made prior to presentation at the next Board. **The Board RECEIVED and NOTED:** • **The Risk Register Report** • **Appendix 1, as a reflection of the risks facing the organisation as at 31st August 2023** • **Appendix 2, which summarises the movement of all risks in August 2023**	**HD**
ICBP/2324/074	**ICB Corporate Committees' Terms of Reference (ToR)** HD advised that updates have been made to the ICB's Corporate Committees' ToR in line with best practice to review them on an annual basis. This links to the audit programme; a piece of work was commissioned in the ICB's first year of existence on the effectiveness of its seven Corporate Committees; part of this was to ensure that there are up to date ToR which accurately reflect the work of the Board and confirm that appropriate delegations are in place. The ToR reflect the system wide membership of the Committees in terms of membership, quoracy and recognise the Non-Executive Director involvement from partner trusts. **The Board APPROVED the updates to the ICB's Corporate Committees' Terms of References**	
ICBP/2324/075	**Integrated Assurance and Performance Report** RW recognised the ongoing work to improve this report and congratulated the team on the information included which will help to provide confidence to tackle the pertinent issues. CC stated that this is a developing piece of work, for which feedback is continuously welcome. The importance of Lead Executive and Lead Non-Executive input into all areas was highlighted in terms of overall assurance going forward. Bringing together quality, performance, activity, finance, and workforce, with increasing clarity in each domain, demonstrating the position in its totality to the Board, is the intent. <u>Quality</u> – Professor Dean Howells (DH) outlined the key messages from a quality perspective, as described in the meeting papers. The following areas were highlighted: • DH is looking forward to the next month and having an opportunity to go through the CQRG work and system quality element, focusing on the Healthcare Acquired Infection structures. Thanks to provider colleagues for their refreshed focus in this area, and the support from NHSE. For assurance, the safety structures will be brought through with a refreshed targeted approach around c.difficile infections, which is one of the key pressure areas being experienced in the system. • The maternity structures will be moving into DH's portfolio shortly. The Saving Babies Care Bundle, version 3, commenced this week at UHDBFT, for which DH thanked colleagues. With agreement from NHSE, the follow up Ockenden assessment will be completed in January 2024; this will provide opportunity to undertake more of the strategic work on maternity over next 2 months.	

- DH is impressed with how well positioned Derby and Derbyshire NHS is on the broader safety improvement work nationally around Patient Safety Incident Response Framework (PSIRF). The theme is around the early warning signs work; via the quality structures there is a great opportunity to finesse how, as a Board, the sub committees receive indications to provide support at an early point and lock in the learning.
- There is great partnership working in place focused on 'right care, right person' and DH will be meeting with DHcFT to ascertain how he can further support this agenda personally.
- DO added that all issues have been very well presented.
- RW considered that there are some big challenges to be addressed, with maternity being very much in the spotlight nationally; the ICB has been working with the Ockenden report for some time now.

Performance – Zara Jones (ZJ) outlined the key messages from a performance perspective, as described in the meeting papers. The following key messages were highlighted:

- Primary Care – From a General Practice (GP) access perspective, the data compares well to that planned, however the fragility in GP continues, with issues around sustainability across some practices and Primary Care Networks (PCNs). Work is being done by the PC Team to stabilise the position where possible and ensure access where it needs to be.
- Dental – The activity planned year to date is significantly behind what has been delivered. Although there is a time lag in relation to this data, it is known that there are significant pressures around dental access. Work continues, now the ICB is responsible for dental commissioning, to look like areas with access issues and what could be done to improve performance.
- Mental Health and Learning Disabilities – Progress has been made in several key areas, although there are still some challenges. Good partnership working has been undertaken for learning disabilities and autism and supporting patients in the inpatient setting. The Transforming Care Programme continues at pace to understand what different partners and organisations need to do to help improve the position this year. Although it has been a challenging summer, this has helped to provide more confidence around delivery which will hopefully yield good outcomes over the year ahead.
- Urgent and Emergency Care – A&E performance looks encouraging against the set plan. Going into winter, it is important to continue at pace and build headroom to ensure access is as good as it can be during this more pressured operational period.
- Ambulance – There is a challenging hill to climb in relation to the Category 2, 30-minute mean target, which is currently behind plan. As the year started with pressures, the target is already behind by a few minutes at a regional level. From a Derbyshire perspective, there is some catching up to do. Areas are being looked at to improve response times, including workforce and recruitment, and other key initiatives that EMAS are taking to improve the position. This is an example of where system working is required to improve and maintain the position.
- Planned care – There continues to be patients waiting over 78 weeks. There are actions in train to reduce these numbers, however this has not progressed as quickly as anticipated, and has been affected by the industrial action. The reductions are predicated on mutual aid and available capacity from other providers.
- Cancer – Although cancer has been in a pressured position for a while now, improvements were seen in recent months. Unfortunately, the

numbers have increased over the last few weeks; a partnership approach is being taken to work together and improve the position. RW added that industrial action is a big factor in this.

Workforce – Linda Garnett (LG) outlined the key messages from a workforce perspective, as described in the meeting papers. The following key messages were highlighted:

- The position against the Workforce Plan, as submitted to NHSE, was provided as at month 4. The data demonstrates that the system is below plan overall in terms of numbers but over plan in terms of finance. The UHDBFT data is currently being amended; it is expected that this will be reconciled by next month to give a more accurate picture. There has been an improvement in recruitment to substantive roles, which means less reliance on temporary staff; this is important from a quality perspective as it results in a consistency of team working.
- Information was presented on the Primary Care (PC) workforce; this data is provided from a difference source – the Digital PC System – and is only available quarterly. The data demonstrated that PC is 210 below plan against the intended position, which is concerning, and is responsible for putting pressure on existing GP staff.
- Work is being undertaken to bring together the actual position, as opposed to what was indicated in the Plan. There are separate returns for finance and workforce which report things differently and work on different timescales. Closer working is being undertaken to provide a more accurate picture of what is happening; LW is grateful to colleagues helping with this. There is a need to work collaboratively to understand how it is impacting on activity and quality.
- RW added that the P&CC will need to look at the granularity of these numbers, to ascertain where the staff are and where skills are missing to help better understand the impacts. The triangulation of activity, workforce and finance is critical.

Finance – Keith Griffiths (KG) outlined the key messages from a finance perspective, as described in the meeting papers. The following key messages were highlighted:

- Quality, activity, and workforce translate into a financial impact; it is important that the report is provided in this order to demonstrate the impact on finances from the challenges highlighted.
- The year commenced with an efficiency requirement of £136m to deliver a breakeven plan. It was recognised that the transformation will take a while to mobilise. The plan was produced knowing that there would be an overspend in the first half of the year, with improvements demonstrated in the latter half, to deliver the net breakeven position by the end of March 2024. The plan was to be overspent at the end of July by £13m, however in reality there is an overspend of £25m due to an additional £12-13m pressure emerging in the first four months of the year. This pressure is driven by the cost of industrial action, inflation, changes in funding policy by the Centre in supporting revenue costs for capital and digital, and issues in the Derbyshire system around the legal requirements to give staff a pay award, all of which have not been funded.
- At the end of July, the actual figures are consistent with plan, however, they are being driven away from plan due to things out of our control. There is a need to continue the great work being done to have a robust view of how to manage winter, and its operational impact, particularly on workforce and how that translates into finances.

- The Treasury are putting £200m into the NHS in recognition of the extra costs incurred for industrial action; at this stage it is not known how much extra resource will emerge. Although breakeven is still predicted there are risks around delivering this. The ICB must deliver what it committed to in the plan, demonstrating efficiency savings of £106m.
- There is a direct impact of the industrial action on clinical and managerial leadership to deliver safe services, maintain and improve performance and create headroom to undertake transformation to deliver cash savings. A lot of planning goes into the preparation for industrial action, and the recovery from it, from which there are significant financial implications.
- The issue is also triangulating into PC. Inflation of more than 10% is being experienced on pharmaceuticals. The longer patients are waiting for procedures, the more they are dependent upon prescribing and medicinal treatment, which is driving up volume and cost pressures. GPs are putting on extra clinics and subsequently prescribing more to help keep people as well as they can be under the circumstances.
- There is a potential risk of a further £13m overspend to meet the unfunded costs of the pay award. Intense conversations are being held with national colleagues to secure another £13m into the Derbyshire system to honour the contractual arrangements in place for the Agenda For Change staff not employed by an NHS body. RW considered that Derbyshire is right to fight for this funding.
- Derbyshire, considering that it spends £3.3bn in public money, is one of the biggest systems in the midlands area. The financial position at the end of month 4, being £12-13m away from plan, means it is the best performing system in the midlands.

<u>Questions / comments</u>

- Thanks were given to LG and her colleagues for the huge amount of work put into the workforce actuals and reconciling the data; it is still a work in progress in terms of understanding why the finances are over plan and the staff numbers are under plan. A point was strongly made at the P&CC that the more whole-time permanent roles there are, the better it is in terms of activity, finance, and quality, thus avoiding the pitfall that, if the numbers are low it will help to close the financial gap; the implications of doing this, in terms of patients and the following year's finances, will be considerable (MG).
- Assurance was provided that a deep dive will be held by the Finance and Estates Committee shortly, picking up on the work around the workforce agenda and its financial implications (JED).
- There is lots of information available on what we do and what the challenges are regarding waiting times and patients in hospital that do not need to be there; it is not however known what the impact and consequences are on patients and their wellbeing. The work being undertaken on the workforce and vacancy rate was acknowledged; it was enquired what the plans are to manage vacancies and improve workforce numbers (DO). LG responded that it is right to focus on improving the ability to recruit substantively to enhance the pipeline. The key priorities that People Services are working on are improving workforce supply and managing pay costs to plan. Retention is an important point; there is a focus on retaining the staff already employed as the more this is done, the better the quality; this will avoid spending time and effort on recruitment and temporary staffing. Going forward LG will highlight further what is being done in this area. The wellbeing offer is being focused on to help staff do a good job with the right tools

	and making a difference to patients. RW requested a discussion as to when and how this is brought back to a future Board. • Relating to the risk of providers running out of cash, it was enquired what scenarios could follow on from this for delivery of care? (DO). KG responded that, until the end of last week, the ICB was still chasing £11m which was due to it in April/May; however, this has now been received. There is cash in some organisations and very little in others; collaborative working is taking place across all system providers to manage short term cash flow issues. The £200m additional national funding needs to translate into physical payments to provide respite to the system; however, the timing of this cannot be guaranteed. It is hoped that more money will flow in a timely fashion with acknowledgement of the cost of industrial action and inflation. It is critical to ensure organisations can pay their staff and suppliers; the last resort is to apply for an interest-bearing loan from the Treasury, for which the ICB will have to demonstrate its ability to repay. The System is trying to avoid this as it will add to its financial pressures. It is hoped that the expected cash will fulfil the capital investment obligations contractually committed to. £2.2bn was received into the Derbyshire system based on its population however it spends £3.2bn, as 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 which UHDBFT incur. It is a material boundary issue that will have implications on income flows this year and baselines for future years. RW requested further discussions around this. • KG is working hard to understand the difference between spend and allocation; without it distracting from the important work of financial recovery and management, CC enquired whether the Board would find it useful, through the Finance and Estates Committee, to receive a sense of what this is about and broaden ownership of the question and hypothesis. RW agreed that it would be useful in the context of moving to a position of knowing where the £3.2bn is spent and whether it is spent to its best affect. JED added that the difference between spend and allocation was discussed by the Finance and Estates Committee, however she is happy to pick this up and report back to the Board. **The Board NOTED the Month 4 Operational Plan performance update against the planned commitments and targets**	**LG** **KG** **JED**
ICBP/2324/076	**Verdict in the trial of Lucy Letby** Dr Chris Weiner (CW) highlighted the importance of recognising the outcome of the Letby trial and the extent of the appalling crimes it has exposed within the NHS. It has sent shock waves through the country, the wider community, the NHS, and its staff, who never expect to work alongside people who might be capable of such crimes. Our thoughts are with the families affected by this, who will live with the impact of these crimes for the rest of their lives. The challenge is to prevent such crimes occurring in the NHS again. There will be an enquiry which will both confirm and challenge assumptions. Over the coming months/years, there will be a clarity of focus on the governance of quality, safety, and culture. It will be considered how leadership and management structures should be governed, potentially leading to a management body. Actions have been clearly identified around Freedom to Speak Up, whistleblowing, and ensuring that fit and proper people are in positions of responsibility. MG has been requested to provide Non-Executive oversight of this work. It is important to recognise that since these crimes occurred, there have been	

	changes in the NHS. Freedom to Speak Up has been strengthened over the past few years. New roles have been introduced in the NHS, including a Medical Examiner's role, which specifically challenges people's views. **The Board:** • **NOTED the NHSE letter dated 18th August 2023 and DISCUSSED the implications for the ICB and Joined Up Care Derbyshire** • **DISCUSSED the requirement for proper implementation and oversight of the national Freedom to Speak Up policy** • **The People and Culture Committee were requested to review the Freedom to Speak Up arrangements holistically across the system and present them to the November Board**	
ICBP/2324/077	**Finance and Estates Committee Assurance Report – July / August 2023** Jill Dentith (JED) presented this report which was taken as read; no questions were raised. JED highlighted that this is the first time this report has been presented in the public domain; it will help provide ongoing transparency on the financial position. To provide assurance around the estates position, and recent issues on RAAC, a report will be presented to the next Committee when a full survey has been completed of the properties within the portfolio and PC premises. There are concerns around the delivery of the efficiency target at this point in the financial year and the significant work still required. The good place that Derbyshire finds itself in the region was acknowledged however it is not sitting on its laurels; further action is required to ensure delivery of a financially balanced position at the end of the year. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/078	**People and Culture Committee Assurance Report – September 2023** Margaret Gildea (MG) presented this report which was taken as read; no questions were raised. MG added that a year in, time has been spent thinking about how to absorb the findings of 360 Assurance. A development session is planned to clarify the P&CC's role verses that of other parts of the system help to prevent duplication. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/079	**Audit and Governance Assurance Report – May / June 2023** Sue Sunderland (SS) presented this report which was taken as read; no questions were raised. SS added that in previous reports, issues had been flagged around a particular contract; these issues have now been resolved and the contract has been retrospectively agreed. Lessons learnt were highlighted to improve future oversight and management of procurement. **The Board RECEIVED and NOTED the report for assurance purposes**	

ICBP/2324/080	**Derbyshire Public Partnership Assurance Report – August 2023** The report was taken as read and no questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/081	**Quality and Performance Committee Assurance Report – July / August 2023** Dr Deji Okubadejo (DO) presented this report which was taken as read; no questions were raised. DO highlighted the good report received from the CQC on maternity services at CRHFT; the report from UHDBFT is awaited. There is further work to do; the Committee will receive a further deep dive in November. The increasing fragility of PC was recognised. It was realised that there was no PC representation on the Committee; this has now been rectified. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/082	**Population Health and Strategic Commissioning Committee Assurance Report – September 2023** This report which was taken as read; no questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/083	**National Patient Safety Strategy – Derbyshire Position Statement – September 2023** Professor Dean Howells (DH) advised that an excellent governance and assurance session was held with NHSE on 6th September, where a comprehensive position statement was provided on preparations for the Patient Safety Incident Response Framework (PSIRF) of the Derby and Derbyshire System. Provider colleagues are currently completing their PSIRF training. Broader assurance will be presented to the Board in due course on the quality structures for the go-live of the whole system. There is relief that the national focus on safety and quality has moved into strategic insight involvement and, more importantly, sustained improvement. **The Board NOTED the content of the report for assurance purposes**	
ICBP/2324/084	**2022/23 Quality Account ICB Statements** Professor Dean Howells (DH) confirmed that it is an ICB's statutory duty to sign off the Quality Accounts; this process has now been completed. Huge thanks were conveyed to providers for their work on this. There is a need to anticipate change nationally on the focus of Quality Accounts from next year. There is a real opportunity to scale up the good practice that filters through Quality Accounts at a Place level to improve the quality metrics across the whole system. It has been a challenging year therefore to see the accounts published with such development has been a great achievement for all providers. **The Board NOTED the 2022/23 Quality Account ICB Statements**	

ICBP/2324/085	**Ratified minutes of the Derby and Derbyshire Health and Wellbeing Boards** • Derby City Health & Wellbeing Board – 16.3.2023 / 27.7.23 • Derbyshire County Health & Wellbeing Board – 13.7.2023 **The Board RECEIVED and NOTED the above minutes for information**	
ICBP/2324/086	**Ratified Minutes of ICB Corporate Committees** • Audit & Governance Committee – 8.6.2023 • People & Culture Committee – 7.6.2023 • Public Partnership Committee – 27.6.2023 • Quality & Performance Committee – 29.6.2023 / 27.7.2023 **The Board RECEIVED and NOTED the above minutes for information**	
ICBP/2324/087	**Forward Planner** **The Board NOTED the forward planner for information**	
ICBP/2324/088.1	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. *Yes. An addition to an existing risk on the unfunded pay award will be made for the next iteration of the Risk Report.*	
ICBP/2324/088.2	Did any of the discussions prompt us to want to change any of the risk ratings up or down? *No*	
ICBP/2324/089	**Any Other Business** Mark Powell (MP) suggested that it would be helpful to undertake a review on the level of duplication of agenda items to ascertain which ones are being taken to Provider Boards and the ICB Board, in order to prevent unnecessary duplication. The Chair indicated that this had been started but wanted to wait until after the development meeting on 19th October to be assessed against our future vision.	
ICBP/2324/090	**Questions received from members of the public** No questions were received from members of the public.	

Date and Time of Next Meetings

Date: Thursday, 16th November 2023
Time: 9am to 10.45am
Venue: via MS Teams

ICB BOARD MEETING IN PUBLIC

ACTION LOG – SEPTEMBER 2023

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.	Agenda item	**January 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.		**Ongoing**
ICBP/2324/073 21.9.2023	Corporate Risk Register – August 2023	Helen Dillistone	HD noted the comments and will request the amendments to be made prior to presentation at the next Board.	Risk Register amended accordingly	**Item complete**
ICBP/2324/075 21.9.2023	Integrated Assurance and Performance Report	Linda Garnett	It was enquired what the plans are to manage vacancies and improve workforce numbers.	There is a continued focus across all providers on recruiting to substantive positions and proactively replacing temporary and agency staff with substantive appointments wherever	**Item complete**

				possible, and work is about to commence on getting underneath non-contractual pay costs to understand the overspend on the pay bill. A deep dive was held at the FEC meeting in September and feedback will be provided to the Board as part of the Assurance Report.	
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.	RW requested further discussions around this.	**November 2023**
ICBP/2324/075 21.9.2023	Integrated Assurance and Performance Report	Jill Dentith	The difference between spend and allocation has been discussed by the Finance and Estates Committee (FEC).	A deep dive was held at the FEC meeting in September and feedback will be provided to the Board as part of the Assurance Report.	**Item complete**

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 096

Report Title	Chair's Report – October 2023							
Author	Sean Thornton, Deputy Director Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Richard Wright, 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 is 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
System Now and Future The NHS family is in a period where we are balancing focus on the immediate challenges of today while setting out the longer-term solutions to deliver our vision. We continue to tackle a range of issues which are creating delays and access issues for our patients, and seeing patients waiting longer for care and treatment than we would wish. We are putting significant thought and effort into managing this position, but we need to ensure that we are taking steps to break that cycle and ensure we are not in this position in five years' time. This Board, and the Boards of our NHS partners, will continue to focus on current performance and provide our updates and assurances on progress to regulators, but we also need to provide focus on the delivery of the future vision. We identified five guiding policies within our Derby and Derbyshire NHS 5-Year Plan back in June, and colleagues from across the NHS family, along with key delivery partners from local councils and the Voluntary, Community and Social Enterprise, met in October to assess our progress and to determine what our actions need to look like for 2024/25 to ensure we remain on track to achieve our ambition. This remains that we will be one united NHS partnership, collaborating with a clear shared purpose to deliver an exceptional patient experience within sustainable healthcare services. In five years, we will be able to offer our population easy access to expert care, address

regional health inequalities, and routinely seize opportunities, in every care interaction, to proactively support broader patient well-being.

The thrust of the October session was to confirm our shared agreement of the vision, to seek to identify any concerns or objections with the guiding policies, and to seek to convert strategic vision into deliverable and measurable actions. Critical success factors emerged that included being able to demonstrate that patient and user experience has consistently improved, where we are focussed on the opportunities available to us when spending our £3bn budget, reaching a position where we have shared clarity on primary, secondary and tertiary prevention, shifting investment to reduce the major risk factors for the 20% of people most in need, and where NHS staff feedback that it is easy to work and innovate in the NHS and easy to integrate with other services providers.

At the end of the session, we stated that our three wider and immediate objectives were that:

1. In the spirit of co creation we did not want anybody across the system to be surprised about what was included and what was not included in the 24/25 plan.
2. That we had the opportunity to think through the consequences of what was included and what was not included in the 24/25 plan.
3. But that we could rationalise all of these against a five-year vision of where we wanted to be and how the public/patients would benefit with a better experience and service.

A further workshop is being planned for 14th December to continue these important conversations.

Reducing health inequalities

ICB Board members are undertaking a development programme to broaden and deepen our understanding and approach to inclusion and equality of access to health and healthcare. Multiple national reviews highlight that there remain unacceptable health inequalities within our health system, including in Derby and Derbyshire. These are related to people's personal, protected characteristics and linked to issues such as where they live, their income and other wider determinants of health. Achieving equality of outcomes remains a priority of our Integrated Care System; the establishment of our Prevention and Health Inequalities Board at the last Integrated Care Partnership meeting is further evidence of how seriously we are taking this agenda. The ICB Board will continue to seek improvements.

Of recent note, the Mental Health, Learning Disability and Autism Delivery Board has overseen collective work to understand service access and gain insight into the service experiences of black and deaf communities. Data and caseload analysis has confirmed that people from our Black communities continue to be over-represented in community mental health caseloads, more likely to be in receipt of inpatient mental healthcare and are also more likely to be detained under the Mental Health Act than people from other ethnic groups. However further work needs to be done to understand in better detail the service experience of people within the Black community.

There has been less data available to analyse the representation of people from the Deaf community across mental health services and a shared priority going forwards is to increase availability of data to better explore and understand issues relating to access and the experience of Deaf people using local mental health services. However, good engagement has taken place with Deaf community groups to provide insight into the experience of mental health services, which has highlighted issues regarding ease of access to interpretation services, choice, flexibility and achieving a greater awareness of the needs of Deaf people when accessing mental health services.

Members of the Delivery Board supported a number of recommendations, including:

- Improving the recording of protected characteristics of people accessing services
- Increasing reliable access to interpretation services for Deaf people

- Increasing the diversity of the system's collective workforce
- Greater involvement of the Deaf community in the design, delivery and procurement of services
- Developing relationships and trust with members of our Black communities, through meaningful engagement.

These recommendations will be implemented across all the organisations that form the Mental Health, Learning Disabilities and Autism Delivery Board, with further updates being shared through this bulletin as the Delivery Board maintains oversight of collective progress.

East Midlands Combined County Authority
The proposed East Midlands Combined County Authority (EMCCA) has moved one step closer to reality after key legislation was approved in Westminster. The Levelling Up and Regeneration Bill has been granted Royal Assent after completing its passage through Parliament, paving the way for the creation of the EMCCA and the region's very-first Mayoral elections next May.

The four councils will now decide on whether to move forward with devolution plans, with decisions expected before the end of the year. The East Midlands devolution deal, agreed with Government ministers last summer, would see Derbyshire Nottinghamshire, Derby and Nottingham benefit from £1.14 billion of funding to invest in local projects related to transport, education and skills, housing, the environment and economic development. The ICB proposed that the NHS should be a party to those discussions during the consultation process earlier in 2023.

The King's Speech
This year's King's Speech, delivered on 7 November, focused on growing the economy, strengthening society and crime reduction. Health-specific announcements included tackling smoking by raising the age of sale for tobacco products and implementing the NHS Long Term Workforce Plan. The promise to raise the age of sale for tobacco products, effectively eliminating smoking for the next generation, aligns with our Stay Well focus on smoking. An accelerator programme, looking to develop twelve weeks of intensive activity to boost our focus on help people to stop smoking, is being developed in full partnership with our local authority smoking cessation service providers, NHS Trusts and enabler functions,

Provider Selection Regime & Procurement Act
NHS England has written to ICB and trust leaders to advise that the Department of Health and Social Care has introduced the Provider Selection Regime (PSR) to Parliament, and, subject to parliamentary process, the regime will come into force on 1 January 2024. It has also published draft statutory guidance to support the implementation of the regulations.

The PSR will cover all commissioning of health services by NHS England, ICBs, NHS trusts/foundation trusts as well as local authorities (including children health visits, sexual & reproductive services and substance misuse services). Meanwhile, the Procurement Bill, which will set new rules for all procurement outside of the scope of the PSR (for instance including NHS procurement of digital tools and social care services), received Royal Assent, becoming the Procurement Act 2023. The Cabinet Office will be developing guidance and regulations to put the Act into effect.

Terms of Lucy Letby Inquiry
Secretary of Health and Social Care Steve Barclay has published the terms of reference for the inquiry following murders and attempted murders committed by former neonatal nurse Lucy Letby. The inquiry will look at the experiences of families of all the babies named in the indictment; the conduct of staff at the Countess of Chester Hospital, part of the Countess of Chester Hospital NHS Foundation Trust; the effectiveness of NHS management and governance structures; and NHS culture.

The inquiry has powers to compel witnesses to produce evidence and is chaired by Lady Justice Thirlwall, one of the country's most senior and experienced judges. The inquiry will not review the jury's verdicts and will make no findings regarding liability in civil proceedings, and a final report will be provided at a time to be confirmed, which will be received by the NHS Derby and Derbyshire Board.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☐	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒

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

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

Not applicable to this report.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 097

Report Title	Chief Executive Officer's Report – October 2023							
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 ICB will commence a formal consultation with staff regarding our organisational structures, starting on Friday 17th November until 7th January 2024. This consultation follows receipt of a letter from NHS England in March 2023 which set out a requirement for all ICBs to reduce running costs by a total of 30% by the end of the financial year 2025/26, with at least 20% of this saving by the end of the financial year 2024/25, and a further 10% in 2025/26. I wanted to ensure that we took a considered approach and I have been working with senior colleagues to maximise savings from our non-pay budget and also to ensure that we have an organisation structure that is fit for purpose. The creation of the new staffing structure across the ICB will affect all staff and it is possible that some current roles may become redundant; we will support any affected staff. The process has meant an inevitable period of uncertainty for ICB colleagues, but everyone has continued to be committed to working on a range of important matters across our system, and this is to their great credit during this period of change. November has seen a period of sustained service pressure for our system, largely driven through a reduction in patient flow through our services. We are not yet managing what we would describe as winter pressure, given that there is limited indication of viral illness in the community, although

there has been a rise in patients with respiratory illness and an increase In patients requiring hospital care due to the acuity of their condition. The weather has not been traditional for November, so it is likely that increases associated with winter are yet to come, and we will need to continue to prepare for that through the delivery of our winter plan.

The weather has created other challenges for NHS services in recent weeks. Storm Babet had a significant impact on all citizens and staff, with extensive flooding occurring in Derby, Chesterfield and many other parts of Derbyshire. Alongside the NHS role in our collective partnership response with the Derbyshire Resilience Forum, the flooding resulted in challenges for staff getting to work and delivering services which rely on the road networks. As is so often the case, NHS staff went above and beyond the call of duty in finding ways to navigate the challenge, and to continue to provide care and support for people who are already vulnerable in our communities. I am very grateful to them and thank everyone who was involved in the immediate response and the ongoing recovery.

ICBs are designated as a Category 1 responder under the Civil Contingencies Act, and we have undertaken significant policy and training work to reflect this change in status since July 2022. The NHS always plays its part in responses to emergencies, but ICBs now have a coordinating role across the NHS family, and this has without doubt been significantly tested during 2023, with not only the recent storms, but also with periods of industrial action, heatwaves and other incidents. We also took part in a significant emergency planning exercise in October that created a terrorist scenario, and it was important and interesting to further understand our role in managing a major incident. All these events bring their own challenges, and we are constantly learning and seeking improvements. We do not take for granted the collaboration that occurs across our NHS, and reflect that emergency planning demonstrates another facet of our work where partners come together effectively to plan and deliver the right outcomes for local citizens.

Finally, I wish to emphasise the success encountered by many of our NHS Teams in local and national awards during the autumn. Links to more information about some of the awards are included below, but the breadth of work being recognised across medicines management, our staff wellbeing programme and for the recognition of Derbyshire Healthcare's support for the armed services community is phenomenal, and I want to congratulate everyone involved in all of these award-winning schemes and others on behalf of the Board.

Dr Chris Clayton
Chief Executive Officer

Chief Executive Officer calendar – examples from the regular meetings programme

Meeting and purpose	Attended by	Frequency
JUCD ICB Board meetings	ICB	Monthly
JUCD ICP Board meeting	ICB	Bi-Monthly
System Review Meeting Derbyshire	NHSE/ICB	Monthly
Quarterly System Review Meetings	NHSE/ICB	Quarterly
ICB Executive Team Meetings	ICB Executives	Weekly
Derbyshire Chief Executives	CEOs	Bi Monthly
EMAS Strategic Delivery Board	EMAS/ICB	Bi-Monthly

Joint Health and Wellbeing Board	DCC/ICB/LA	Bi-Monthly
NHS Midlands Leadership Team Meeting	NHSE/ICB	Monthly
Partnership Board	CEOs or nominees	Monthly
East Midlands ICS Commissioning Board	Regional CEOs/NHSE	Monthly
Team Talk	All staff	Weekly
JUCD Finance & Estates Sub Committee	ICB	Monthly
Midlands ICS Executive & NHSEI Timeout	ICB/NHSE	Ad Hoc
2022/23 Financial Planning	NHSE/ICB	Ad Hoc
ICB Development Session with Deloitte	ICB	Ad Hoc
Meeting with Derby and Derbyshire MPs	ICB CEO/Chair	Ad Hoc
ICB Remuneration Committee	ICB	Ad Hoc
Place & Provider Collaborative	ICB	Ad Hoc
Derbyshire Dialogue	ALL	Ad Hoc
System Escalation Calls (SEC)	ICS/LA	Ad Hoc
NHS National Leadership Event - London	NHSE	Ad Hoc
NHS Clinical Leaders Network	NHSE	Ad Hoc
Joint Emergency Services Interoperability Protocol (JESIP) Training	ICB	Ad Hoc
ICS Connected Leadership Programme – Leeds	ICB	Ad Hoc
Derbyshire Distributed Leadership Meeting	NHS Executives	Ad Hoc
East Midlands Joint Committee	East Midlands ICB CEOs	Bi-Monthly
Derbyshire LHRP Meeting	NHSE/LA/ICS	Monthly

National developments, research and reports

Hundreds of thousands of NHS patients to be offered the chance to travel for treatment

As part of the NHS elective recovery plan, hundreds of thousands of NHS patients who have been waiting the longest for treatment will be offered the opportunity to travel to a different hospital, if it means they could be seen sooner. From 31 October, any patient who has been waiting longer than 40 weeks and does not have an appointment within eight weeks will be

contacted by their hospital via letter, text, or email.

Expanded NHS support available for patients in GP practices across the country
The support on offer for patients at their GP practice is expanding, thanks to thousands more healthcare staff working in local communities and the new GP access recovery plan. More than 31,000 additional staff have been recruited into healthcare roles at general practices across the country since 2019 – meaning an expanded team of health professionals are now available to help patients get the right care when they need it, in addition to seeing their GP or practice nurse.

Public asked to shape future use of health data by the NHS
Members of the public will be asked to help shape how the NHS uses their health data to improve patient care, as part a series of major events next year. The events, starting in the new year and continuing until March 2025, will gather public views on digital and data transformation in the NHS. Among the programmes and topics to be discussed will be the Federated Data Platform – a key software platform that joins up existing NHS data to help speed up diagnosis, reduce waiting times and hospital stays.

See also: Open letter from NHS medical leaders to patients and the public

New treatment that could prove curative for blood cancer patients to be offered by the NHS
Hundreds of people with an aggressive type of blood cancer, known as diffuse large B-cell lymphoma (DLBCL) are set to benefit from a potentially curative new treatment option on the NHS, with approval of the drug glofitamab. Glofitamab is to be made available for patients with previously treated DLBCL after being given the green light by the Medicines and Healthcare products Regulatory Agency (MHRA) and the National Institute of Health and Care Excellence (NICE).

More than half a million people have made organ donations via NHS App
People across England are being encouraged to use the NHS App as an easy way to register their organ donation decision – as more than 7,000 patients actively wait for a transplant. The total number of organ donation decisions registered for the first time through the NHS App has increased by over a fifth over the last year.

Local developments

"Significant progress" made by NHS Derby and Derbyshire, says NHS England
NHS Derby and Derbyshire made "significant progress" in its first nine months, according to NHS England. The comments were made in NHS England's annual assessment of Derby and Derbyshire Integrated Care Board's (ICB) performance in 2022/23.

PIDMAS (Patient Initiated Digital Mutual Aid System)
PIDMAS (Patient Initiated Digital Mutual Aid System) was launched on 31 October. This is a new initiative as part of patient choice, where patients who have been waiting more than 40 weeks for their treatment are offered the option to have their care transferred to another hospital where they may be seen more quickly. The work is being led and managed by the Integrated Care Board alongside our two acute hospitals. Eligible patients will be contacted directly by their NHS trust or independent sector provider and people are asked to not contact their GP practice or hospital. Further information can be found on the NHS England website.

Virtual wards summit – examining the roll out of "virtual wards" across Joined Up Care Derbyshire
Leaders from across health and care in Derby and Derbyshire came together to discuss current progress with the roll out of virtual wards across Derby and Derbyshire and to understand the opportunities available to support the success of virtual wards. The aim of the summit was for colleagues to connect, collaborate and create.

See also: Health and care staff from across Joined Up Care Derbyshire invited to visit Virtual Ward Hub at Chesterfield Royal Hospital

Plans approved for new health facilities in Belper
Plans for a new NHS community health services hub serving Belper have been granted planning approval by Amber Valley Borough Council. It paves the way to begin the process of inviting tenders and appointing a contractor for the development of state-of-the-art health facilities on the site of the former Belper Clinic, on part of the Babington Hospital site on Derby Road, Belper.

Self management facilitator service
In February 2023 Derbyshire Community Health Services started piloting an innovative new 'self-management facilitator' service in Derby. The self-management facilitation team, known as the SMFs, is a team of specialist nurses and nursing assistants who are highly trained in advanced communication skills, clinical procedures, teaching techniques and behavioural change models. The aim of the pilot was to provide support to self-care at home and increase independence for many people receiving care and also to embed a cultural shift in how patients and staff consider self-care as an appropriate alternative option. The patients have been overwhelmingly positive about their experience and the pilot scheme has proved successful in releasing vital capacity back into our Derby city community nursing team. There is an ambition to scale-up the service across Derbyshire in the future.

Four new community drop-in hubs opened for neurodiverse children and young people
Four new community neurodiversity drop-in hubs have opened across Derbyshire to support children, young people, their families and their carers. Local charities and voluntary organisations are providing advice, support and guidance to children and young people – and to their families and carers – as part of a plan to improve services. Neurodivergence includes conditions such as autism spectrum, attention deficit hyperactivity disorder, foetal alcohol syndrome, dyslexia, dyspraxia, and social anxiety.

"Warmth" and "community" make top Derbyshire practice among the best in the Midlands
A Derbyshire GP practice that achieved some of the highest patient satisfaction scores in the whole of the Midlands region has been congratulated by NHS leaders. Hartington Surgery, in the Peak District, scored 97% positive patient satisfaction in the recent annual patient survey. This places it in top spot among Derbyshire's 113 GP practices and among the top 10 in the NHS England Midlands region.

Neonatal team at Queen's Hospital Burton achieve Bliss Baby Charter Gold accreditation
The Neonatal team at Queen's Hospital Burton has been awarded the Bliss Baby Charter Gold accreditation, which recognises exemplary care to the babies cared for in the unit and their families. The team, which cares for babies who are unwell or have been born prematurely, is one of only 13 departments to achieve Gold accreditation out of 191 units in the UK.

Derbyshire Healthcare NHS Foundation Trust receives gold award from the Defence Employer Recognition Scheme

Derbyshire Healthcare NHS Foundation Trust has received the highest badge of honour employers can receive from The Ministry of Defence. The gold award recognises the Trust's ongoing commitment and advocacy for our armed forces community, as an employer. The Trust was recognised for its proactive approach to recruit and support veterans, reservists, cadet force adult volunteers and military family members.

Joined Up Care Derbyshire 'Opioid Change Management Programme' receives highly commended award

The Joined Up Care Derbyshire 'Opioid Change Management Programme' received highly commended at the October Prescqipp awards.

JUCD win Most Inclusive Menopause Friendly Employer award

Joined Up Care Derbyshire has won the Most Inclusive Menopause Friendly Employer Award at the prestigious 2023 Menopause Friendly Employer Awards. Joined Up Care Derbyshire delighted the independent panel with its rich understanding of menopause inclusivity in the workplace. Of special note is the Menopause Inequalities Programme which seeks to better understand and support the impact of ethnicity and diverse gender identities.

JUCD wellbeing team win HPMA excellence in people awards

Joined Up Care Derbyshire (JUCD) Wellbeing took home the University of Bradford award for cross-sector working at the recent Healthcare People Management Association (HPMA) Awards. JUCD wowed the judging panel with its hugely successful wellbeing initiative - a collaboration of over eight anchor organisations which focuses on a joined-up approach to working to develop and deliver an improved wellbeing service to support a wider workforce across the system.

Publications that may be of interest:

Joined Up Care Derbyshire – October 2023 Newsletter
Joined Up Careers Autumn Newsletter
Team Up Bulletin - October 2023

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☐	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐			

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

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

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

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

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

Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 098

Report Title	Integrated Care Board Risk Register Report – as at 31st October 2023							
Author	Rosalie Whitehead, Risk Management & Legal Assurance Manager							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Chrissy Tucker, Director of Corporate Delivery							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☒	Information	☐
Appendices	Appendix 1 – ICB Risk Register Appendix 2 – Movement in risk summary – October 2023							
Assurance Report Signed off by Chair	Not applicable.							
Which committee has the subject matter been through?	Finance and Estates Committee Population Health and Strategic Commissioning Committee System Quality Group Public Partnerships Committee Audit and Governance Committee							

Recommendations

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

- the Risk Register Report;
- Appendix 1, as a reflection of the risks facing the organisation as at 31st October 2023;
- Appendix 2, which summarises the movement of all risks in October 2023;
- **APPROVE CLOSURE** of Risk 02 relating to changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards.

Purpose

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

Background

The ICB Risk Register is a live management document which enables the organisation to understand its comprehensive risk profile and brings an awareness of the wider risk environment. All risks in the Risk Register are allocated to a committee who review new and existing risks each month and agree the latest position on the risk, advise on any further mitigating actions that might be required, or approve removal of fully mitigated risks.

Report Summary

The report details the ICB's very high operational risks in order to provide assurance that robust management actions are being taken to mitigate them. It also summarises any movement in risk scores, new risks to the organisation and any closed risks.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☒
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

The report covers each strategic risk.

Financial impact on the ICB or wider Integrated Care System

Yes ☒	No☐	N/A☐

Details/Findings	**Has this been signed off by a finance team member?**
Strategic risk SR4 describe the system's financial risk. *There is a risk that the NHS in Derby and Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move to a sustainable financial position and achieve best value from the £3.1billion available funding.*	Keith Griffiths, Executive Director of Finance

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

No conflicts of interest have been identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

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

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

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

CORPORATE RISK REGISTER REPORT

INTRODUCTION

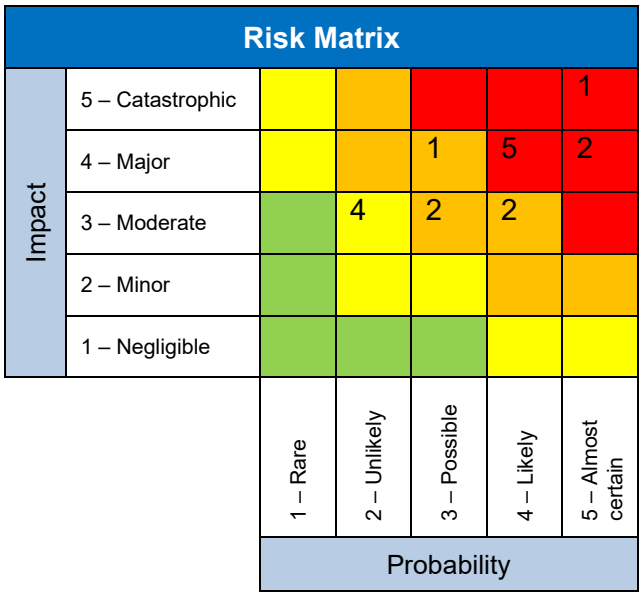
The purpose of this report is to present the ICB Board with the very high (red) operational risks from the ICB's Corporate Risk Register in order to provide assurance that robust management actions are being taken to mitigate them.

VERY HIGH OPERATIONAL RISKS

The ICB currently has 8 very high (red) operational risks in its Corporate Risk Register.

The table to the right shows the profile of the current risks scored for **all** operational risks on the Corporate Risk Register. Full details for each risk are described in Appendix 1.

A summary of the latest position regarding these risks is outlined in paragraph 2.1 below.



Very High (Red) Operational Risks

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
Risk 01	*The Acute providers may not meet the new target in respect of 76% of patients being seen, treated, admitted or discharged within 4 hours by March 2024, resulting in the failure to meet the ICB constitutional standards and quality statutory duties.* **Update:** • The System Operational Coordination Centre (OCC) have established daily system calls to check in with the system every morning. This includes obtaining an operational update from each provider and raise any concerns and/or issues. • A report is being developed as an output of this meeting.	Overall score 20 **Very High** (5 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	<u>September performance:</u> • CRH reported 79.4% (YTD 79.0%) and UHDB reported 73.6% (YTD 73.5%). This makes CRH compliant with the local 75% target. • CRH: The combined Type 1 and 3 streamed attendances remain high, with an average of 234 Type 1 and 37 streamed attendances per day. • UHDB: The volume of attendances remains high, with Derby seeing an average of 212 Type 1 adult attendances per day, 83 children's Type 1s and 151 at the co-located Urgent Treatment Centre. At Burton there was an average of 203 Type 1 attendances per day and 20 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 14 Resuscitation patients and 199 Major patients per day and Burton seeing 72 Major/Resus patients per day.		
Risk 03	*There is a risk to the sustainability of individual GP practices (due to key areas detailed) across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.* **Update:** • Resilience meetings are in place looking both at supporting individual and system resilience across general practice. • Early warning score development is progressing and will be discussed within an upcoming resilience meeting. • The General Practice Improvement programme take up is improving with a mixture of individual practice and PCN involvement of which completion of the Support Level framework is integral. • The winter plan has been developed using a scenario of funding/no funding and options for both for consideration.	Overall score 16 **Very High** (4 x 4)	Population Health and Strategic Commissioning Committee
Risk 06	*Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.* **Update:** • Month 6 pressures faced by the System, in the main, continue to be those outside the control of JUCD partners. Operation activity pressures are being identified; however, it is expected that mitigations will be found by the Boards of each JUCD partner. Efficiency delivery is now more	Overall score 16 **Very High** (4 x 4)	Finance, Estates and Digital Committee

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	aligned to plan, however there has been a greater reliance on non-recurrent schemes, which will impact 24/25 and beyond. • Delivery Boards continue to monitor progress each month and drive financial ownership against competing priorities. • Indicative Medium Term Financial Plans (MTFP) are drafted, however further work is underway to ensure full triangulation between activity, workforce and finance. A proposal for the approach to improve productivity has been set out, which will impact all elements of the triangulated MTFP. • The Estates Strategy is not yet in place; therefore partners may not be able to support their estate that will facilitate the end strategy. This is being overseen by a Strategy Group; the national timeline is now March 2024.		
Risk 09	*There is a risk to patients on Provider waiting lists due to the continuing delays in treatment resulting in increased clinical harm.* **Update***:* • It should be noted there is significant 'lag' in the submission of information to the ICB in advance of the report submission; on occasion a delay of two quarters. • The Providers advise that these delays are due to their internal governance processes. • Assurances have been received from all Providers that they have established processes to regularly reassess clinical pathways in alignment with local and national guidelines. • DCHS currently holds an Amber rating for this KPI due to the ongoing refinements of their Standard Operating Procedure (SOPs). Nevertheless, there is an overarching SOP in place for the Trust, and all planned care and specialist services have formulated their draft clinical harm SOP. • The development of service specific SOPs is underway, starting with key services, and the plan is to gradually implement them across other services. No moderate or severe harms were reported in Quarter 1 and Quarter 2 across the Derbyshire System.	Overall score 16 **Very High** (4 x 4)	System Quality Group
Risk 19	*Failure to deliver a timely response to patients due to excessive handover delays and transfer of patients to the appropriate care setting from Acute Hospitals. Risk of leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential significant levels of harm.*	Overall score 20 **Very High** (5 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	Update: • There has been an extension of home care provision to support discharges out of Royal Derby Hospital and United Hospitals Derby and Burton (UHDB), the contract negotiations are due to start in November. • Connex Voluntary Community and social Enterprise (VCSE) has been launched supporting 10 discharges per week into the High Peak.		
Risk 20	*Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.* **Update:** • There are no plans to reduce the number of contingency hotels within Derby City or Derby County, therefore no change in this risk.	Overall score 16 **Very High** (4 x 4)	System Quality Group
New 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 (e.g. DHU, CRH subsidiary body, UHDB PFI, DCHS outsourced staff) leaves the Derbyshire system with potential £13m,recurrent liability. As this is a national decision the ICB does not have any mitigations.* **Update:** • As the ICB cannot mitigate against this risk it must be accepted.	Overall score 25 **Very High** (5 x 5)	Finance, Estates and Digital Committee
New 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 UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.* **Update:** • UHDB is in Tier 1 for cancer performance and is monitored on a weekly basis by the national team.	Overall score 16 **Very High** (4 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	• Development of UHDB Tumour Site Recovery Action Plans (with support from NHSEI Intensive Support Team (IST) are due for October 2023. • A Lower Gastrointestinal (LGI) triage pathway has been developed, pending full implementation at UHDB. • Gynaecology triage is in place at Royal Derby Hospitals (RDH). • Urology Triage piloted at RDH. • Investment to develop Derbyshire Pathfinder (Derbyshire Practices only) to support primary care pathways.		

RISK MOVEMENT

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

Two new risks were proposed in October 2023:

1. 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 (e.g. DHU, CRH subsidiary body, UHDB PFI, DCHS outsourced staff) leaves the Derbyshire system with potential £13m,recurrent, liability. As this is a national decision the ICB does not have any mitigations.*

   This risk is scored at a very high 25 (probability 5 x impact 5) and is the responsibility of the Finance, Estates and Digital Committee. The Committee approved this new risk at the meeting held on 24th October 2023.

2. 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 UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.*

   This risk is scored at a very high 16 (probability 4 x impact 4) and is the responsibility of the System Quality Group. The Group approved this new risk at the meeting held on 7th November 2023.

CLOSED RISKS

One risk is recommended to be closed.

1. Risk 02: *Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the ICB.*

This risk is currently scored at a moderate 6 (probability 2 x impact 3).

This risk is now recommended to be closed further to an addendum paper being presented to the Senior Leadership Team. As a result of this, the option to allow Midlands and Lancs Commissioning Support Unit to continue to process the applications was taken. Monitoring of progress will now be via the All Ages Continuing Health Care (CHC) operational group.

Closure of this risk was approved by the System Quality Group at the meeting held on 3rd October 2023.

CONCLUSION

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

- the Risk Register Report;
- Appendix 1, as a reflection of the risks facing the organisation as at 31st October 2023;
- Appendix 2, which summarises the movement of all risks in October 2023;
- **APPROVE CLOSURE** of risk 02 relating to changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards.

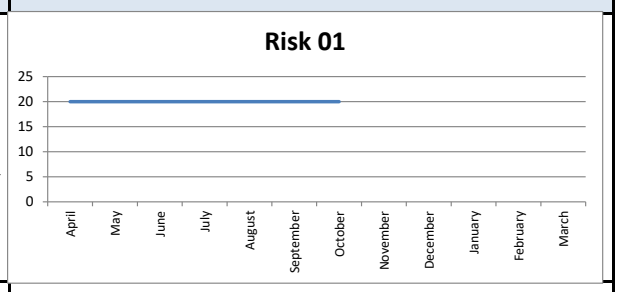
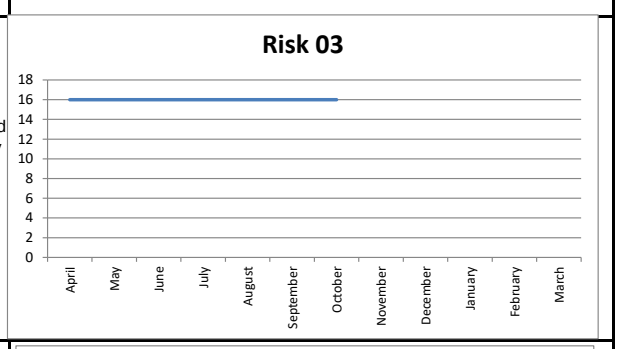
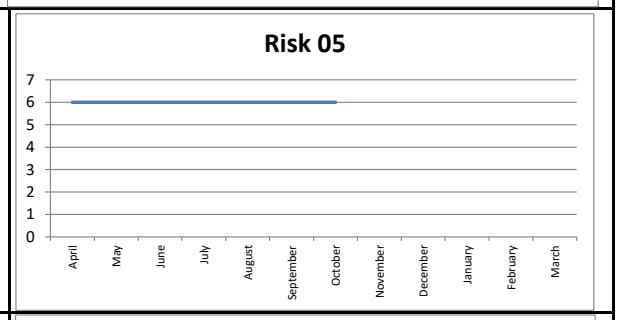
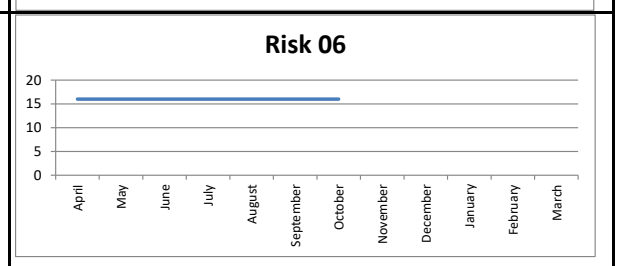
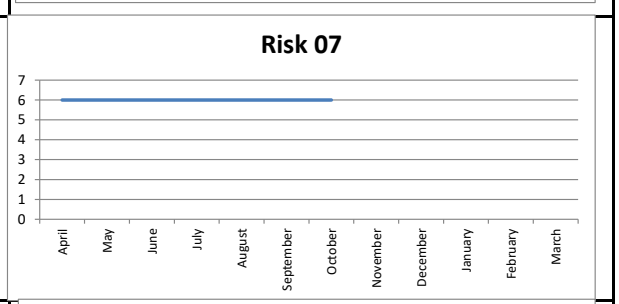
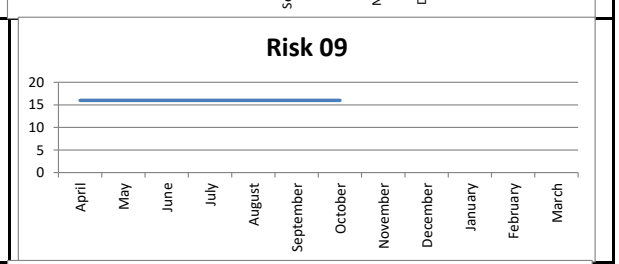
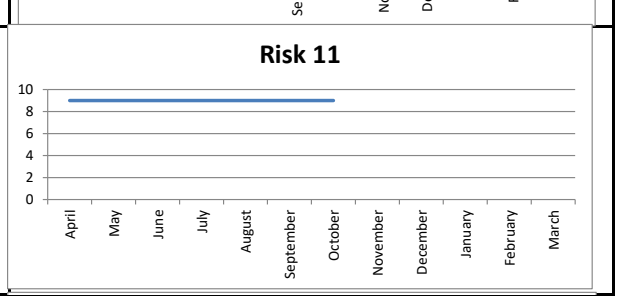
Appendix 1 - Derby and Derbyshire ICB Risk Register - as at October 2023

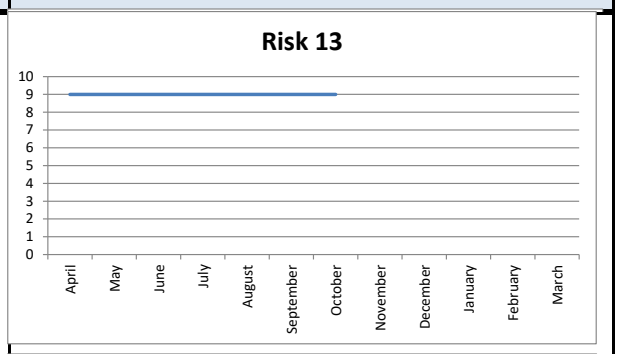
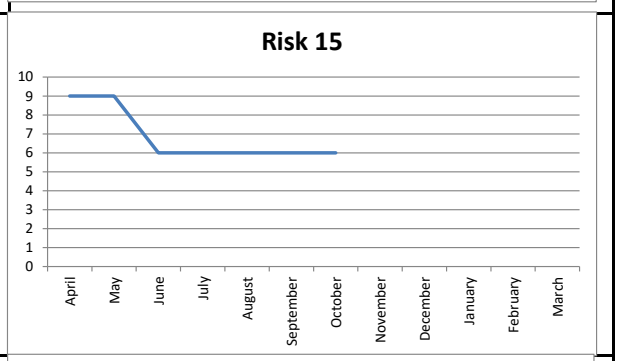
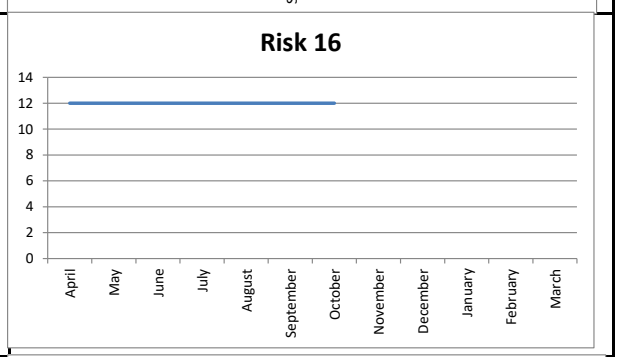
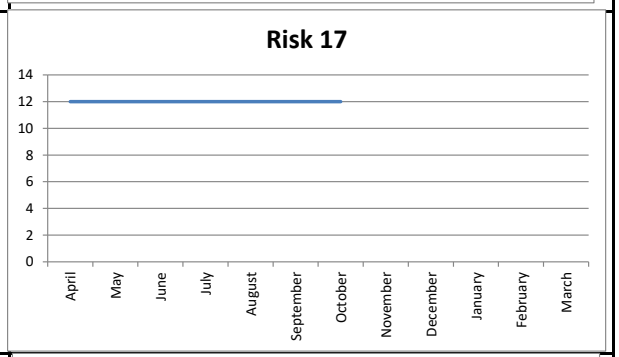
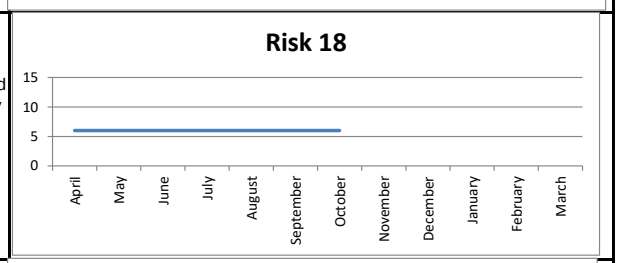
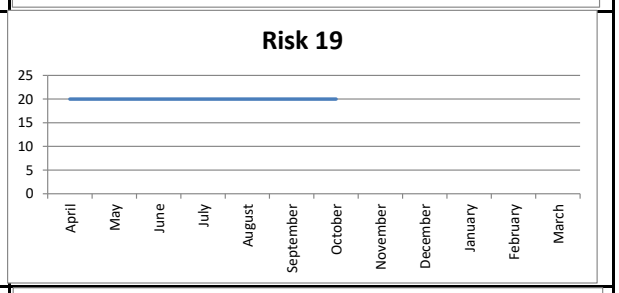
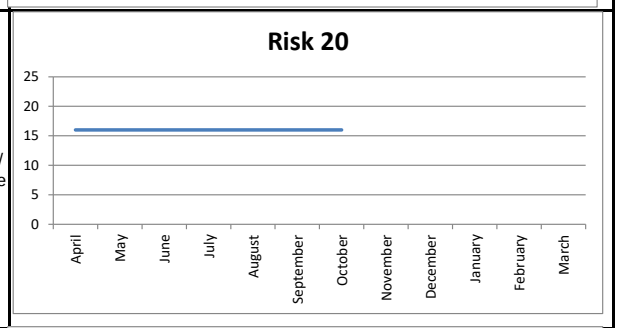
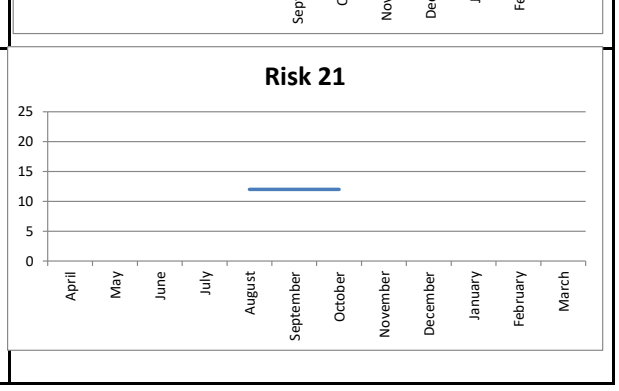
NHS Derby and Derbyshire Integrated Care Board

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
01	23/24	The Acute providers may not meet the new target in respect of 76% of patients being seen, treated, admitted or discharged from the Emergency Department within 4 hours by March 2024, resulting in the failure to meet the ICB constitutional standards and quality statutory duties.	System Quality Group	Constitutional Standards/ Quality	3	4	12	Governance: - The ICB are active members of the Derbyshire Urgent and Emergency Critical Care Board (UECC) which has oversight and ownership of the operational standards. The performance dashboard is under further development to allow greater scrutiny of performance and any areas of concern to be highlighted and acted upon accordingly. - Providers update the OPEL reporting website daily by 11am and can escalate concerns and requests for support via the ICB urgent care team in hours, or the on-call director out of hours. - All providers across the Derbyshire Health and Social Care System participate in the System Operational Resilience Group (silver command/tactical) and System Escalation Calls (gold command/strategic). These meetings are stood up by exception only. The purpose of this silver command level group is to co-ordinate and deliver the actions necessary to respond to significant issues which are affecting, or likely to affect, the functioning of an effective operation at a intra and inter sector level across the Health and Social Care System. This group reports into the System Escalation Group (SEC) which represents Gold Command. - The System Operational Coordination centre (OCC) was established on 1st December 2022, operation 7/7 8am-8pm with on-call cover to support out of hours. The updated Minimal Viable product for the OCC was released by NHSE on 18/07/2023 and is currently being reviewed and actioned by the UEC team. The OCC have established daily system calls to check in with the system every morning at 9.30 this includes getting an operational update from each provider and raise any concerns and/or issues. A report is being developed as an output of this meeting. ECIST have visited the QHB site and shared their observations, expected to visit the RDH site within the next 4-6 weeks. NHSE have commissioned KPMG to review the midland systems to understand where the driving factors are, this review will help direct focus toward the improvements required in our system (if different to what our key priorities are)	Actions taken: - Review of the Directory of Services to ensure all appropriate patients go to UTCs rather than EDs - Identifying other failed pathway referrals that lead to unnecessary ambulance conveyances, forming a plan to remedy these. Use findings from the Rapid Improvement Fortnight MDT Hub to identify failed pathways and support future development of a Unscheduled Care Coordination Hub (UCCH). Next steps is to re-introduce this for the winter period as a minimum, which will be known as the Derby & Derbyshire Clinical Navigation Hub Plus (DDCNH+) / Single Point of Access (SPoA). DDCNH+ is utilised to support Industrial Action and Bank Holidays. - Improving ambulance handover times through increased senior ownership within EDs and applying Releasing Time To Care principles in EMAS. - The HALO role is no longer in place due to the post holder moving on to a new opportunity. Alternative options are being explored to support ambulance handover times. - Taking a system-wide approach to Same Day Emergency Care working to increase same-day discharges to improve patient flow. - Same day emergency care (SDEC) and urgent treatment centre (UTC) pathways have been developed and continue to increase for EMAS to access, in order to reduce the number of patients directed to ED. - The OCC regularly review the OPEL dashboard to support their operational discussion and to give a full picture on their operational resilience, which supports the system to understand where the pressures are, the impact this has and actions required to support. The new Opel framework reporting needs to be in place by 4th December 2024, both acutes are working through this with the support of the UEC and OCC team. - Daily regional 10am calls continue as Operational Coordination Centre (OOC) and Regional Control Centre (RCC) calls. - As a result of the SORG refresh work, the weekly SORG meetings have been stood down and will be stood up when required going forward (process for escalation has been agreed and shared). A new specification for the OCC has been released by NHSE and is being worked through currently. Part of this will be improving reporting by implementing a smart system which is currently be explored by the UEC and OCC team. The OCC have re-established the daily check in calls with system partners to support managing the day to day operations, improve system working and relationships. A highlight report is being developed alongside BI and performance colleagues as an output of this meeting. - Evaluation of the DDCNH has been completed and full proposal presented at UECC Board . Pilot will continue beyond November 2023, to March 2024. DDCNH & DDCNH+/SPoA will be consolidated into one model going forward. Awaiting a Go Live date for the DDCNH+/SPOA elements. - NHS UTC Standards have been published. The ICB is now working with UTC providers to develop a range of KPI's which will monitor UTC performance against these standards.	September 2023 performance CRH reported 79.4% (YTD 79.0%) and UHDB reported 73.6% (YTD 73.5%). This makes CRH compliant with the local 75% target. CRH: The combined Type 1 & 3 streamed attendances remain high, with an average of 234 Type 1 and 37 streamed attendances per day. UHDB: The volume of attendances remains high, with Derby seeing an average of 212 Type 1 adult attendances per day, 83 children's Type 1s and 151 co-located UTC. At Burton there was an average of 203 Type 1 attendances per day and 20 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 14 Resuscitation patients & 199 Major patients per day and Burton seeing 72 Major/Resus patients per day.	5	4	20	5	4	20	3	3	9	On going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Oct-23	Nov-23	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Amy Ward Senior Operational Resilience Manager Dan Merrison Senior Performance & Assurance Manager Jasbir Dosanjh
02	23/24	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the ICB.	System Quality Group	Statutory/ Financial	3	3	9	•The implementation date for Liberty Protection Safeguards (LPS) to replace DoL has been deferred by government, date for implementation not yet confirmed. The new code of practice is currently in draft and is out for public consultation until 07.07.2022 . Midlands and Lancs CSU continue to re-review and identify care packages that potentially meet the 'Acid Test' and the MCA/DoLS staff members are preparing the papers for the CCG to take to the Court of Protection as workload allows. • ICB DoL policy will be updated when the LPS Code of Practice is available. • The ICB is required to submit 100% health funded packages of care that meet the DoL threshold to the Court of Protection (CoP) authorisation, there is an agreement with the LA for the joint funded cases which the LA submit on both our behalves and charge the ICB 50% of the submission fee. There is a reputational risk to the ICB if found guilty of an unauthorised DoL for someone in receipt of CHC funding with associated compensation costs. • Due to the delay in the implementation of LPS the CCG will continue to make applications under the existing Re X process. There is still a backlog of cases that the Court of Protection have not yet processed. • The management oversight of this work is now the responsibility of the MLCSU DoL Lead following agreement between the former CCG and MLCSU. •The Designated Nurse for Safeguarding Adults sits on the CSU Operational Group where any issues in relation to this work are raised.	The Re X DoLS Options Paper was agreed by the December Governing Body meeting and is now being implemented. A further paper was taken Q & P to seek permission for the Safeguarding Adults Team and the CSU MCA/DoLS worker to submit Re X DoLS applications that are 100% funded directly to the CoP. This has been agreed and a framework for this to happen is in place. This has been agreed and a framework for this to happen is being developed and an account with the COP has been set up.	April: The government has pulled the plans for LPS to replace DoL Therefore the ICB won't be picking up the role of responsible body under LPS so the planning that was needed for this and the risk will be able to be removed from the risk register in due course. The risk can be reviewed for closure once the ICB has seen the paper from the CSU regarding clearing the back log and the time frame for the ambers and greens to be with the court. It will be for the new government in 2024/25 to decide whether to resurrect the plans or not. Risk score probability and impact decreased accordingly for the current position. May: A paper is being prepared regarding the ongoing risk to the ICB of having a number of cases (45) that are RAG rated Amber and Green which have not yet been submitted to the CoP. June/July: Paper prepared awaiting confirmation of which meeting the papers needs to be presented to. August: Further paper to be presented to SLT for a decision to be made on the options. September: The risk can now be closed from the risk register. An addendum paper has been presented to SLT, the option to let CSU continue to process the applications was taken. Monitoring of progress will be via the All Ages CHC operational group.	2	3	6	2	3	6	3	3	9	Sept 23	SR1 SR2 SR3 SR4 SR7 SR9	Oct-23	Nov-23	Prof Dean Howells Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding Michelle Grant, Designated Nurse Safeguarding Adults/MCA Lead
03	23/24	There is a risk to the sustainability of individual GP practices (due to key areas detailed) across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.	Population Health & Strategic Commissioning Committee	Primary Care	5	4	20	Governance processes to enable identification of potential practices requiring support. Development of Primary Care sub-group to fulfil the ICB delegation requirements in relation to Primary Medical care services. CQC and ICB summit/routine meetings to review and provide assurance re: individual practices who are due to or have had a CQC inspection resulting in a rating of requires improvement or special measures. Quality Assurance programme including development of data dashboard, triangulation of information, practice highlight report and Quality Assurance / system level framework development. Clinical Governance Leads network for sharing best practice. Primary Care Networks The Primary Care Networks will provide a way that practices can support each other in smaller groups and deliver services at scale. Over time this will provide a safe forum for practices to seek help from peers and another route for help for struggling practices. Primary Care Assurance and Delivery Board Establishment of Primary Care Assurance and Delivery Board to oversee the delivery of the Primary Care Transformation programme inclusive of estates, IT, workforce - additional roles, access. General Practice Provider Board Establishment of General Practice Provider Board to support a single, unified, appropriate representative and learned Derbyshire GP voice into the Integrated Care System.	Move existing actions across PLUS Workforce: Increasing numbers of GP's choosing salaried or locum roles rather partnership due to the additional workload and responsibilities expected. Changing population health needs: Growing population generally, as well as increasing number living over 65 with multiple complex medical conditions combined with changing public expectations around immediacy of service provision. Access: the ICB is supporting the General Practice Improvement Programme and Modernising General Practice Programmes. GPIP has an intermediate and intensive programme supported by the System Level Framework (internal quality assurance plan) ICB representative on the Midlands Region Primary Care (Access) Board. Patient expectations and the impact of modernising general practice may have a negative impact on practice stability. Estates: Development of a System Estates forum. Inadequate estates (esp. PCN), The expansion of ARRs roles is causing significant pressure on general practice estate with many practices / PCNs unable to house the number of staff employed. Information Technology: Transition funding is available to support the move to Modern General Practice Access Model (MGPAM). As per the National delivery plan for recovering access to primary care MGPAM has 3 components: Better digital telephony, Simpler online requests, Faster navigation, assessment and response Cloud Based Telephony Systems - 33 practices within DDICB have been identified as having analogue telephony systems in place ,NHSE/I funding to move to CBT to support patient access (15 practices agreed to upgrade to Cloud Based Telephony, 4 practices declined to upgrade, 11 practices had already upgraded to Cloud Based Telephony and 3 practices missed deadline) Integration in general practice and system partners to use data consistently and constructively to help practices and the system understand patient need/behaviours and system response. Winter Resilience: ICB are implementing a process where PCN's are able to challenge their achievements which is in line with the commitment from the ICB to ensure that PCN income is maintained as a result of the support provided to the system during the challenging winter period, the ICB will aim to jointly understand and agree the position with the PCN. Practices ability to support winter system pressures.	August/September: Primary Care Resilience meeting took place end of July 23 and a meeting is planned for September 23, this is to develop a system plan with a focus on primary care intelligence, core offer and support for practices in crisis. Further work is taking place prior to the September meeting to develop a more advanced quality dashboard to support the early identification of practices who would benefit from additional support. October: Resilience meetings in place both looking at supporting individual and system resilience across general practice, Early warning score development progressing and will be discussed within upcoming resilience meeting. General Practice Improvement programme take up improving with a mixture of individual practice and PCN involvement of which completion of the Support Level framework is integral. Winter plan developed using scenario of funding/ no funding and options for both for consideration.	4	4	16	4	4	16	4	3	12	On going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Oct-23	Nov-23	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care
05	23/24	If the ICB does not sufficiently resource EPRR and Business Continuity functions and strengthen emergency preparedness policies and processes it will be unable to effectively act as a Category 1 responder which may lead to an ineffective response to local and national pressures.	Audit and Governance Committee	Corporate	4	4	16	• ICB active in Local Health Resilience Partnership (LHRP) and relevant sub groups • On-call staff are required to receive Met Office Weather Alerts. These will be cascaded to relevant teams who manage vulnerable groups • Executive attendance at multi agency exercises. • Internal Audits have evaluated Business Continuity preparedness. • Derbyshire-wide Incident Plan in existence • Joint Emergency Services Interoperability Protocol (JESIP) training made available to on-call staff • Staff member trained in Business Continuity and member of professional body • Staff member competent to train Loggists internally and there are sufficient number now trained • Derby and Derbyshire ICB represented on LHRP and LRF sub-groups including, HEPOG, Training and Exercising sub-group. Risk Assessment Working Group, LRF Tactical, Human Aspects and Derbyshire Health Protection Response Group. • On-call rota being revised to introduce two tier system with improved resilience • Comprehensive training undertaken for On-call staff to National Standards	• The On Call Forum has met regularly and has provided an opportunity to share experience and knowledge •The former CCG fully participated in the response to the COVID pandemic and submitted evidence to NHSEI as part of the 2020/21 EPRR National Core Standards • Continued collaborative working with Provider organisations and other stakeholders including the LRF and NHSEI Regional teams	August Policies and plans approved at August meeting of Audit & Governance Committee allowing them to be submitted as evidence for the 2023 National Core Standards self assessment due by the deadline of 31 August. All relevant evidence has now been uploaded for the ICB. Providers are in the final stages of uploading theirs and dates have been set for the "confirm and challenge" process. A further out of hours test of communications took place in August with overall good response and any lessons learned forwarded to providers. Industrial action continued throughout the month with Junior Doctors and Consultants with the ICB leading actions to mitigate the impact. September Core Standards Submission has been made to NHS England with self assessed grading of substantially compliant. The EPRR team is currently challenging all standards for system providers, close of process anticipated e/o October 2023. Further testing and training planned for 2024. Full EPRR workplan for 2024 being drawn up against key identified EPRR risks. Industrial Action continues to pressurise providers and the ICB EPRR team in conjunction with the EPRR core standards process October Core Standards Submission has been made to NHS England with self assessed grading of substantially compliant, likely due to challenges that this will be changed to partially compliant as was predicted, inordinate amount of challenge from NHS England this year however the ICB will accept comments and work to improve standards position for 2023/24 submission. The EPRR team is currently challenging all standards for system providers, this has lead to an increase in non compliant providers in line with increased challenge from Regional team, close of process anticipated e/o October 2023. Further testing and training planned for 2024. Full EPRR workplan for 2024 being drawn up against key identified EPRR risks. Industrial Action continues to pressurise providers and the ICB EPRR team in conjunction with the EPRR core standards process	2	3	6	2	3	6	2	2	4	On going	SR4 SR5 SR6 SR8	Oct-23	Nov-23	Helen Dillistone - Chief of Staff	Chris Leach Head of EPRR
06	23/24	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.	Finance, Estates and Digital Committee	Finance	4	4	16	Sep update: Actions are continually being taken against the detailed risk log to take smaller actions to mitigate the overriding risk. System strategies surrounding estates and digital plans, sharing risk across the System, and engagement into the ePMO to improve reporting, all play a part. Development of the Delivery Boards' objectives, including their role in financial efficiency delivery and ownership of such. The System moves towards understanding its underlying position and how this impacts a triangulated Medium Term Financial Plan.	Sep update: System YTD and forecast outturn continues to be monitored weekly. Delivery of the 23/24 is reliant on planned cash releasing efficiencies. Financial Sustainability Board has been established to support this. Improving the Delivery Boards' understanding of the financial plans, and their access to BI, to support the development of efficiency schemes alongside organisations CIPs for system benefits realisation. Ensure all relevant stakeholders included in the planning process, for triangulation and consistency.	Sep Update: At Month 5 YTD system performance was £32.3m deficit against £17.3m planned, driven by pressures not included in the plan such as industrial action, pay award shortfall, and excess inflation, and Microsoft licensing. There is a shortfall in efficiencies delivered YTD of £2.8m, which continues to be a concern. The FSB has identified pay related efficiencies as a key focus area that will have a significant impact on delivering targets for 2023/24. Delivery Boards have now received financial allocations, and are monitoring progress each month. Medium term financial plans (MTFP) are currently being developed, with a multi-disciplinary System planning workshop organised for this month. OD Framework at approval stage. This planning and ongoing reporting is supported by finance and workforce task & finish groups, with a local tool being developed to ensure full triangulation with activity. The ongoing risks are: - efficiency schemes needing to embed and deliver the increasing target. If the YTD shortfall continues and equally increases, the financial position will be difficult to recover. - triangulation of workforce, finance and activity for reporting and plans, and hence the understanding of productivity. - estates strategy is not yet in place, therefore partners may not be able to support their estate that will facilitate the end strategy. This is being overseen by a strategy group; national timeline is now expected to slip to March 2024 - liquidity risk should cash releasing efficiency schemes not be delivered. A revised application to NHSE by CRH was put forward early August, however System cash review is being considered.	4	4	16	4	4	16	2	3	6	On going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Oct-23	Nov-23	Keith Griffiths, Chief Financial Officer	Darran Green, Acting Operational Director of Finance Donna Johnson Acting Assistant Chief Finance Officer
07	23/24	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	Audit and Governance Committee	Corporate	4	3	12	• Staff files from Scarsdale site are to be moved to a locked room at the TBH site. This is interim until the new space in Cardinal is available. There are still staff files at Scarsdale and Cardinal Square they are safely secured. Due to Covid-19 the work has been placed on hold as staff are all working from home. • EA's/PA's at Cardinal Square have been contacted and a list is being pulled together of names and files (current or leavers) held ensuring that these are all securely saved in locked filing cabinets. Work is being completed at Cardinal Square by staff who do regularly attend site to compile the list and confirm who may be missing. • Consider an electronic central document management system (DMS) This action remains once we are in a position to move the project forward.	• A project team has been organised to work on the risks, ensuring that a standardised format and tick list is developed of the relevant paperwork to keep in HR files. This piece of work will take a significant amount of time before the ICB can even consider looking at a document management system. • Information Governance are currently working to secure a contract for archiving, this will ensure that staff leavers files are securely archived with the correct paperwork. • Project team are obtaining guidance with other NHS organisations to consider a document management system.	August - No change - Limited progress due in part to workload and holiday absences within the HR team. September - No change - Limited progress due to workload and holiday absences within the HR team. October - No change - insufficient resource within the HR team to progress this work at the current time. Resources to be reviewed with a view to completing prior to the move from Cardinal Square to the Council House.	2	3	6	2	3	6	1	2	2	Apr-24	SR8	Oct-23	Nov-23	Helen Dillistone - Chief of Staff	James Lunn, Head of People and Organisational Development
09	23/24	There is a risk to patients on Provider waiting lists due to the continuing delays in treatment resulting in increased clinical harm.	System Quality Group	Clinical	4	4	16	• Risk stratification of waiting lists as per national guidance • Work is underway to attempt to control the growth of the waiting lists – via MSK pathways, consultant connect, ophthalmology, reviews of the waiting lists with primary care etc. • Providers are providing clinical reviews and risk stratification for long waiters and prioritising treatment accordingly.	• An assurance group is in place to monitor actions being undertaken to support these patients which reports to PCDB and SQP • Providers are capturing and reporting any clinical harm identified as a result of waits as per their quality assurance processes • An assurance framework has been developed and completed by all providers the results of which will be reported to PCDB • A minimum standard in relation to these patients is being considered by PCDB • Work to control the addition of patients to the waiting lists is ongoing	• Monthly groups are in place with all 4 providers represented • Completion of assurance framework quarterly is undertaken by all providers and reports to PCDB quarterly, and to SQG • Identified harm is reported on STEIS and all providers are monitoring this • A risk stratification tool is being piloted by providers June 2023: Q3 data from paper to QPC - Every Provider is rated amber for one or more Key Performance Indicator (KPI). No indicator is rated red. However, a common theme that needs exploring in future tracking is Root Cause Analysis (RCA) and Harm Review and Equal Access to All. The target to achieve all KPIs is Month 12 22/23. CRH, UHDB and DHcFT have all confirmed that the processes should be in place for each of the standards by the end of Q4, Month 12 22/23. In terms of completing all processes by Q4 DCHS have undertaken the implementation of the risk stratification and harm review process as an iterative process whereby the SOPs are being embedded in the highest priority areas first with plans to roll out to wider services over time (priority services are wound care, podiatry, and community nursing). DCHS are hopeful that the SOP implementation within the priority areas will be complete by Q1 2023-24. September: Each Provider is rated amber or green for one or more Key Performance Indicator (KPI). No indicator is rated red. The target to achieve all KPIs was Month 12 22/23. UHDB and DHcFT have previously both confirmed that the processes will be in place for each of the standards by the end of Q4, (M12 22/23). However, ongoing work continues in the Equal access to all section. A piece of work is currently ongoing to review waiting times by ethnicity and deprivation. This work is progressing through the Systems Intelligence Group into Planned Care Delivery Board. For monitoring and assurance purposes, the Patient Safety Team, and Quality Team will liaise with Planned Care Board. It has been acknowledged that full assurance in relation to the framework is difficult due to the volume of patients waiting, and ongoing system and service pressures. There has however been substantial progress in relation to Communication and Waiting Well and Harm reviews whilst Equality of Access remain challenging. Equality of Access has been one area which is being looked at system wide. Concerns and Complaints remain in some areas, but Providers are resolving these at a local level and continue to work within their processes. In view of this, the risk rating proposed to be reduced to 12. *Decrease in risk score not agreed at System Quality Group meeting on 3rd October 2023 due to the current risks and pressures in the system.* October update: It should be noted there is significant 'lag' in the submission of information to the ICB in advance of the report submission; on occasion a delay of 2 Quarters. The Providers advise that these delays are due to their internal governance processes. Assurances have been received from all Providers that they have established processes to regularly reassess clinical pathways in alignment with local and national guidelines. DCHS currently holds an Amber rating for this KPI due to the ongoing refinements of their SOPs. Nevertheless, there is an overarching SOP in place for the Trust, and all planned care and specialist services have formulated their draft clinical harm SOP. The development of service specific SOPs is underway, starting with key services, and the plan is to gradually implement them across other services. No moderate or severe harms were reported in Q1 and Q2 across the Derbyshire System.	4	4	16	4	4	16	3	2	6	Feb-24	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Oct-23	Nov-23	Prof Dean Howells Chief Nursing Officer	Letitia Harris Assistant Director of Clinical Quality Lisa Falconer Head of Clinical Quality (Acute)
11	23/24	If the ICB does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	Audit and Governance Committee	Corporate	4	4	16	Helen Dillistone, Net Zero Executive Lead for Derbyshire ICS NHSE Memorandum of Understanding in place NHSE Midlands Greener Board established and meets monthly Derbyshire ICS Greener Delivery Group established and meets bi monthly NHSE Midlands regional priorities identified Derbyshire Provider Trust Green Plans approved by individual Trust Boards and submitted to NHSE Derbyshire ICS final draft Green Plan has been approved through the Derbyshire Trust Boards during March and May. The CCG Governing Body approved the Green Plan on the 7th April 2022. Approved ICS Green Plan submitted to NHSEI end March 2022 and confirmed CEO and GB sign off 7th April 2022. Derbyshire ICS Green Plan Action Plan in place and priorities identified for 2022/23. Development of Derbyshire ICS Green Plan Dash Board. Monthly Highlight Reporting to NHSE in place. Quarterly review meetings with NHSE Green Director Lead	Helen Dillistone, Net Zero Executive Lead for Derbyshire ICS NHSE Memorandum of Understanding in place NHSE Midlands Greener Board established and in place Derbyshire ICS Greener Delivery Group established and in place NHSE Midlands regional priorities identified Derbyshire Provider Trust Green Plans approved by individual Trust Boards and submitted to NHSE Derbyshire ICS final draft Green Plan will be approved through the Derbyshire Trust Boards during March and approved by the CCG Governing Body on the 7th April 2022. Derbyshire ICS final draft Green Plan has been approved through the Derbyshire Trust Boards during March and May. The CCG Governing Body approved the Green Plan on the 7th April 2022. Approved ICS Green Plan submitted to NHSEI end March 2022 and confirmed CEO and GB sign off 7th April 2022	October 2023 - Healthier Futures MOU Funding commitments approved at the ICS Greener Group Feb 2023. Liftshare Scheme Project launched 12th June. Air Quality Project with 2 Derbyshire School in process and will be evaluated in the summer ICS Dashboard developed for measuring performance and reduction in carbon emissions, Data presented to ICS Green Group 26/10/2023 and agreed to report annual. Largest carbon emission reduction will be delivered through Medicines workstream and agreed as key priority area to focus for the ICS. Derby and Derbyshire ICS is the best performing ICS in the Midlands for reduction in Inhalers of 28%. ICS Green Plan was reviewed by Audit and Governance Committee at August meeting and reported to the ICB Board through the ICB Board Committee Assurance Report Quarter 2 - September 23 Highlight Reports reported to NHSE SRO Review Meeting with NHSE take place quarterly, and took place 29 September 2023. NHSE System Ambition for 2023/24 detailing 23/24 priorities to be finalised. NHSE and ICB Derbyshire Green meeting with CEO and SRO 17 October 2023 Derby and Derbyshire ICB implemented the Net Zero mandatory training on ESR to all ICB staff on 1st October 2023. 10% of staff have completed in first month of launch and take up will be monitored by central ESR team Travel and transport Survey – intention is to run the survey in the next 12 months Joint working with Local Authority – ICB are members of and work together on the Air Quality Group – links to ICB wellbeing strategy The current risk score 3x3 = high 9, is reasonable this cannot be reduced until the ICS starts to achieve its targets through the action plan for 2023/24. The risk does not require an escalation in risk score, the score reflects the ICB position.	3	3	9	3	3	9	3	2	6	Mar-24	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Oct-23	Nov-23	Helen Dillistone - Chief of Staff	Suzanne Pickering Head of Governance

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
13	23/24	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.	Public Partnerships Committee	Corporate	4	4	16	• Detailed work programme for the engagement team • Clearly allocated portfolio leads across team to share programmes • Assessment of transformation programmes in ePMO system underway to quantify engagement workload. January: Ongoing assessment of ePMO programmes nearing conclusion. January: System comms leads have agreed distributed leadership approach to assessing work programmes within delivery boards and other system groups. Mapping to take place January & February, with review session planned for 2 March. September: Team has agreed portfolios and business partner arrangements to help horizon scan and plan for future work.	•Implementation of planning tool to track and monitor required activity, outputs and capacity •Links with e-PMO to embed PPI assessment and EIA processes into programme gateways •Distributed leadership across system communications professionals being implemented to understand delivery board and enabler requirements •Establishment of workstream approach to main programme areas to take place July/August 2022 to ensure prioritisation of projects is clear across system.	•Wrike planning tool in training phase (31.5.22); implementation during July/August 2022 •Agreement (8.6.22) on positioning of PPI assessment and EIA tools within e-PMO gateway processes, for implementation July 2022. Access to system granted to engagement team; training on system and assessment of activity to start August 2022. •Distributed leadership agreement among system communications group; paper to System Leadership Team (8.7.22) to confirm arrangements and flag risks deferred to future meeting. PPI Guide agreed at Engagement Committee, Senior Leadership Team and presented at Team Talk - will be developed into training programme with the aim of standardising the approach to engagement progression and equipping project teams to progress their own schemes with technical expertise provided from the engagement team. Revision and refresh of Communications and Engagement Team portfolios and priorities undertaken July 2022. April: Mapping due to take place January & February has been delayed due to other system communications priorities, including industrial action. This will be revisited at the System Communications Group meeting on 4th May. May: Distributed comms leadership reviewed, updates on progress received for P&C Committee, Children's, Planned Care & Digital. Further discussions within ICB on strategic long term conditions priorities. Discussions to assess priorities continue through May with stock take in June. May: ICB structure conversations continue in line with running cost allowance requirements. Protection of existing resource likely, no scope for growth. May: Working with regional ICB colleagues to confirm resource options for delivery of POD communications and engagement and region-wide engagement exercises. June: Workshop with regional ICB communications leads looking at best practice resourcing models and comparing impact of RCA reductions, seeking to focus on collaborative/do once approach. July/August 23: Ongoing assessment of priorities, in line with newly emerging 5-year plan and IC strategy. Ongoing anticipation of ICB structure outcomes to seek to stabilise team and confirm roles. Temporary appointments within the engagement team risk adding to the capacity challenge, with ongoing instability due to delays with the ICB structures development. There is a risk of loss of staff in the autumn/winter 2023 period which will compound the capacity risk. Similarly, vacancies arising within the Communications Team cannot be advertised whilst the ICB structure discussions continue, further compounding capacity risk. The combination may result in the need to increase the score of this risk. September: ICB structures due at REMCOM during October, followed by staff consultation period. September: Head of Communications retires 10 November 2023, unable to permanently replace. Campaigns Manager leaves 13 October, replacing on temporary basis. October: Remcom review of structures complete, now subject to staff consultation in November 2023.	3	3	9	3	3	9	2	2	4	Jul-24	SR2 SR4 SR5 SR7 SR8 SR9	Oct-23	Nov-23	Helen Dillistone - Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement
15	23/24	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	Audit and Governance Committee	Corporate	4	4	16	The former CCG team worked closely with the NHSEI team to understand current and future operating model, the work transferred, the staff required and the governance arrangements. This work enabled understanding of the detail of the transfer and shaped the transfer so that capacity could be ensured or better understand and plan for any gap. If a gap was identified, this would be escalated within the ICB for further discussion. Discussing were taking place around the possibility of the existing team remaining as presently - as a centrally managed team. This would limit the risk that the team fragments and any loss of economy of scale.	Pre-delegation assurance framework process September 2022. It is likely that the NHSEI East/West Midlands team will be retained but risks remain re potential contractual costs and capacity. Derbyshire is not required to take on delegated functions until 2023.	March: Joint Working Agreements have been drafted and are due to be signed by the end of this month, one to reflect arrangements between NHSE and ICBs and a second to reflect working arrangements between ICBs in the East Midlands. Discussions are taking place between NHSE and host ICBs, however the operational details of how the host will work with each ICB have not yet been confirmed. April: The operational details of the working relationship between the East Mids. ICBs are not yet confirmed in order to be able to assess any impacts on capacity or resource. Risk score remains the same. June: Probability decreased to 2, on the basis that Notts ICB will be the host organisation and a Standard Operating Framework has been shared. The current understanding is that our ICB will not require additional resource as a result of the delegation of pharmacy, optometry and dental services. However, specialised services are due to be delegated in April 2024 and work is currently underway to understand any impacts from that. The score will increased at that time if appropriate July/August/September: No further update, position remains the same. October - It is not clear yet whether there will be any impacts on the ICB from the delegation of Specialised Services. Birmingham and Solihull ICB will be the host ICB for those services but the detail is not yet worked through to enable us to understand any impacts on Derby and Derbyshire ICB, therefore no change to the score currently.	3	2	6	2	3	6	2	2	4	Apr-24	SR4 SR6 SR7 SR9	Oct-23	Nov-23	Helen Dillistone - Chief of Staff	Chrissy Tucker - Director of Corporate Delivery
16	23/24	With the review of ICB structures there is risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.	Audit and Governance Committee	Corporate	4	3	12	Regular communication with staff. Sharing information with staff as soon as this became available. Continuation of regular 1 to 1 wellbeing checks. Compliance with Organisation Change & Redundancy Policy.	No significant change in sickness absence.	July: Promotion of JUCD wellbeing self care pack, Body MOTs as well as wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider - Confidential Care. Sickness absence levels reduced to 2.3%. August: Promotion of wellbeing offers and activity timetable at Team Talk. Continued promotion of mental health first aiders and our employee assistance provider - Confidential Care. Sickness absence levels increased in July to 2.86%. September: Updated provided by Chief Executive at Team Talk in September. Continued promotion of wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider. Sickness absence levels increased in August to 2.97% October: Updated provided by Chief Executive at Team Talk in October along with an overview of the HR Framework and proposed restructure timeline by HR. Continued promotion of wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider. HR have also communicated further support available for staff related to the upcoming organisational change, including the following:- •The NHS leadership Academy webinar on embracing change and uncertainty •Personal resilience •Looking after yourself •Supporting others in difficult times •How to work with emotions and care for your teams Sickness absence levels increased in September to 3.6% (last year for September = 2.91%).	4	3	12	4	3	12	3	2	6	Dec-23	SR4 SR6	Oct-23	Nov-23	Linda Garnett Interim ICB Chief People Officer	James Lunn, Head of People and Organisational Development
17	23/24	Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.	Public Partnerships Committee	Corporate	4	3	12	The system has an agreed Communications & Engagement Strategy which continues to be implemented. This includes actions supporting broadening our communications reach across stakeholders, understanding current and future desired relationships and ensuring we are reaching deeper into the ICB and components parts to understand priorities and opportunities for involvement. The Public Partnership Committee is now established and is identifying its role in assurance of softer community and stakeholder engagement. Communications and Engagement Team leaders are linked with the emerging system strategic approach, including the development of place alliances, seeking to understand the relationships and deliver an improved narrative of progress. April: Engagement approach in IC Strategy underway with sessions during May. JFP engagement and stakeholder management approach now in development. August: JFP engagement approach remains in development.	*- Continued and accelerated implementation of the Communications and Engagement Strategy actions plan priorities across stakeholder management, digital, media, internal communications and public involvement. *- Continued formation of the remit of the Public Partnership Committee *- Key role for C&E Team to play in ICB OD programme *- Continued links with IC Strategy development programme *- Continued links with Place Alliances to understand and communicate priorities	April: JFP engagement planning now underway, as routine member of JFP Working Group. April: IC Strategy engagement underway, with sessions being promoted in May for each area of focus. May: IC Strategy engagement sessions being delivered. Summary version of strategy in production, along with public relations plan to share strategy among stakeholders. May: Partner engagement and governance routes being plotted for Joint Forward Plan. June: Briefing to City HOSC secured; progression on stakeholder management database; CEO MP briefings to recommence summer 2023. Ongoing engagement planning to support IC Strategy and NHS JFP. July/August: JFP published; engagement approach in development with aim to commence foundation discussions on change with wider stakeholder groups in autumn. Place Alliance communications and engagement approach progressing with case study development. Engagement frameworks development progressing, most notably insight framework pilots to inform change programme and strengthen decision-making. September: Recruitment commences for remaining PPC lay members. September: Evaluation framework discussions underway, leading to development of Lay Reference Group. This will be the main sub-group of the PPC. September: c15 expressions of interest received for insight framework pilots. October: Insight review pilots now being established. National interest in process. Framework also flagged in ICP and NHS Plan strategic discussions as underpinning our approach to user involvement in decision-making.	4	3	12	4	3	12	3	2	6	Jul-24	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8	Oct-23	Nov-23	Helen Dillistone - Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement
18	23/24	There is a risk of patient harm through existing safeguarding concerns due to patients being able to pro-actively view their medical record from 1st November 2022. This is a result of national changes to the GMS contract required by NHSEI.	Population Health & Strategic Commissioning Committee	Primary Care	4	3	12	Information cascaded to all practices detailing processes needing to be put in place before 1st November. Signposting to National webinars and hosting of local webinar. Local Information cascaded including contact details for support through NECS CSU. Work with Derbyshire LMC & FAQs circulated including a range of options for practices prior to 1st November including the application of a system code which if applied prior to the 1st of November can block patient access – to no records (practice ready for go live date) /to all records/ to patients were records still need to be reviewed. Linked with JUCD Communications team and patient facing information developed.	The GMS Contract has included Patient access to medical records since 2019, this has not been enforced, NHSEI/I communicated with systems during September 2022 to inform that this would go live on1st November 2022. Nationally, patients registered with practices using System One and EMIS IT Systems will have full access to their prospective medical records from the 1st of November 2022 (Access to retrospective records will be sought through existing processes). All records where there is a potential for patient harm to occur as a result of viewing the record need to be reviewed before the 1st of November 2022; all records where there is an existing safeguarding concern need to be reviewed There remain a number of uncertainties re; what will be viewable and when including Secondary Care Communications/ Local Authority Communications A survey has been circulated asking for practices to inform which option they have adopted in order to target support to those practices who require support. To continue to communicate updates to general practice. Working with communications – circulate information to support patients and practices.	November/December: Surveyed all General Practice and as of 25th November 17 practices have applied the code not to share for over 80% of their patient population. As part of the survey practices have submitted a plan to support increasing the level of access for their patients. January 2023 - NHSE have requested practices to submit plans for access from those practices who have applied code 104 to over 80% of their population, TPP will be enabling access as of 1st February, practices have again received the option to pause if required. No change to risk score. February 2023 NHSE have requested practices to submit plans for access from those practices who have applied code 104 to over 50% of their population, TPP will be enabling access as of 1st February, practices have again received the option to pause if required. No change to risk score. April: GP feedback has been gained at Clinical Governance meeting. There were no risks highlighted from those present. Across the ICB, 21 practices have code 104 applied to over 50% of their patients. The ICB will follow up these practices and signpost support from NECS. The risk will remain until all practices are offering access to patient records for more than 50% of their patients. Risk probability decreased from 3 to 2. June/July: GP feedback has been gained at Clinical Governance meeting. There were no risks highlighted from those present. Across the ICB, 20 practices have code 104 applied to over 50% of their patients. The ICB will follow up these practices and signpost support from NECS. The risk will remain until all practices are offering access to patient records for more than 50% of their patients. August/September 2023 - As of October 31st all practices are required to allow patients access to their records. The Primary Care Quality Team have sent further updates to all practices in August with links for support through EMIS and NECS. October: The ICB is supplying weekly updates to PCNs with regards to practices and access of patients to the NHS app including access to records. Practices have been kept up to date with webinars and communications regarding all aspects of the switch on, no safeguarding concerns have been raised to the ICB to present, additional feedback has been sought at Clinical Governance leads meetings. Review the risk following go live date in the event that concerns are raised re practice implementation or safeguarding.	2	3	6	2	3	6	2	2	4	Dec-23	SR1 SR4 SR8 SR9	Oct-23	Nov-23	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Hannah Belcher, Assistant Director of GP Commissioning and Development- Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care
19	23/24	Failure to deliver a timely response to patients due to excessive handover delays and transfer of patients to the appropriate care setting from Acute Hospitals. Risk of leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential significant levels of harm.	System Quality Group	Clinical	5	5	25	Discharge 1. ASCDF funded home care through CHS till end oct 23, plan to continue at current level till Feb 24 for discharge and flow support 2. DCHS led CRT providing reablement care for P1, increased investment through ASCDF to increase provision 2. P1 Strategy to be finalised Oct 23 3. Transport : Clinical Nav ensuring transport to community bedded care is booked to reduce incomplete discharges out and lost bed days in community beds, started CRH to be rolled out across all wards and to UHDB 4. Community Health Therapists working closely with County Adult Care and Community Response Teams to ensure P1 clients have clear goals and a planned date of discharge. This will help reduce the intensity and duration of care packages thus freeing up capacity 5. ASCDF funding VCSE 'home and settle from hospital' scheme to transport and support P0 discharges home plus county schemes coming on line in Oct / Nov : will reduce delays for P0/P1 patients awaiting discharge and reduce readmission rates as patients supported once discharged. 6. County ASC transformation to provide increased and improved P1 capacity. Launch date Jan 24 7. ASCDF funding staff to improve discharges out of CRH and UHDB, focus on weekend discharges 8. Care transfer hub process improvement work 9. OPTICA to provide IT solution for discharge planning identifying delays and supporting with prioritisation of tasks (aim to reduce duplication and better decision making) 10. integration in City of health and social care delivery to one reablement model of care 11. ASCD to mental health to improve flow through MH beds to enable increased capacity 12. CRH and UHDB focused work on ward processes to improve flow. Roll out of UHDB strength based approach to discharge (started ward 311) UEC interventions 1. SEC and SORG interventions. 2. Overview of HHO delays and robust scrutiny of progress to delivery improvement trajectories. 3. Performance management of workforce and abstraction rates to ensure necessary resources are in place to respond to demand 4. Implementation of EMAS Hospital Handover Harm Prevention Tool at Acute Trusts. 5. Ongoing work in commissioning Same Day Emergency Care and direct access to specialties such as surgery, gynaecology and urology and community providers implementing urgent two-hour community response to suitable patients, thereby increasing the number of patients who can be safely treated in their own homes. 6. Regular monitoring of Actions and risk by CQRG. 7. Local system governance structures to manage difficult decisions: Derbyshire System pressures can be safely treated in their own homes. 8. HALO - recruited to support both Acutes and crews with handover delays, directing appropriate patients to SDEC, supporting pinning off etc	Discharge 1. accept discharge to assess is a joint responsibility of health AND social care to deliver 2. Accept discharge out of P2 beds will have parity of impact with acutes as will create flow (25% P2b beds have patients in delay) 3. Reduce the number of handoffs within our pathways and improve faster access to pathways through joint improvement work 4. Accept OPTICA will lead to improved transparency of system delays and enable prioritisation of patient needs for discharge. All system partners to support embedding of tool 5. accept largest gain is in providing more pathway 1 access to support discharge flow, avoid use of temporary beds to place patients into who are in delay and acknowledge this leads to poor outcomes for patients and higher costs for the system 6. Accept there is limited care home capacity to accept needs of patients who have complex needs, where these are sought for discharge there will likely be delays to source 7. Reduce the delays caused by patients awaiting discharge letters / meds for discharge, 8. reduce the number of patients being discharged after midday and increase early morning discharges, this is achieved through improved discharge planning and decision making and access to transport 9. Accept decisions regarding discharge need to be made as a system with no one provider making unilateral changes to delivery without consulting with others through governance route of SDG 9. accept that process work around care transfer hubs requires transformation support of the system to enable true change to occur 10. transfer bed learning from ward 311 strength based approach to UHDB is learnings can be used by the wider hospital 11. Provide assurance that ASCDF is delivering additional discharge capacity to the system through monitoring of impact and outcomes 12 accept there is a large decrease in weekend discharges due to reduced weekend staffing on wards and some providers. Unless there is significant investment in workforce across wards and community this will continue 13 accept there is a large opportunity to focus on P0 discharges which are 90+% of all flow which will likely not be supported by the care transfer hubs. UEC System actions to reduce hospital handover delays. System urgent care improvement action plans. ECIST - will be visiting the RDH site and providing recommendations and supporting the trust to improve their Type 1 performance, handover delays and reduce their bed occupancy levels Work ongoing to develop a memorandum of understanding (MOU) which sets out the commitment between ICB, Acute Providers, NHSE and Ambulance Trusts to support ambulance crews ending their shift on-time, when in attendance at busy emergency departments with ambulance handover delays. Recruited 1 x HALO, start date to be agreed.	April 23 : plans to be agreed to allocate ASC discharge fund to support increase in discharges April 23 : discharge reporting review. Move to weekly update reporting May 23 : OPTICA discharge support tool to improve data on delays and flow May 23 : ASC county consultation ends and transformation of P1 services can commence May 23 : recruitment to pathway 1 team (DCHS) to support discharge, funded through DCHS May 23 : workshops to transform Pathway 1 process and flow commence with PDSA improvement cycle June 23 : Derby City disability direct launch scheme to support 10 P0 discharges per week with transport and support at home. This is being well utilised July 23 : County LA transformation date delayed until Jan 24. Currently reviewing options appraisal to look at alternative provision of P1 to support discharge through IPE (Integrated Place Exec board) July 23 : initial round of schemes to be funded through the health element of the ASCDF (Adult Social Care discharge fund) in July, approved schemes to IPE board for ratification before final approval at ICB for funding. Schemes include roles at CRH and UHDB to enable 7 day discharges, County scheme to support P0 discharges home with transport and support at home on discharge, Mental health transformation to reduce Length of stay in beds. August - No update Sept 23 : Identification of P1 gap of approx. 49 discharges per week if CHS care ends in Nov, paper to execs to approve extension of CHS until ASC transformation is embedded (Feb 24), POG development support and agreement of system flow meeting, twice weekly, with all system partners to unblock flow from all providers. TOR agreed and to be shared with SDG. Require system support to facilitate this shift in meetings to outcomes, challenge and delegated decision making. Care transfer hub work to commence Oct 23 at CRH, request transformation support into these meetings Oct 23 : extension of home care provision to support discharge out of RDH and UHDB, contract negotiations due to start Nov. Connex VCSE launched supporting 10 discharges per week into high peak	5	4	20	5	4	20	2	2	5	December 23	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Oct-23	Nov-23	Dr Chris Weiner Chief Medical Officer	Jo Warburton Dan Webster
20	23/24	Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.	System Quality Group	Clinical	4	5	20	Local Partners continue to work closely together and meet regularly with the Home Office, SERCO and the East Midlands Councils Strategic Migration Team to discuss any issues, concerns or points to escalate in regard to the Contingency Hotels. Health and Social Care are providing services to meet the needs of the service users placed within our area.	Regular meetings with the Home Office, Serco and East Midland Councils Strategic Migration team to discuss concerns/ issues identified and points to escalate further – meetings have been taking place weekly and now going to be fortnightly DDICB are working closely with Primary Care Networks/ GP practices to commission/ deliver Primary Care Services to asylum seekers placed with our geographical area - all hotels and AIA have GP practice cover Both Health and Social Care services to continue to meet the statutory needs of looked after children - although under significant pressure Looked after children services are being offered All partners working closely together to try and meet the needs of asylum seekers and raise any concerns to the Home Office, SERCO and East Midlands Councils Strategic Migration team - concerns/ issues identified are being raised via meetings. Formal letters of concern have also been written to the Home Office.	update 24/07/23 - ongoing concerns with the use of contingency hotels - 4 of the 7 settings - two in the city and two in the county will be increasing the capacity to help come with the demand of asylum seekers needing to be placed. Also there are meetings taking place with Serco and Home Office in regard to a setting in Derbyshire being used as dispersal accommodation - this will have a potential capacity of 247. in light of the recent developments there is no change in the risk - as concerns are ongoing. 21/08/22 Ongoing challenges with contingency hotels- Hotel use continues. Two of the city Hotels are due to increase their room capacity to help met the demand of asylum seekers needing to be accommodated. 20/09/23 - There are no planned reductions in the use of contingency hotels in the city or the county. Concerns also regarding the number of unaccompanied asylum seeking children arriving in the city and county. 20/10/23 No plans to reduce the number of contingency hotels within the city or county - therefore no change in risk	4	4	16	4	4	16	3	3	9	December 23	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Oct-23	Nov-23	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children
21	23/24	There is a risk that contractors may not be able to fulfil their obligations in the current financial climate. The ICB may then have to find alternative providers, in some cases at short notice, which may have significant financial impact.	Finance, Performance and Digital Committee	Finance	4	4	16	Understand financial pressures facing our providers. Maintain Contract Database Proactive Procurement	Contractors will at short notice inform the ICB that they can no longer fulfil their contractual obligations. This risk should cover a wide range of contracts from the supply of health care (General Medical practitioners and Individual care packages) to the supply of goods and services. Maintain a close working relationship with key with providers. Use contract database to understand which contracts are due for renewal and plan well ahead. Work closely with colleagues in A&GEM Procurement team to ensure we are aware of latest information available in the various markets the ICB works in	September/October: The ICB is close to agreeing all contracts perceived to be at risk of inflation/cost of living, the ICB would expect to have been notified or assessed the probability of this occurring. A more robust link between contract expiry and procurement planning has been established.	3	4	12	3	4	12	2	3	6	Ongoing	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Oct-23	Nov-23	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Lana Davidson Senior Contract Manager
NEW RISK 22	23/24	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 (e.g. DHU, CRH subsidiary body, UHDB PFI, DCHS outsourced staff) leaves the Derbyshire system with potential £13m,recurrent, liability. As this is a national decision the ICB does not have any mitigations.	Finance, Performance and Digital Committee	Finance	5	5	25	It is not possible to mitigate against this risk occurring. This is a national decision and there is no current indication that this will change.	As the ICB cannot mitigate against this risk it must be accepted. The organisations which are affected are aware of this decision and the further risk to the health and care system is that staff may be demotivated, feel undervalued, feel that they are being treated unfairly and may leave the organisations, therefore increasing the risk of inadequate workforce in Derbyshire to support our patients.	No progress to report.				5	5	25				Ongoing	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Oct-23	Nov-23	Keith Griffiths, Chief Financial Officer	Keith Griffiths / Darran Green
NEW RISK 23	23/24	There is a risk to Joined Up Care Derbyshire (JUCD) performance against the Cancer Standards, including 28 Day Faster Diagnosis Standard, 62 Day Waits and 104+ days due to an increase in referrals from Staffordshire into UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.	System Quality Group	Clinical	4	4	16	There is a growth in 2 week wait referrals seen by UHDB comparing Jul-22 – Jun 23to 2019/20. Overall the activity for UHDB has increased by 29% compared to an overall growth nationally of 18%. This position is being driven by particularly large increases for patients from Staffordshire and to a lesser extend from LLR whilst the increase for Derbyshire is much closer to the national average. •The East Midlands Cancer Alliance has agreed to fund posts for 18 months at UHDB, as a Tier 1 Trust to support recovery, particularly for triage to build front end capacity to meet additional demand. •Work with Staffordshire ICB to understand drivers for referral increase	•Recruitment to range of posts funded through EMCA to support recovery. •Prioritisation of Best Practice timed pathways across key tumour sites – LGI, Urology, Skin and Gynae •Development of UHDB tumour site recovery action plans (with support from NHSEI IST team) due – Oct-23 •Development of referral triage functions: Gynae, LGI and Urology •Work underway to understand drivers for variance in Histology TAT at tumour site level. •Work going to enhance access to PET scanning (Longer term ambition to develop PET service within Derbyshire) •Oncology challenges supported through regional alliance support – longer term workforce development	•UHDB is in Tier 1 for cancer performance so monitored on a weekly basis by the national team. •Development of UHDB tumour site recovery action plans (with support from NHSEI IST team) due – Oct-23 •LGI Triage pathway developed. Pending full implementation at UHDB. •Gynae Triage in place at RDH. •Urology Triage piloted at RDH. •Investment to develop Derbyshire Pathfinder (Derbyshire Practices Only) to support primary care pathways •Recruitment – to EMCA funded roles ongoing. •IST Support to develop existing recovery action plans. •BPTP development continues. •Data analysis completed with NHSEI support to develop understanding of changes to activity levels. •SSICB Commissioning lead and GP Clinical Lead part of JUCD system workstreams to develop solutions to address this. •SSICB Primary Care Group now in place and UHDB part of this •Skin Recovery focus in place with additional capacity identified and outsourcing planned to support elective and cancer priorities. •Plans to develop Cancer PCN Leads network across JUCD (included connection to Staffordshire practices).	4	4	16	4	4	16	2	4	8	September 2024	SR1 SR8 SR9	Oct-23	Nov-23	Prof Dean Howells Chief Nursing Officer	Monica McAllindon Head of Cancer

Appendix 2 - ICB Risk Register - Movement - October 2023

Risk Reference	Risk Description	Previous Rating (September)			Residual/ Current Risk Rating (October)			Movement - October	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
01	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the ICB constitutional standards and quality statutory duties.	5	4	20	5	4	20	⟺	The System Operational Coordination Centre (OCC) have established daily system calls to check in with the system every morning. This includes obtaining an operational update from each provider and raise any concerns and/or issues.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager	
02	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the ICB.	2	3	6	2	3	6	**Risk recommended for closure**	The risk can now be closed from the risk register. An addendum paper has been presented to SLT, the option to let CSU continue to process the applications was taken.	Prof Dean Howells Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding Michelle Grant, Designated Nurse Safeguarding Adults/MCA Lead	**Risk recommended for closure**
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	⟺	Resilience meetings in place both looking at supporting individual and system resilience across general practice.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care	
05	If the ICB does not review and update existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known and unknown risks to the Derby and Derbyshire ICB, which may lead to an ineffective response to local and national pressures.	2	3	6	2	3	6	⟺	Core Standards Submission has been made to NHS England with self assessed grading of substantially compliant, likely due to challenges that this will be changed to partially compliant as was predicted.	Helen Dillistone - Chief of Staff	Chris Leach, Head of EPRR	
06	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.	4	4	16	4	4	16	⟺	The System moves towards understanding its underlying position and how this impacts a triangulated Medium Term Financial Plan.	Keith Griffiths, Chief Financial Officer	Darran Green, Acting Operational Director of Finance	
07	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to the former Derby and Derbyshire CCG this data is not held consistently across the sites.	2	3	6	2	3	6	⟺	Insufficient resource within the HR team to progress this work at the current time. Resources to be reviewed with a view to completing prior to the move from Cardinal Square to the Council House.	Linda Garnett Interim Chief People Officer	James Lunn, Head of People and Organisational Development	
09	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	3	4	16	3	4	16	⟺	No moderate or severe harms were reported in Q1 and Q2 across the Derbyshire System.	Prof Dean Howells Chief Nursing Officer	Letitia Harris Clinical Risk Manager	
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	⟺	Derby and Derbyshire ICS is the best performing ICS in the Midlands for reduction in Inhalers of 28%.	Helen Dillistone Chief of Staff	Suzanne Pickering Head of Governance	

Risk Reference	Risk Description	Previous Rating (September)			Residual/ Current Risk Rating (October)			Movement - October	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
13	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.	3	3	9	3	3	9	⇔	Remcom review of structures complete, now subject to staff consultation in November 2023.	Helen Dillistone Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement	
15	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	2	3	6	2	3	6	⇔	It is not clear yet whether there will be any impacts on the ICB from the delegation of Specialised Services.	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.	4	3	12	4	3	12	⇔	Sickness absence levels increased in September to 3.6% (last year for September = 2.91%).	Linda Garnett Interim Chief People Officer	James Lunn, Head of People and Organisational Development	
17	Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.	4	3	12	4	3	12	⇔	Insight review pilots now being established.	Helen Dillistone Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement	
18	There is a risk of patient harm through existing safeguarding concerns due to patients being able to pro-actively view their medical record from 1st November 2022. This is a result of national changes to the GMS contract required by NHSE/I.	2	3	6	2	3	6	⇔	The ICB is supplying weekly updates to PCNs with regards to practices and access of patients to the NHS app including access to records.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care	
19	Failure to deliver a timely response to patients due to excessive handover delays and transfer of patients to the appropriate care setting from Acute Hospitals. Risk of leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential significant levels of harm.	5	4	20	5	4	20	⇔	Extension of home care provision to support discharge out of RDH and UHDB, contract negotiations due to start November 2023.	Dr Chris Weiner Chief Medical Officer	Jo Warburton Dan Webster	
20	Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.	4	4	16	4	4	16	⇔	No plans to reduce the number of contingency hotels within the city or county - therefore no change in 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 ICB is close to agreeing all contracts perceived to be at risk of inflation/cost of living, the ICB would expect to have been notified or assessed the probability of this occurring.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Lana Davidson Senior Contract Manager	

Risk Reference	Risk Description	Previous Rating (September)			Residual/ Current Risk Rating (October)			Movement - October	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
NEW 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 (e.g. DHU, CRH subsidiary body, UHDB PFI, DCHS outsourced staff) leaves the Derbyshire system with potential £13m,recurrent, liability. As this is a national decision the ICB does not have any mitigations.				5	5	25	NEW RISK	As the ICB cannot mitigate against this risk it must be accepted.	Keith Griffiths, Chief Financial Officer	Keith Griffiths / Darran Green	NEW RISK
NEW 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 UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.				4	4	16	NEW RISK	UHDB is in Tier 1 for cancer performance so monitored on a weekly basis by the national team.	Prof Dean Howells Chief Nursing Officer	Monica McAllindon Head of Cancer	NEW RISK

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 099

Report Title	Board Assurance Framework Quarter 2 2023/24							
Author	Rosalie Whitehead, Risk Management & Legal Assurance Manager							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Summary of Quarter 2 BAF Appendix 2 – Quarter 2 2023/24 BAF strategic risks 1 to 10.							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Finance and Estates Committee Population Health and Strategic Commissioning Committee Quality and Performance Committee People and Culture Committee Public Partnership Committee							

Recommendations

The ICB Board are recommended to:

- **APPROVE** the Quarter 2 BAF strategic risks 1 to 10;
- **NOTE** the decrease in risk scores for Strategic Risk 1 and Strategic Risk 2 from a very high score of 20 to a very high score of 16; and
- **NOTE** 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.

Purpose

The purpose of this report is to present to the Board the Quarter 2 2023/24 Board Assurance Framework.

Background

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

The Board Assurance Framework is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's aims and objectives. The BAF provides

the Board with a framework to support identification of key areas of focus for the system and updates as to how those key areas are being addressed.

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

The strategic risks are the risks that face the system, including the ICB. The ICB however will take a system coordination role to develop the framework that underpins the delivery and will require 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.

Report Summary

Quarter 2 BAF 2023/24

Following previous feedback from the ICB Board and Internal Audit, further development and strengthening of the Strategic Risks has been undertaken and is reflected in the Quarter 2 BAF. During quarters 1 and 2, the BAF has been modified to include the cross referencing of gaps in control and assurance to the relevant actions. A significant review has been undertaken of gaps in controls and assurances to ensure they address the risk areas and where gaps did not address the risk areas they have been removed. Actions to address gaps in controls and assurances have been reviewed, updated and marked as complete where required. Updates for quarter 2 are highlighted in blue.

Appendix 1 provides the summary of the Quarter 2 BAF and Appendix 2 provides the detailed Quarter 2 2023/24 BAF strategic risks 1 to 10.

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

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

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

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

Following the last meeting and discussions held, the Working Group recommended to decrease the risk score for both Strategic Risks 1 and 2. This is as a result of the Integrated Care System increasing in maturity, the work carried out and progress so far this year.

Strategic Risks 1 and 2 were recommended to be decreased from a very high score of 20 to a very high score of 16, effective from September 2023. This decrease was approved at the Quality and Performance Committee meeting held on 2nd November 2023.

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

Strategic Risk 7: *There is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.*

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

Strategic Risk 9*: There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.*

A thorough review of both strategic risks 7 and 9 has been undertaken during quarter 2, several system gaps in control and system gaps in assurance have been removed from the risks. These were identified as gaps where they did not address the risk areas, gaps not being relevant any longer as the ICB continues to mature or duplicated elsewhere in the risk.

BAF Strategic Risk 7

Strategic Risk 7 has been refreshed regarding the gaps in controls and assurances to ensure they addressed the risk areas and where gaps did not address the risk areas they have been removed. Following the review of actions, the Committee have agreed that the risk profile for this risk remains at risk score 12.

BAF Strategic Risk 9 – Risk Description

During Quarter 2, a new strategic risk was proposed at the System Finance, Estates and Digital Committee. The proposed description for the risk was: *Risk that available resources are distributed to meet immediate priorities and do not take account of long-term System strategic objectives.*

After consideration of the new strategic risk with Senior Officers, it was felt that the risk was a contributing factor to risk 9, therefore it was proposed that the risk is incorporated into Strategic Risk 9 with a revised risk description. This then eliminates the need for a further separate strategic risk and duplication.

Original Strategic Risk 9 description: *There is a risk that the gap in health and care widens due to a range of factors* ***(recognising that not all factors may be within the direct control of the system)*** *which limits the ability of the system to reduce health inequalities and improve outcome.*

New Strategic Risk 9 description: *There is a risk that the gap in health and care widens due to a range of factors* ***including resources used to meet immediate priorities*** *which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.*

BAF Strategic Risk 9 - Strategic Threats

The original four strategic threats were proposed to be reduced to two strategic threats:

- Threat 1 - Original description: Resource required for restoration of services post-Covid impacts progress of health inequalities programme. Revised description: The

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

- Threat 2 - The cost of living crisis worsens health inequalities. PHSCC agreed that this threat was removed, due to this threat being out of the control of the ICB and System.

- Threat 3 -The population may not engage with prevention programmes. This threat remains the same.

- Threat 4 - The ICS aim to achieve too much in too many areas with limited resources. PHSCC agreed that this threat was removed as this is incorporated into the revised wording in respect of threat 1.

The risk profiles of risk 9 have been reviewed and considered by the Committee and have not changed during quarter 2 and the risk score remains a 16 due to the nature of the long-term risk.

Transfer of BAF Strategic Risk 8

The original risk description for Strategic Risk 8 was - *There is a risk that the system does not:*

A. establish intelligence and analytical solutions to support effective decision making; and

B. deliver digital transformation.

During quarter 2, the original Strategic risk 8, which was the responsibility of the Finance, Estates and Digital Committee, was split into two separate risks. This was to clearly identify the data and intelligence element and digital transformation as two separate strategic risks.

- Strategic Risk 8: *There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.*
  This risk is now the responsibility of the Population Health and Strategic Commissioning Committee.

- Strategic Risk 10: *There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.*
  This risk remains the responsibility of the Finance, Estates and Digital Committee.

The changes were approved at the Population Health and Strategic Commissioning Committee meeting held on 12th October 2023. Following the review of actions, the Committee have agreed that the risk profile for this risk remains at risk score 12.

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

Strategic Risk 4: *There is a risk that the NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.*

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

Following discussions at the Finance, Estates and Digital Committee meeting held on 26th September, it was agreed that, as the intelligence and analytical solution risk is led by Dr

Chris Weiner, this risk should be owned by the Population Health and Strategic Commissioning Committee and not the Finance, Estates and Digital Committee.

The ownership of this risk has now been transferred to the Population Health and Strategic Commissioning Committee. This was presented and agreed at the Population Health and Strategic Commissioning Committee meeting held on 12th October 2023.

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

  The risk profiles have been reviewed and considered by the Committee, the risk score remains at a high score of 12 for quarter 2

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

  The risk profiles have been reviewed and considered by the Committee, the risk score remains at a high score of 12 for quarter 2 due to the work required and the recurrency of programme funding is still outstanding.

- Strategic Risk 4: *There is a risk that the NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.*

  The Finance, Estates and Digital Committee have reviewed the final quarter 2 position for the risk and the risk profile remains at a very high 16.

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

Strategic Risk 5: *There is a risk that the system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.*

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

Actions have been reviewed and completed for Strategic Risks 5 and 6, however the profile of the risk scores for both risks have not changed during quarter 2. This is due to the long-term nature of the risks and many of the drivers are out of the control of the system.

5. Public Partnership Committee – Strategic Risk 3

There is a risk that the population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.

An outline set of actions have been developed to address the threats posed by the risk, and the Committee has reviewed the deep review of actions which supports greater visibility on progress through the course of the year as the risk is mitigated.

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

6. Actions completed during Quarter 2

The following table details actions which have been completed during quarter 2 across the Strategic Risks.

Action Reference Number	Action	Action date completed
1T1.2A	Development of Integrated Care Strategy / Joint Forward Plan	30.06.23
1T1.3A	Triangulation with Provider System BAF	30.06.23
1T2.1A, 2T3.1A	Development of a system Health Inequalities strategy as part of the wider Integrated Care Partnership strategy	30.06.23
1T3.2A, 4T3.4A	Development of Operational Plan	30.06.23
2T1.2A	Clarification of the scope and Terms of References of Provider Collaborative Leadership Board and System Delivery Boards	30.09.23
2T3.1A	Development of a system Health Inequalities strategy as part of the wider Integrated Care Partnership strategy	30.09.23
4T3.2A	CIP Engagement Plan being implemented	30.06.23
5T1.1A	Refresh of 22/23 workforce plan	30.06.23
5T1.2A	Develop 2023/24 workforce plan	30.06.23
10T1.1A	Secure agreement on digital and technology resource funding - budget being formalised for 23/24 budget only, still to agree recurrent funding	Complete for 23/24 funding 30.06.23
10T1.4A	Formally incorporate Primary Care digital and technology governance within D3B	30.06.23
3T1.5A	Assess current team skills in cultural engagement and communications. ○ Health literacy bite-sized training (various team members and team discussion)	30.06.23
3T2.1A	Delivery of Communications and Engagement Strategy Stakeholder chapter to scope processes on relationship managing and stakeholder perceptions, resulting in business case. ○ Management tool identified with Head of Digital	30.06.23
3T2.4A	Develop proposal and business case for UEC behaviour/insight programme following social marketing principles.	31.07.23

Each responsible Executive and the Committee reviewed and approved their final Quarter 2 2023/24 strategic risks at the Committee meetings in October prior to this report being presented to the ICB Board on 16th November 2023.

Identification of Key Risks					
SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☒

SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does nor establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency	☒

The report covers each strategic risk.

Financial impact on the ICB or wider Integrated Care System

Yes ☒	No☐	N/A☐

Details/Findings	**Has this been signed off by a finance team member?**
Strategic risk SR4 describe the system's financial risk. *There is a risk that the NHS in Derby and Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move to a sustainable financial position and achieve best value from the £3.1billion available funding.*	Keith Griffiths, Executive Director of Finance

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

No conflicts of interest have been identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?					
There are no implications or risks which affect the ICB's obligations under the Public Sector Equality Duty.					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings The ICB Corporate Risk register defines the risk to the achievement of Net Zero Targets and the delivery of the Derbyshire ICS Green Plan.					

Appendix 1 - ICB Board Assurance Framework (BAF) - Quarter 2 2023/24 Summary

Joined Up Care Derbyshire

The key elements of the BAF are:

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

Key to lead committee assurance ratings:

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

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

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

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

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

Risk scoring = Probability x Impact (P x I)

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

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

Reference	Strategic risk	Responsible committee	Executive lead	Last reviewed	Target risk score	Previous risk score	Current risk score	Risk appetite risk score	Movement in risk score	Overall Assurance rating
SR1	There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to delivery consistently safe services with appropriate levels of care.	Quality & Performance	Prof Dean Howells	02.10.2023	10	20	16	12	↓	Partially assured
SR2	There is a risk that short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	Quality & Performance	Prof Dean Howells	02.10.2023	10	20	16	12	↓	Partially assured
SR3	There is a risk that the population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	Public Partnership Committee	Helen Dillistone	31.10.2023	9	16	16	12	↔	Partially assured

Reference	Strategic risk	Responsible committee	Executive lead	Last reviewed	Target risk score	Previous risk score	Current risk score	Risk appetite risk score	Movement in risk score	Overall Assurance rating
SR4	There is a risk that the NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	Finance, Estates and Digital Committee	Keith Griffiths	13.10.2023	9	16	16	12	⟷	Partially assured
SR5	There is a risk that the system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	People & Culture Committee	Linda Garnett	26.10.2023	16	20	20	16	⟷	Partially assured
SR6	There is a risk that the system does not create and enable One Workforce to facilitate integrated care.	People & Culture Committee	Linda Garnett	26.10.2023	9	12	12	9	⟷	Partially assured
SR7	There is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	Population Health & Strategic Commissioning Committee	Michelle Arrowsmith	05.10.2023	9	12	12	12	⟷	Partially assured
SR8	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	Population Health & Strategic Commissioning Committee	Dr Chris Weiner	05.10.2023	8	12	12	12	⟷	Partially assured
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	Population Health & Strategic Commissioning Committee	Michelle Arrowsmith	05.10.2023	12	16	16	12	⟷	Partially assured
SR10	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	Finance, Estates and Digital Committee	Jim Austin	17.10.2023	10	12	12	12	⟷	Partially assured

Appendix 2 - ICB – Board Assurance Framework (BAF)

Strategic Risk SR1 – Quality and Performance Committee

Strategic Aim – To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Prof Dean Howells, Chief Nursing Officer **ICB Chair** :Adedeji Okubadejo, Chair of Quality & Performance Committee	**System lead:** Prof Dean Howells, Chief Nursing Officer, Dr Robyn Dewis **System forum:** Quality and Performance Committee	**Date of identification:** 17.11.2022 **Date of last review:** 02.10.2023

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

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

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control Ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 Lack of timely data to improve healthcare intervention	• Derbyshire ICS Integrated Quality and Performance Report has been refined and is reported and managed by the System Quality and Performance Committee monthly. These will highlight areas of significant concern. • System Deep Dives provide further assurance at the Quality and Performance Committee. Deep dives are identified where there is lack of performance/ or celebration of good performance • The Integrated Assurance and Performance Report has been developed and is reported to public ICB Board bimonthly. Specific section focuses on Quality. • Health inequalities programme of work supported by the strategic intent function of the ICS, the anchor institution and the plans for data and	1T1.1C 1T1.2C 1T1.3C 1T1.4C 1T1.5C 1T1.6C	Intelligence and evidence are required to understand health inequalities, make decisions and review ICS progress. Plan for data and digital need to be developed further. Lack of real time data collections. Requirement for streamlining Data and Digital needs of all Partners (Including LA's). Finalised and implemented System BAF. Lack of confidence with data associated with the Transforming Care Programme (TCP).	• Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • System Quality Group assurance to the Quality and Performance Committee and ICB Board. • System Quality Group assurance on System risks and ICB Risks. • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • Agreed ICB Quality Risk escalation Policy. • Risk Escalations from SQG to Q&P. • Quality and Safety Forum provides assurance into the System Quality Group and meets bi-monthly. This provides the detailed sense check of reporting.	1T1.1AS 1T1.2AS	The Integrated Assurance and Performance Report is in place and will continue to be developed further as reported to ICB Board. Consistent escalation reporting across the system to be agreed.

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	digital management. This reports to the PHSCC. • Agreed ICB Quality Risk Escalation Policy. • Risk Escalations from System Quality Group to Quality and Performance Committee. • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023. • ICB and ICS Exec Teams in place. • Integrated Care Strategy in place and published.	1T1.7C	Lack of confidence in the delivery of the 3 year maternity plan.	• Recovery Action Plan submitted at the Learning Disabilities and Autism (LDA) Mental Health Delivery Board. • Maternity Reporting into the Local Maternity and Neo natal System (LMNS).		
Threat 2 Lack of system ownership and capacity by the Integrated Care Partnership (ICP) and County and City Councils	• Agreed System Quality infrastructure in place across Derbyshire • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023. • Agreed System Quality and Performance Dashboard to include inequality measures • Agreed NHSE Core20PLUS5 Improvement approach to support the reduction of health inequalities. • ICB Board and Derbyshire Trusts approved and committed to the delivery of the Derbyshire ICS Green Plan. • Agreed Derby and Derby City Air Quality Strategy. • Integrated Care Strategy in place and published. • Derbyshire ICS Health Inequalities Strategy has been developed and woven into the ICS Strategy and has been approved by the ICP.			• Dr Robyn Dewis, Director of Public Health Derby City is the Chair of Health Inequalities Group across the System • Approved Integrated Care Partnership (ICP) Terms of Reference by the ICP and ICB Board. • ICP is now formally meeting in Public from February 2023. • County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Agreed Core20PLUS5 approach across Derbyshire. • Derbyshire ICS Health Inequalities Strategy has been developed and woven into the ICS Strategy and has been approved by the ICP.		
Threat 3 Ineffective Commissioning of services across Derby and Derbyshire	• Derbyshire Cost Improvement Programme (CIP) in progress and Service Benefit Reviews challenge process is in place to support efficiencies. • Agreed Prioritisation tool is in place. • Population Health Strategic Commissioning Committee providing clinical oversight of commissioning and decommissioning decisions. • Robust system QEIA process for commissioning/ decommissioning schemes • Agreed targeted Engagement Strategy – to implement engagement element of Comms & Engagement strategy. • Robust Citizen engagement across Derbyshire and reported through Public Partnerships Committee.	1T3.1C 1T3.2C 1T3.3C	Commissioning to focus on patient cohorts, with measures around services to be put in place to support reduction of inequalities. Increase Patient Experience feedback and engagement. Cost Improvement Programme (CIP) Subject to Electronic Programme Management Officer (EPMO) and the Quality and Equality Impact Assessment processes.	• Agreed ICS 5 Year Strategy in place • Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • Population Health Strategic Commissioning Committee assurance to the ICB Board via the Assurance Report. • System Quality Group assurance to the Quality and Performance Committee and ICB Board. • System Quality Group assurance on System risks and ICB Risks • Public Partnerships Committee Public assurance to ICB Board.	1T3.1AS	2023/24 Operational Plan in place and submitted to NHSE

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Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	• Integrated Care Strategy in place and published. • Joint Forward Plan in place and now published.			• NHSE Assurance Reviews and Assurance Letters provide evidence of compliance and any areas of concern. • Winter Plan in development for discussion at ICB Board on 19.10.23		

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1 -	1T1.1A	Development of Intelligence and dashboard to evidence Core20PLUS5 principles	1T1.1C 1T1.2C 1T1.3C 1T1.4C	Dr Robyn Dewis	Quarter 2 2023/24	Commenced	Population Health and Strategic Commissioning Committee	Partially assured
	1T1.2A	Development of Integrated Care Strategy / Joint Forward Plan	1T1.1C 1T3.3C	Michelle Arrowsmith	Quarter 2 2023/24	Completed 30.06.23	ICB Board/ Integrated Care Partnership/ Population Health and Strategic Commissioning Committee	Partially assured
	1T1.3A	Triangulation with Provider System BAF	1T1.5C	Chrissy Tucker	Quarter 2 2023/24	Completed 30.06.23	ICB Board/Corporate Committees	Partially assured
	1T1.4A	Development of Recovery Action Plan which is submitted at the Learning Disabilities & Autism (LDA) Mental Health Delivery Board.	1T1.6C	Jo Hunter	Quarter 3 2023/24	Commenced	Learning Disabilities and Autism (LDA) Mental Health Delivery Board	Partially assured
	1T1.5A	Production of Maternity Reporting process into the Local Maternity and Neo natal System (LMNS).	1T1.7C	Jo Hunter	Quarter 3 2023/24	Commenced	Local Maternity and Neo natal System Board	Partially assured
Threat 2	1T2.1A	Development of a system Health Inequalities strategy as part of the wider Integrated Care Partnership strategy	1T2.1C 1T2.1AS	Dr Robyn Dewis	Quarter 2 2023/24	Completed 30.06.23	Population Health and Strategic Commissioning Committee	Partially assured
Threat 3	1T3.1A	Development of Patient Experience Plan	1T3.2C	Elaine Belshaw	31.12.23	Commenced	System Quality Group	Partially assured
	1T3.2A	Development of Operational Plan	1T3.1C IT3.1AS	Executive Team	Quarter 1 2023/24	Completed 30.06.23	ICB Board	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR2 – Quality and Performance Committee

Strategic Aim – To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	Committee overall assurance level	Partially assured	
	ICB Lead: Prof Dean Howells, Chief Nursing Officer **ICB Chair** :Adedeji Okubadejo, Chair of Quality & Performance Committee	**System lead:** Prof Dean Howells, Chief Nursing Officer, Dr Robyn Dewis **System forum:** Quality and Performance Committee	**Date of identification:** 17.11.2022 **Date of last review:** 02.10.2023

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

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

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

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

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	2T1.1A	Develop the Intelligence and evidence to understand health inequalities	2T1.1C	Dr Robyn Dewis	Quarter 2 2023/24	Commenced	Population Health & Strategic Commissioning Committee	Partially assured
	2T1.2A	Clarification of the scope and Terms of References of Provider Collaborative Leadership Board and System Delivery Boards	2T1.2C 2T1.3C	Tamsin Hooton	Quarter 2 2023/24	Complete 30.09.23	Provider Collaborative Leadership Board/ System Delivery Boards	Partially assured
	2T1.3A	ICB Board Development Session to discuss Provider Collaborative Leadership Board and System Delivery Boards	2T1.2C 2T1.3C	Helen Dillistone	Quarter 4 2023/24	Commenced	ICB Board	Partially assured

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	2T1.4A	Annual Review of the Integrated Care Partnership to determine alignment and relationships between ICP, Health and Wellbeing Boards and the ICS	2T1.4C 2T1.3C	Helen Dillistone/ICP Chair	Quarter 4 2023/24	Not yet commenced	Integrated Care Partnership	Partially assured
Threat 2	2T2.1A	Develop Patient Experience Plan	2T2.1C 2T2.2C	Elaine Belshaw	31/12/2023	Commenced	System Quality Group	Partially assured
Threat 3	2T3.1A	Development of a system Health Inequalities strategy as part of the wider Integrated Care Partnership strategy	2T3.1C 2T3.1AS 2T3.2C	Dr Robyn Dewis	Quarter 2 2023/24	Completed 30.06.23	Population Health & Strategic Commissioning Committee	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR3 – Public Partnership Committee

Strategic Aim – To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	Committee overall assurance level	Partially assured	
	ICB Lead: Helen Dillistone, Chief of Staff **ICB Chair:** Julian Corner, Chair of Public Partnership Committee	**System lead:** Helen Dillistone, Chief of Staff **System forum:** Public Partnership Committee	**Date of identification:** 17.11.2022 **Date of last review:** 31.10.2023

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

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

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

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

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

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started? Update**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	**3T1.2A**	Ongoing implementation of Engagement Strategy frameworks Evaluation Framework – planning workshop Co-production Framework – first scoping session Insight Framework – Tool drafted and socialised. Board development session ahead of seeking pilots. Governance Framework – PPI and HOSC Guides developed. Final framework to follow conclusion of other frameworks.	3T1.3C 3T1.1AS	Karen Lloyd HM BF KL KL	31 March 2024 3.7.23 20.6.23 17.8.23 31.3.24	Commenced Commenced Commenced Commenced Commenced	Public Partnership Committee	Partially assured
	3T1.3A	Ongoing implementation of Insight Framework approach Tool drafted and socialised. Board development session Piloting of tool	3T1.4C 3T1.1AS	Karen Lloyd KL KL/ST/HD KL	31 March 2024 8.6.23 17.8.23 31.3.24+	Commenced Commenced Commenced Commenced	Public Partnership Committee	Partially assured
	3T1.4A	Programme of work to roll out PPI Guide with system partners, including general practice Clarification of PPI expectations for GP Clarification of NHS FT resource and role in engagement delivery Meeting with ICB commissioning directors to discuss process Ongoing opportunities to promote approach.	3T1.5C 3T1.1AS 3T1.2AS	Karen Lloyd KL ST KL/ST KL	31 March 2024 30.09.23 30.9.23 8.9.23 31.3.24+	Commenced Commenced Commenced Commenced Commenced	Public Partnership Committee	Partially assured
	3T1.5A	Assess current team skills in cultural engagement and communications, including channel assessment, and devise action plan to close gaps/implement training and development. Health literacy bite-sized training (various team members and team discussion) Team skills audit and PDPs Community profiles development, including knowledge of communications preferences for population segments. Confirm pilot areas. Internal channels benchmarking and evaluation External channels benchmarking and evaluation Forge closer team links and shared work programmes with behavioural psychology team.	3T1.6C 3T1.1AS 3T1.3AS	Sean Thornton Various MH ST/KL DLB DB DB	30 September 2023+ 30.6.23 30.6.23 31.7.23 30.9.23 30.9.23 30.9.23	Commenced Completed Commenced Commenced Commenced Commenced Commenced	Communications and Engagement Team	Partially assured
	3T1.6A	Completion of ICB self-assessment and submission to NHSE	3T1.4AS 3T2.1AS 3T3.1AS	Helen Dillistone	End of Quarter 3	Commenced	Corporate Delivery Team/Public Partnership Committee/Audit and Governance Committee	Partially assured
Threat 2	**3T2.1A**	Delivery of Communications and Engagement Strategy Stakeholder chapter to scope processes on relationship managing and	3T2.1C 3T2.1C 3T2.2C	Andy Kemp	31 March 2024+	Commenced	Public Partnership Committee	Partially assured

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		stakeholder perceptions, resulting in business case. Management tool identified with Head of Digital Configuration of tool for ICB purposes Population of tool with local data, inc. GDPR compliance Use of tool for distribution purposes Development of tool for stakeholder management purposes, including profiling	3T2.4C	AK GC-T AK AK AK/LM	30.06.23 30.6.23 31.8.23 From 1.9.23 31.12.23	Completed Commenced Commenced Commenced Commenced	Communications and Engagement Team	Partially assured
	3T2.2A	Meet with ePMO colleagues to understand change model approach to system transformation, including financial context for 23/24.	3T2.1C 3T2.3C	Sean Thornton	30 June 2023+	Commenced	Communications and Engagement Team	Partially assured
	3T2.3A	Delivery of Communications and Engagement Strategy Internal Communications chapter to create platform for engagement with ICB and system staff, building on existing mechanisms. Internal channels benchmarking and evaluation Team Derbyshire programme continues Scope communications support for GP Provider Board (inc. PCNs) and GP Task Force System leader key message briefings to start Roll out of online engagement platform tool for staff	3T1.1C	David Lilley-Brown DLB DLB ST DLB/ST DLB/HofC	31 March 2024 30.9.23 Ongoing 30.9.23 1.10.23 1.2.24	Commenced Commenced Commenced Commenced Commenced Commenced	Communications and Engagement Team	Partially assured
	3T2.4A	Develop proposal and business case for UEC behaviour/insight programme following social marketing principles.	3T2.1C	Donna Broughton	31 July 2023	Completed	Communications and Engagement Team	Partially assured
	3T2.5A	Completion of ICB self-assessment and submission to NHSE	3T2.1AS	Helen Dillistone	End of Quarter 3	Commenced	Corporate Delivery Team/Public Partnership Committee/Audit and Governance Committee	Partially assured
Threat 3	**3T3.1A**	Allied to ePMO programme review, implement scoping exercise across system/ICB delivery boards and other groups to establish baseline of work System C&E leads undertake delivery board and committee scoping ICB team undertake scoping in line with portfolios Collation of all priorities and capacity assessment Resource/capacity assessment presented to NHS Executive Team	3T3.1C	Sean Thornton System C&E ICB C&E ICB/System C&E ST	30 September 2023+ 30.6.23 30.6.23 31.8.23 30.9.23	Commenced Commenced Commenced Commenced Commenced	Communications and Engagement Team	Partially assured
	3T3.2A	Programme of work to roll out PPI Guide with system partners, including general practice	3T3.2A	Karen Lloyd	31 March 2024+	Commenced	Public Partnership Committee	Partially assured
	3T3.3A	Completion of ICB self-assessment and submission to NHSE	3T3.1AS	Helen Dillistone	End of Quarter 2/ Quarter 3	Commenced	Corporate Delivery Team/Public Partnership Committee/Audit and Governance Committee	Partially assured
Threat 4	**3T4.1A**	Allied to ePMO programme review, implement scoping exercise across system/ICB delivery boards and other groups to establish baseline of work	3T4.1C	Sean Thornton	30 September 2023	Commenced	Communications and Engagement Team	Partially assured

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	3T4.2A	Confer with regional ICB leads on appetite for potential benchmarking approach to understand approaches, team roles, capacity.	3T4.1C 3T4.2C 3T4.1AS	Sean Thornton	31 March 2024	Commenced	Communications and Engagement Team	Partially assured
	3T4.3A	Implement remaining elements of Communications and Engagement Strategy chapters	3T4.1C 3T4.3C	Sean Thornton & team	31 March 2024+	Commenced	Public Partnership Committee	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR4 – Finance, Estates and Digital Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Keith Griffiths, Chief Finance Officer **ICB Chair:** Jill Dentith, Finance, Estates and Digital Committee Chair	**System lead:** Keith Griffiths, Chief Finance Officer **System forum:** Finance, Estates and Digital Committee	**Date of identification:** 17.11.2022 **Date of last review**: 13.10.2023

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.**	**Risk appetite: target, tolerance and current score** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee**		**Initial** **16**	**Current** **16**	**Target** **9**

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

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

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
			and level of productivity / efficiency required. The integrated assurance and performance report needs to be developed further to triangulate areas of activity, workforce, and finance.			
Threat 2 Shortage of out of hospital provision across health and care impacts on productivity levels	• Not aware of effective controls now, and the solution requires integrated changes across social care and the NHS • Collaborative escalation arrangements in place across health and care to ensure maximum cover out of hospital and flow in hospital is improved. • Programme delivery boards for urgent and elective care review	4T2.1C 4T2.2C 4T2.3C 4T2.4C 4T2.5C	National shortage in supply of out of hospital beds and services for medically fit for discharge patients prevents full mitigation. New Workforce strategy and Clinical Model required, alongside clear priorities for improving population health. Triangulated activity, workforce, and financial plan. Do not fully understand the low productivity levels and the opportunities to improve via the clinical workforce. Benchmark against pre Covid data and activity as a starting point to get to sustainable levels.	• Integrated assurance and performance report and tactical responses agreed at Board level. Assurances for permanent, long-term resolution not available. • National productivity assessment tool now available to assist all systems across the country, which will be used to influence 23/24 planning and delivery.(EA)	4T2.1AS	The Integrated Assurance and Performance Report is in place and will continue to be developed further as reported to ICB Board.
Threat 3 The scale of the challenge means break even can only be achieved by structural change and real transformation. failure to deliver against plan and/or to transform services	• The CIP and Transformation Programme is not owned by leads, managed, implemented, and reported on for Finance to build into the system financial plan. • EPMO system has been established and is led by Transformation Director. • EPMO has list of efficiency projects only that are not developed to a level where the financial impact can be assured. • Long term national funding levels are insufficient and uncertain, meaning despite radical improvements in efficiency and structural, transformational change, a financial gap to breakeven will remain. • Development of Financial Sustainability Board to understand and alleviate the financial challenges.	4T3.1C 4T3.2C 4T3.3C 4T3.4C 4T3.5C	Need to embed and cascade ICB savings target / CIP plan – staff at all levels to understand imperative and role in identification of savings / innovation. Ownership of system resources held appropriately. The EPMO System is not fully developed, owned, and managed to make the savings required. Programme delivery boards need to refocus on delivering cash savings as well as pathway change. The provider collaborative needs to drive speed and scope through the programme delivery boards	• Reconciliation of financial ledger to EPMO System. • SLT monthly finance updates provided – including recalibration of programme in response to emerging issues. • Finance and Estates Committee oversight. • Weekly system wide Finance Director meetings focussed on long term financial stability, with real evidence of effective distributive leadership and collegiate decision making.	4T3.1AS	2023/24 Operational Plan in place and submitted to NHSE.

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

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	**4T1.1A**	Development of Triangulated Demand, Workforce and Financial plan for 24/25	4T1.1C 4T1.2C 4T1.6C	Michelle Arrowsmith	31.01.24	Commenced	Finance/Performance/Quality Committees ICB Board	Partial assurance given the transparency and debate at Board level, recognising the socio-economic environment the health and care sectors are currently navigating and the scale of the tasks that lie ahead – both operationally and culturally.
	4T1.2A	Benchmark exercise and Report against pre covid levels of activity	4T1.1C 4T1.4C	Linda Garnett, Keith Griffiths	Ongoing - Q4 2023/24	Commenced	People and Culture/Finance Estates and Digital Committee	
	4T1.3A	Develop management processes to deliver plans and level of productivity required Implementation and maintenance of the e-PMO to track efficiencies Delivery boards looking at efficiency and productivity in addition to internal provider actions e.g. planned care board and Get it right first time (GIRFT)	4T1.1C 4T1.3C 4T1.5C	Chair of Provider Collaborative/ Tamsin Hooton/Provider DOFs	Ongoing - 2024/25	Commenced	PCLB/ Director of Finance Group	
	4T1.4A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met	4T1.1C 4T1.1AS	Executive Team	Ongoing – 2024/25	Commenced	ICB Board	
Threat 2	**4T2.1A**	Development of new Workforce and Clinical Models Plan	4T1.2C 4T2.2C 4T2.4C	Linda Garnett/ Chris Weiner Angela Deakin	End of Quarter 3 2023/24	Commenced	People and Culture Committee/ CPLG	Partial assurance given the transparency and debate at board level,

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
		Cardio Vascular plan currently being developed to target population health management and health inequalities across Derby and Derbyshire on a PLACE based approach.						recognising the socio-economic environment the health and care sectors are currently navigating and the scale of the tasks that lie ahead – both operationally and culturally
	4T2.2A	Development of Triangulated Demand, Workforce and Financial plan	4T2.1C 4T2.3C	Executive Team	End of Quarter 3 2023/24	Commenced	People and Culture Committee/ Finance Estates and Digital Committee	
	4T2.3A	Benchmark exercise and report against pre covid levels of activity	4T2.1C 4T2.5C	Executive Team	End of Quarter 3 2023/24	Commenced	People and Culture/Finance Estates and Digital Committee	
Threat 3	**4T3.1A**	Develop and embed EPMO System The system e-PMO has developed significantly in Quarter 2. It is now being used by all providers (to varying degrees) Delivery Boards and programmes. Financial efficiencies are being recorded, and we now have £98m plans on e-PMO. A report on system efficiencies is being generated from the e-PMO for Financial Sustainability Board (FSB) and SFEDC as well as going to the TCG and PCLB.	4T3.3C 4T3.4C 4T3.5C	Tamsin Hooton	Ongoing – Q4 2023/24	Commenced	Finance, Estates and Digital Committee / PCLB	Partial assurance through evidence of improving reporting and accountability, although real delivery is yet to be seen
	4T3.2A	CIP Engagement Plan being implemented Currently all CIPs are provider based (the ICB has a £44.2m CIP challenge), except for £4m System Delivery Boards. At a system level, this is being supported by sharing of schemes and good practice from the e-PMO, via DoFs and provider PMO/improvement teams, system wide workshop to share schemes in Sept. Work has been done with Delivery Boards to support them in developing their schemes, including sharing data pack on opportunities. Further process looking at waste in clinical pathways will commence Q3 2023/204.	4T3.1C 4T3.4C 4T3.5C	Tamsin Hooton	End of Quarter 1 2023	Completed 30.06.23	Delivery and Trust Boards	Partially assured
	4T3.3A	Development of a consistent approach to measuring productivity	4T3.2C	Tamsin Hooton	Quarter 3 2023/24	Commenced	Delivery and Trust Boards	Partially assured
	4T3.4A	Development of Operational Plan	4T3.1AS	Executive Team	Quarter 1 23/24	Complete 30.06.23	ICB Board	
Threat 4	**4T4.1A**	National Allocations unclear	4T4.1C 4T4.1AS	Executive Directors / NEMs	Ongoing – 2024/25	Commenced	TBC	Not assured
Threat 5	**4T5.1A**	The ICB will continue to lobby the Regional and National teams	4T5.1C 4T5.1AS	Keith Griffiths	Ongoing – 2023/25	Commenced	TBC	A significant change in allocation policy at National level will need to take place to rectify this issue.

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR5 – People and Culture Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Linda Garnett, Interim Chief People Officer **ICB Chair:** Margaret Gildea, Chair of People and Culture Committee	**System lead:** Linda Garnett, Interim Chief People Officer **System forum:** People and Culture Committee	**Date of identification:** 17.11.2022 **Date of last review:** 26.10.2023

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.**	**Risk appetite: target, tolerance and current score** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **16**		**Initial** **20**	**Current** **20**	**Target** **16**

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

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control Ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 Lack of system alignment between activity, people and financial plans	• An Integrated planning approach has been agreed across the system covering finance activity and workforce. • Agreed System level SRO for Workforce Planning supported by Workforce Strategy and Planning Assistant Director • The System People and Culture Committee provides oversight of workforce across the system	5T1.1C 5T1.2C 5T1.3C	There is not an agreed integrated planning tool or system across all partners due to affordability. The Primary Care workforce plans are not aligned with other system plans. Develop 2024/25 workforce plan.	• Monthly monitoring of workforce numbers and temporary staffing spend vs budget and agency spend. • Approved System 'One Workforce' Strategy and Workforce plan • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • The Workforce Advisory Group brings together all component part to discuss workforce and planning and system engagement of the plan. • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce.	5T1.1AS 5T1.2AS	Work is underway to develop an integrated performance assurance report which includes Quality, Performance, Workforce and Finance. Activity delivered should be informing everything but there are further issues requiring resolution in that area. Consistent escalation reporting across the system to be agreed.

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

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	5T1.1A	Refresh of 2022/23 workforce plan	5T1.2C	Sukhi Mahil	Q1 2023/23	Complete 30.06.23	People & Culture Committee	Partially assured
	5T1.2A	Develop 2023/24 workforce plan	5T1.1C	Sukhi Mahil	Q1 2023/24	Complete 30.06.23	People & Culture Committee	Partially assured
	5T1.3A	Develop the workforce planning approach to inform the 2024/25 plan and future projections	5T1.3C	Sukhi Mahil	Q3 2023/24	Commenced	People & Culture Committee	Partially assured

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Threat 2	5T2.1A	Continue to spread and embed well-being offer. Review and evaluate feedback from Health and Wellbeing survey to continue to develop and improve wellbeing service offering. Work is ongoing with good levels of engagement across JUCD in activities, and over 4000 colleagues participating in activities each month. The evaluation from the HNA is underway and will be completed in Sept.	5T2.3C 5T2.2AS	Nicola Bullen	September 2023	Commenced	People & Culture Committee People Services Collaborative Delivery Board	Partially assured
	5T2.2A	Review Occupational Health Services to ensure they are focused on promoting health and wellbeing. The health promotional activity largely sits within the JUCD Wellbeing programmes of work including activity timetable, lifestyle and wellbeing and health inequalities, with Occupational Health supporting the health Surveillance programmes. There is a significant programme of work around health surveillance as well as a quarterly activity programme that is produced for all staff across Derbyshire.	5T2.2AS	Nicola Bullen	Quarter 2 2024/25	Ongoing	People & Culture Committee People Services Collaborative Delivery Board	Partially assured
	5T2.3A	Pursue alternative funding sources, consider measures to mitigate impact of services reducing, utilise wellbeing support in place across the system. Funding is likely to be received through NHS Midlands a combined bid with Northants ICB, this will be confirmed by end of Sept '23	5T2.1C	Nicola Bullen	Ongoing from Quarter 2 2023/24	Commenced	People & Culture Committee People Services Collaborative Delivery Board	Partially assured
Threat 3	5T3.1A	Continue to develop system wide recruitment campaigns to meet demand for health and care across Derbyshire	5T3.1C 5T3.2C 5T3.3C	Susan Spray	System Recruitment campaigns planned as a rolling programme	Commenced	People & Culture Committee	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR6 – People and Culture Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Linda Garnett, Interim Chief People Officer **ICB Chair:** Margaret Gildea, Chair of People and Culture Committee	**System lead:** Linda Garnett, Interim Chief People Officer **System forum:** People and Culture Committee	**Date of identification:** 17.11.2022 **Date of last review:** 26.10.2023

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

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

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

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

Actions to treat threat.

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Subgroup Assurance	Committee level of assurance
Threat 1	6T1.1A	Develop One Workforce Strategy aligned to support delivery of the Integrated Care Strategy, and Joint Forward Plan (JFP) and includes the response to the NHS Long Term Workforce Plan and NHS People plan.	6T1.1C	Sukhi Mahil	Initial draft by Autumn (aligned to JFP timescales)	Commenced	ICS Executive	Partially assured
Threat 2	6T2.1A	System Wide TNA process to be developed and implemented	6T2.1C	Faith Sango	Quarter 3 2023/24	Commenced	Workforce Advisory Group	Partially assured
Threat 3	6T3.1A	Develop One Workforce Strategy in response to the Integrated Care Strategy, JFP and anticipated People plan	6T3.1C 6T3.1AS	Sukhi Mahil	Initial draft by Autumn (aligned to JFP timescales)	Commenced	ICS Executive	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR7 – Population Health and Strategic Commissioning Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**
	ICB Lead: Michelle Arrowsmith, Chief Strategy and Delivery Officer **ICB Chair:** Julian Corner, Chair of PHSCC	**System lead:** Michelle Arrowsmith, Chief Strategy and Delivery Officer **System forum:** Population Health and Strategic Commissioning Committee
		Date of identification: 17.11.2022 **Date of last review:** 05.10.2023

Strategic risk (what could prevent us achieving this strategic objective)	**Risk appetite: target, tolerance and current score**	**Initial**	**Current**	**Target**
There is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	**RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **12**	**12**	**12**	**9**

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

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

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

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

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	7T1.1A	Produce and embed the use of a universal prioritisation framework to guide resource allocation decisions.	7T1.1C 7T1.3C 7T1.4C 7T1.5C	Michelle Arrowsmith	Quarter 3 – Quarter 4 2023/24	Commenced	PHSCC	Partially Assured
	7T1.2A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met.	7T1.1AS	Michelle Arrowsmith	Ongoing- Bi-monthly	Bi-monthly	ICB Board	Partially Assured
	7T1.3A	Delivery Boards to develop a process to share decisions and challenge actions enhancing transparency and shared understanding of impact.	7T1.2C	Tamsin Hooton	Quarter 4 2023/24	Commenced	Delivery Boards/ Provider Collaborative Leadership Board	Partially assured
Threat 2	7T2.1A	Surge planning process established / all year-round planning approach – this does not prevent operational pressures but helps to predict and plan better the response H2 planning – first draft 25.09.23. Awaiting formal feedback.	7T2.1C	UECC Board / UECC SRO / MA Sam Kabiswa	End of Quarter 2 2023/24. H2 planning completed 25.09.23, awaiting feedback	Commenced	UECC Board	Partially assured
	7T2.2A	Delivery Boards to develop a process to share decisions and challenge actions enhancing transparency and shared understanding of impact.	7T2.2C	Tamsin Hooton	Quarter 4 2023/24	Commenced	Delivery Boards/ Provider Collaborative Leadership Board	Partially assured
Threat 3	7T3.1A	Prioritisation process agreed in the system to better manage our time and use of resource	7T3.1C	ICB / ICP	Quarter 3 – Quarter 4 2023/24	Commenced	PHSCC	Partially assured
	7T3.2A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met.	7T3.1AS	Michelle Arrowsmith	On-going bi-monthly	Bi-monthly	ICB Board	Partially assured

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 4	7T4.1A	Development of log System ICB/ICP Board decisions	7T4.1C	Chrissy Tucker	Quarter 4 2023/24	Commenced	ICB Board/ICP Board	Partially assured
	7T4.2A	Develop a process to measure impact of agreed actions across the system. To be delivered as part of the Joint Forward Plan implementation – System wide Evaluation Strategy of the impact of the Joint Forward Plan and the Integrated Care Strategy.	7T4.2C	Sam Kabiswa	Quarter 4 2023/24	Commenced	ICB Board/ICP Board	Partially assured
	7T4.3A	Surge planning process established / all year-round planning approach – this does not prevent operational pressures but helps to predict and plan better the response.	7T4.3C	Michelle Arrowsmith	End of Quarter 3 2023/24	Commenced	Urgent Care Delivery Board	Partially Assured
	7T4.4A	Delivery Boards to develop a process to share decisions and challenge actions enhancing transparency and shared understanding of impact. Workshop session held 27/9/23, to agree a process to develop plans in a co-ordinated way, including a system wide benefits realisation approach to understand impact, and interface with a system prioritisation approach. The proposed approach will be further discussed via the TCG and taken to the PCLB and System planning group for support.	7T4.4C	Tamsin Hooton	Quarter 4 2023/24	Commenced	Delivery Boards/ Provider Collaborative Leadership Board	Partially Assured
	7T4.5A	Development of a process to support system oversight and delivery of system aims and Joint Forward Plan.	7T4.5C	Chrissy Tucker	On-going – Q4 2023/24	Not yet commenced	ICB Board/ICP Board	Partially Assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR8 – Population Health and Strategic Commissioning Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Chris Weiner ICB Medical Director **ICB Chair:** Julian Corner, Chair of PHSCC	**System lead:** Chris Weiner, ICB Medical Director **System forum:** Population Health and Strategic Commissioning Committee	**Date of identification:** 17.11.2022 **Date of last review:** 05.10.2023

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

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

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control Ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
<u>Threat 1</u> Agreement across the ICB on prioritisation of analytical and BI activity is not realised and therefore funding and associated resources are not identified to deliver the analytical capacity	• Agreed and publicly published Digital and Data Strategy • Digital and Data Board (D3B) in place. This provides board support and governance for the delivery of the agreed Digital and Data strategy. • D3B responsible for reporting assurance to ICB Finance and Estates Committee and assurance and direction from the Provider Collaborative Leadership Board. • Strategic Intelligence Group (SIG) established with oversight of system wide data and intelligence capability and driving organisational	8T1.1C 8T1.2C 8T1.3C	Senior system analytical leadership role to be created within ICB structures Senior analytical leadership role to co-ordinate: - Delivering value from NECS contract - Co-ordinating work across SIG - Identifying opportunities for more effective delivery of PHM Identified three priority areas of strategic working:	• Data and Digital Strategy • CMO and CDIO from ICB executive team are vice chairs of the D3B. • Regional NHSE and AHSN representation at D3B provide independent input. • D3B minutes demonstrating challenge and assurance levels • Provider Collaborative Leadership Board Minutes demonstrating challenge and assurance levels • Monthly Reporting to Finance and Estates Committee, ICB Board, NHSE and NHS Executive Team • Evidence of compliance with the ICB	8T1.1AS	The Integrated Assurance and Performance Report is in place and continues to be developed further as reported to ICB Board.

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	improvement to optimise available workforce and ways of working • Analytics and business intelligence identified as a key system enabler and priority for strategic planning and operationally delivery in the Digital and Data strategy • NHSE priorities and operational planning guidance 23/24 requires the right data architecture in place for population health management • Digital and Data identified as a key enabler in the Integrated Care Partnership strategy	8T1.4C 8T1.5C	- System surveillance intelligence - Deep dive intelligence - Population Health Management. Strategic Intelligence Group (SIG) needs formalising and structured reporting through to D3B and direct link to ICB Strategic Intent function and ICB planning cell JUCD Information Governance Group needs formalisation and work required on using data for planning purposes.	Scheme of Reservation and Delegation • A staffed, budgeted establishment for ICB analytics (workforce BAF link required) • Data Sharing Agreements in place across all NHS providers, ICB, hospices and local authorities for direct care purposes.		

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	8T1.2A	Agree structure of ICB analytics team and role of Chief Data Analyst Work dependent on restructure agreement.	8T1.2C	Chris Weiner	December 2023	Commenced	Executive Team	Partially assured
	8T1.3A	Recruitment of analytics team Work dependent on restructure agreement.	8T1.2C	Chris Weiner	Quarter 4 2023/24	Not started	To be agreed	Partially assured
	8T1.4A	Co-ordination and local prioritisation through SIG with leadership provided by internal business intelligence team	8T1.3C 8T1.4C	Chris Weiner	April 2024	Commenced	Business Intelligence Team	Partially assured
	8T1.5A	Execution of planned investment in analytical skills development in line with ICB plan Work dependent on restructure agreement.	8T1.4C	Chris Weiner	October 2023	Commenced	Business Intelligence Team	Partially assured
	8T1.6A	Formalise JUCD IG group and draft data sharing agreements for using data for purposes other than direct care	8T1.6C	Chris Weiner/ Ged /CT	Quarter 2 2023/24	Commenced	JUCD IG Group	Partially assured
	8T1.7A	SIG being reconstituted and reset	8T1.5C 8T1.6C	Chris Weiner	Quarter 3 2023/24	Commenced	Strategic Intelligence Group	Partially assured
	8T1.8A	Continue to strengthen the ICB Board Integrated Assurance and Performance Report data and information.	8T1.1AS	Executive Officers	Ongoing/ Bi monthly	Commenced / on going	ICB Board	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR9 – Population Health and Strategic Commissioning Committee

Strategic Aim – Reduce inequalities in health and be an active partner in addressing the wider determinants of health.	Committee overall assurance level	Partially assured	
	ICB Lead: Michelle Arrowsmith, Chief Strategy and Delivery Officer **ICB Chair:** Julian Corner, Chair of PHSCC	**System lead:** Dr Robyn Dewis **System forum:** Population Health and Strategic Commissioning Committee	**Date of identification:** 17.11.2022 **Date of last review:** 05.10.2023

Strategic risk (what could prevent us achieving this strategic objective)	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	**Risk appetite: target, tolerance and current score**	**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee **12**	**16**	**16**	**12**

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

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

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

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

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	9T1.1A	Monthly monitoring of financial position and the ICB requirement to break-even.	9T1.1C	Darran Green	Quarter 4 2023/24	On-going - Annually	Finance, Estates and Digital Committee/ ICB Board	Partially assured
	9T1.2A	Prioritisation of actions needed to implement strategy	9T1.2C	Kate Brown	Quarter 3 2023/24	Commenced	ICB Board/ICP Board	Partially assured
	9T1.3A	Review alternative funding formula to Carr Hill – scope cost and logistics	9T1.3C	GPPB/Clive Newman/Finance	April 2024	Commenced	GPPB/PHSCC	Partially assured
	9T1.4A	NHS England Regional Prevention Group monitor Core 20 plus 5 performance and review and agree any mitigations should targets fall below threshold.	9T1.4C	Angela Deakin	Ongoing – 2024/25	Commenced	Long Term Plan Prevention Programmes Working Group meeting	Partially assured
	9T1.5A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met	9T1.1AS	Michelle Arrowsmith	On-going- bimonthly	Bi-monthly	ICB Board	Partially assured
Threat 2	9T2.1A	Prevention and Health Inequalities Board being set up	9T2.1C	Chris Weiner / Angela Deakin	November 2023	Monthly	Population Health Strategic Commissioning Committee	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR10 – Finance, Estates and Digital Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Jim Austin, Chief Digital Technology Officer **ICB Chair:** Jill Dentith, Chair of Finance, Estates and Digital Committee	**System lead:** Keith Griffiths, Executive Director of Finance **System forum:** Finance and Estates Committee Data and Digital Board	**Date of identification:** 17.11.2022 **Date of last review:** 17.10.2023

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.**	**Risk appetite: target, tolerance and current score** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **12**		**Initial** **12**	**Current** **12**	**Target** **10**

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

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

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

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All assurances are classified as positive assurance unless specified as a Negative Assurance (NA)

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	10T1.1A	Secure agreement on digital and technology resource funding - budget being formalised for 23/24 budget only, still to agree recurrent funding	10T1.1C	Jim Austin / Darran Green	June 2023	Complete for 23/24 funding 30.06.23	D3B	Partially assured
	10T1.2A	Develop and roll out staff digital literacy programme. Linked to Project Derbyshire (Digital HR) – no resource allocated / prioritised at this time. Planning work commenced	10T1.2C	Jim Austin / Workforce lead/AR	From 24/25 financial year	Commenced	D3B , Digital Implementation Group	Partially assured
	10T1.3A	Adopt ICB prioritisation tool to enable correct resource allocation	10T1.1C	Jim Austin / Darran Green	TBC – requires prioritisation tool	Not started	D3B	Partially assured
	10T1.4A	Formally incorporate Primary Care digital and technology governance within D3B	10T1.1C	Jim Austin / Chrissy Tucker	June 2023 – Completed	Complete 30.06.23	D3B	Partially assured
Threat 2	10T2.1A	Formalise link to Public Partnership Committee, Scheduled for August 2023. Some engagement now delivered.	10T2.1C	Jim Austin /Sean Thornton	Quarter 3 2023/24	Commenced	Public Partnership Committee	Partially assured
	10T2.2A	Work with ICB communications team and Provider communications teams to integrate digital strategy messaging into current engagement programme.	10T2.3C	Jim Austin /Sean Thornton	Ongoing – 2024/25	Commenced	Public Partnership Committee	Partially assured
	10T2.3A	Deliver digital (and data) messaging through ICB communications plan.	10T2.3C	Jim Austin /Sean Thornton	June 2023+	Commenced	Public Partnership Committee/ DB3	Partially assured
	10T2.4A	Meetings with Rural Action Derbyshire completed and Derbyshire County Council lead role, joint engagement strategy being developed.	10T2.4C	Jim Austin /Sean Thornton	Ongoing – 2024/25	Commenced	Public Partnership Committee/ DB3	Partially assured

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NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 100

Report Title	Primary Care Model for Derby and Derbyshire							
Authors	Ian Hall, External Advisor, Arden GEM NHS Commissioning Support Unit Ian Potter, Managing Director, Derby & Derbyshire GP Provider Board Limited							
Sponsor (Executive Director)	Dr Chris Weiner, Chief Medical Officer							
Presenters	Dr Andy Mott, Medical Director, Derbyshire GP Provider Board Dr Duncan Gooch, GP, Derbyshire GP Provider Board Ian Potter, Managing Director, Derby & Derbyshire GP Provider Board Limited							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 – Primary Care Model for Derby and Derbyshire							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	ICB Board (development session) ICB Primary care team ICB Population Health and Strategic Commissioning Committee ICB Integrated Place Executive Primary and Community Care Delivery Board Place Alliance Managers LMC GP practices PCN Clinical Directors and PCN Managers Primary Care Leadership Group Provider Collaborative Leadership Board							

Recommendations
The ICB Board is requested to: • **ENDORSE** the new Primary Care Model for Derby and Derbyshire; • **APPROVE** the attached document - "The Primary Care Model for Derby and Derbyshire"; • **SUPPORT** 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; and • **DISCUSS** the approach by which the GP Provider Board will discuss and access support for implementation.

Purpose

The document titled "The Primary Care Model for Derby and Derbyshire" is attached at Appendix 1. The core purpose of this document is to seek support for a new, sustainable Primary Care Model for Derby and Derbyshire.

The Integrated Care Board is asked to consider the document, approve the content and discuss support for its implementation, in line with the Recommendations section of this report.

Background

Summary

The Primary Care Model seeks to provide a new, shared vision for improving quality of care and staff working lives, building on improvement work already in train and the considerable strengths of our current services. The document seeks to provide hope and demonstrate how we can mitigate the crisis facing primary care.

The GP Provider Board (GPPB) has been asked by the ICB to lead this important piece of work and will oversee further development and implementation of the model. This will involve working collaboratively with JUCD partners in agreeing improvement plans and close connections with the JUCD system governance architecture, primarily through the Primary and Community Care Delivery Board, the Integrated Place Executive and the Provider Collaborative Leadership Board.

The proposed Model and draft versions of the document attached have been widely considered, as outlined in the section above. There has generally been strong support expressed for the Model, with suggestions made to further strengthen the approach. Key themes that have emerged from this engagement and resulted in changes to the content of this document are:

- increased recognition of the need for interpretation and adaptation of the Model to reflect local context;
- need to ensure the implementation of the Model is aligned with existing or emerging policy requirements in primary care to avoid confusion amongst staff and competing priorities;
- a broader set of outcomes the Model will need to contribute to;
- the opportunities for collaboration with system partners on implementing the Model and supporting delivery;
- the need for an integrated approach with Place and community transformation;
- the need to describe the changes through the positive impact it will have for patients in each cohort; and
- the opportunities for elevating the role of primary care in supporting the delivery of system priorities, and benefits that impact all providers.

Scope

The core scope of the Model is the care delivered or overseen by General Practices and Primary Care Networks (PCNs). However, the new model is consistent with and will inter-relate with the Joined Up Care Derbyshire (JUCD) approach for transforming community services, including the Team Up service, reflecting the critical role community services have in supporting primary care. The model also assumes co-ordinated input from mental health, secondary, local authority funded and VCSE provided care, and other elements of primary care - community pharmacy, optometry, and dentistry services.

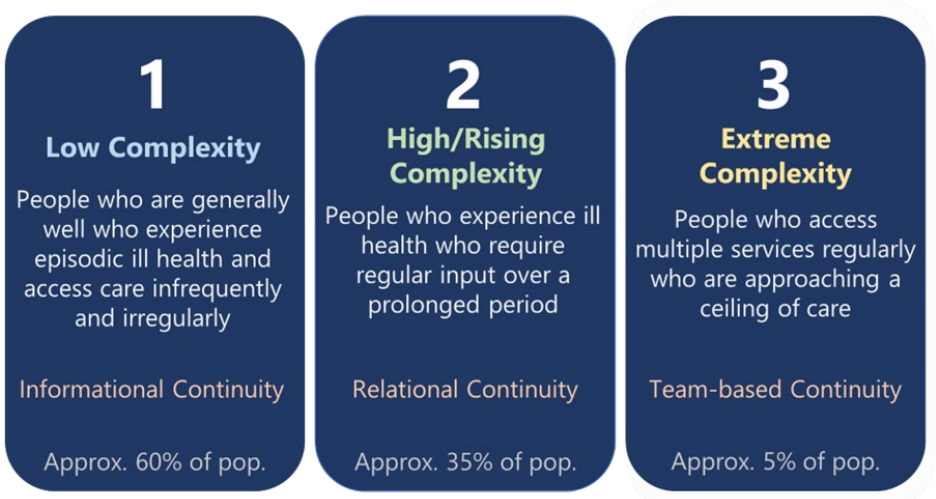
Strategic Context and Current State

The Model is based upon key national policy recommendations (primarily the Fuller Stocktake) and the document provides a comprehensive set of national and system level drivers for the changes included within the Model. It also summarises key strengths of primary care in Derby and Derbyshire, the key challenges it faces and opportunities for change.

The aims and key areas of focus from the Derby and Derbyshire Integrated Care Strategy have been used to inform the Primary Care Model and the Year 1 Improvement Goals – specifically please refer to Goals no.'s 4 and 5. The Model is also consistent with and will actively support the prioritised actions to strengthen primary care included within the Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28.

Vision

The vision is for a sustainable, thriving primary care system that is at the core of integrated care delivery in Derby and Derbyshire, at all levels of scale. Delivering this vision requires a radical re-imagining of how primary care services are provided, with the population stratified into three cohorts – (1) low complexity, (2) high and rising complexity, and (3) extreme complexity – please see below:



There will be standardised care models for each cohort that optimise care quality within the constraints we face, providing all people with access to comprehensive, coordinated, and continuous services. This innovative clinical model is informed by the Fuller Stocktake, feedback from users and local stakeholders, and clinical models that are operational and delivering significant benefits in other Integrated Care Systems. Further detail on the Model and the cohorts is included in the document.

Aims for the Model

The following aims have been developed:

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

Year 1 Improvement Goals and Enabling Actions

The following improvement goals are designed to support delivery of the Integrated Care Strategy and the guiding policies for action from the Five-Year Plan and illustrate how primary care is central to the delivery of JUCD health and care system objectives. Further detail under these goals is included in the document:

1. undertake population stratification and mobilise the Primary Care Model through an operating framework that maximises care quality and staff wellbeing;
2. implement a digital triage process in support of our aim for a consistent offer of primary care access for all people;
3. ensure there is access to enhanced care-coordination for all people with extreme complexity;
4. deliver primary and secondary prevention activities for circulatory disease, respiratory disease, and cancer, that have been prioritised by JUCD prevention and inequalities leads.
5. agree and deliver specific primary care actions that best support Age Well priority actions, releasing benefits from community services transformation including recommendations from the recent diagnostic review undertaken by Newton Europe; and
6. deliver reactive and proactive care that supports key system objectives for UEC and patient flow.

Outcomes and Evaluation

A set of sentinel measures and an outline outcomes measures framework has been produced, and an approach to evaluation will form part of the Implementation Plan.

Next Steps

The GPPB will oversee production of an Implementation Plan by December 2023 which will inform the 2024/25 JUCD Operational Plan from a General Practice and primary care service perspective. The Implementation Plan will need to reflect the following requirements:

- further development of outcomes framework with high-level evaluation methodology.
- risk management framework – Including initial risk and issues logs;
- communications and engagement plan;
- resource requirements for programme management and delivery of the Plan;
- governance arrangements for overseeing implementation;
- roll-out methodology and timescales;
- alignment with Community transformation.

There is also a focus in the document on the enabling functions/ actions that will be critical to the successful delivery of the improvement goals. Not all of the areas set out below are in the gift of GPPB and offer an opportunity for greater coordination and leadership across the ICB and partners. Key areas:

- Culture and Organisational Development (including quality management and leadership);
- Governance;
- Workforce;
- Digital/ AI, data;
- Estates; and
- Engagement and Communications.

Matters for Consideration

Within the Implementation Plan there will be a need to rapidly develop plans for the delivery of the Year 1 Goals for the Primary Care Model. The intention is to produce driver diagrams for each Goal and identify the critical path drivers, the improvement projects that will need mobilising, and the support that will be needed from JUCD partners and the ICB, such as analytical expertise, programme management, quality improvement, and digital support. The aim is to undertake this work in time to inform the discussions regarding the 2024/25 JUCD Operational Plan.

Given the scale of transformation, interdependencies with other integration initiatives the next stage of the model can be informed by learning from similar large scale transformation initiatives

and must be rooted in robust methodology for creating sustainable change. It is envisaged that by having clear scope and goals, it will be possible to build on existing relationships and draw on the diverse expertise across Derbyshire and to develop shared system leadership.

Building on the work undertaken to date, it will be critical that the Implementation Plan is integrated with the outputs from the JUCD Community Transformation Group. This will mean the ICB, other providers and partners can have joined up conversations with primary care and community services about what is required to support these major transformation programmes.

"The Primary Care Model for Derby and Derbyshire" states that the GP Provider Board will connect into the JUCD system governance architecture primarily through the Primary and Community Care Delivery Board, the Provider Collaborative Leadership Board, and the Integrated Place Executive given the critical relationships between Place and the Primary Care Model and the IPE's delegated role for implementing the Derby and Derbyshire Integrated Care Strategy, and its leadership of the Community Transformation Programme. The ICB is asked to consider how we can best ensure that JUCD 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.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☐	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

Yes ☒	No☐	N/A☐

Details/Findings

Financial modelling has not been undertaken at this stage. Further data analysis is required to establish the population numbers for each segmented cohort, after which financial modelling can commence. It is anticipated however that there will be significant system level financial benefits that will arise from implementation of the Model, given:

- successful General Practice improves economic activity in a local area and influences how productive our local towns and cities are. Every pound invested in the NHS results in around £4 back to the economy (*reference no. 6 in document*) and there is evidence to show that increasing spending in primary and community care will have a greater impact than commensurate spending in acute care (*ref. 7*);

Has this been signed off by a finance team member?

Not applicable.

• significant workforce benefit can be gained from the automation of administrative processes - some studies have shown that over 70% of a clinician's working time is spent on administrative tasks (*ref. 8*) and 44% of all administrative work in general practice can be mostly or fully automated (*ref. 9*)."; • the benefits of improved prevention activities in primary care. For example, improved diagnosis and management of hypertension can see a return on investment of 3.8 within a year for over 65-year-olds, and within 3 years for all adults (*ref. 23*); and • there is significant failure demand in primary care, which if reduced, will increase capacity to deal with value demand, thereby improving productivity.	

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:** TBC	**Summary:** An equality impact assessment will be undertaken, with support provided by the ICB, with outcomes included in the Implementation Plan. It is expected that the Model will help to address health inequalities, given the intention to address unwarranted variation in the delivery of services.

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☒	No☒	N/A☐	**Summary:** The implementation of the new Primary Care Model will be subject to a planned approach to public engagement led by the ICB given its duties in relation to primary care services. A Patient and Public Involvement, Assessment and Planning Form is in the process of being completed.

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 currently 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

It is anticipated that a better understanding will be gained through discussions about the estate and building requirements for supporting implementation of the Model. This work will be undertaken with JUCD estates leads and the required environmental impact assessments will be undertaken under their guidance, with the outcomes included in the Implementation Plan.

Appendix 1

Derbyshire GP Provider Board

The Primary Care Model for Derby and Derbyshire

November 2023

Derbyshire GP Provider Board

Key Points at a Glance

Our Vision

Our vision is for a sustainable, thriving primary care system that is at the core of integrated care delivery in Derby and Derbyshire, at all levels of scale.

Delivering this vision requires a radical re-imagining of how primary care services are provided, with the population stratified into three cohorts – 1. low complexity, 2. high and rising complexity, and 3. extreme complexity.

There will be standardised care models for each cohort that optimise care quality within the constraints we face, providing all people with access to comprehensive, coordinated, and continuous services.

This innovative clinical model is informed by the Fuller Stocktake, feedback from users and local stakeholders, and clinical models that are operational and delivering significant benefits in other Integrated Care Systems.

Successful implementation will require a joined up approach to ensure there is alignment with existing primary care developments and policy asks, and enabling support from across the GP Provider Board, the ICB and Joined Up Care Derbyshire (JUCD) partners.

Our aims are to;

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

Our Year 1 Goals are to;

1. Undertake population stratification and mobilise the Primary Care Model through an **operating framework** that maximises care quality and staff wellbeing
2. Implement a **digital triage process** in support of our aim for a consistent offer of primary care access for all people
3. Ensure there is access to enhanced **care-coordination** for all people with extreme complexity
4. Deliver primary and secondary **prevention activities** for circulatory disease, respiratory disease, and cancer, as prioritised by JUCD prevention and inequalities leads
5. Agree and deliver specific primary care actions that best support **Age Well priority actions**, releasing benefits from community services transformation including recommendations from the recent diagnostic review undertaken by Newton Europe
6. Deliver reactive and proactive care that supports key system objectives for **urgent and emergency care and patient flow**

Contents

1. Introduction

"General practice is the beating heart of the NHS and when it fails the NHS fails"
The future of general practice, House of Commons Health and Social Care Committee, October 2022 (1)

1.1 What is primary care?

Primary care is a critical component of any health system. It provides the majority of health care to the population, delivering up to c.90% of interventions (2).

Primary care aims to support first contact, accessible, continuous, comprehensive and coordinated person-focused care, as illustrated in the following infographic.

Primary care is also the key process in a health system for providing promotive, protective, preventative, curative, rehabilitative and palliative services throughout the life course (3) and provides care coordination across different levels of the system.

The majority of primary care in Derby and Derbyshire is provided by General Practice and Primary Care Networks (PCNs), supported by services which include community pharmacy, optometry, and dentistry. It is important to note the distinction between General Practitioners (GPs), General Practice and broader primary care as these terms can often become blurred and incorrectly used interchangeably.

Successful General Practice plays a key role in the health of the population in England, with over 1 million people attending a General Practice surgery every day (1), and GPs are critical to this provision and to delivering improved population health outcomes. 4.7 lives are saved by each GP in England each year, just through the preventative medicine they practice (4), and mortality levels are more closely associated with the supply of GPs than hospital physicians – with a 6% reduction in mortality observed for every extra GP per 10,000 people (5) and a correlation observed between continuity of care and improved outcomes.

Successful General Practice also improves economic activity in a local area and influences how productive our local towns and cities are. Every pound invested in the NHS results in approximately £4 back to the economy (6) and there is evidence to show that increasing spending in primary and community care will have a greater impact than commensurate spending in acute care (7).

1.2 Purpose and scope of this document

The core purpose of this document is to seek agreement to a new, sustainable Primary Care Model for Derby and Derbyshire. The aim is to give people hope, by demonstrating how we can mitigate the crisis facing primary care, through a shared vision for improving quality of care and staff working lives. In doing so we will build on improvement work already in train and the considerable strengths of our current services.

The core scope of this document is the care that is delivered or overseen by General Practices and PCNs. However the new model is consistent with and will inter-relate with the Joined Up Care Derbyshire (JUCD) approach for transforming community services, including the Team Up service, reflecting the critical role community services have in supporting primary care. The model also assumes co-ordinated input from mental health, secondary, local authority funded and VCSE provided care, and other elements of primary care - community pharmacy, optometry, and dentistry services.

1.3 Implementation

We have proposed six Year 1 Improvement Goals and initial actions for key enabling functions (see Section 6) that will be pivotal to gaining momentum and delivering our stated aims. Detailed actions will be included in an Implementation Plan that will be produced by December 2023. This will describe how the GP Provider Board, working with the Primary and Community Care Delivery Board, the Integrated Place Executive, the Provider Collaborative Leadership Board, the Integrated Care Board (ICB) and partners across the JUCD system, will plan the changes necessary and ensure the new Primary Care Model works optimally, at the core of integrated care.

The need for support from the ICB and all sectors within the JUCD system is a theme that runs throughout this document. General Practice is pivotal to the delivery of the Derby and Derbyshire Integrated Care Strategy and the NHS' Five Year Plan 2023/24 to 2027/28, and enabling resources need to be made available, as they are for other JUCD organisations, to support this delivery.

To be fully effective the Primary Care Model will need to be adopted across all neighbourhoods in Derby and Derbyshire, whilst recognising the need for adaptation to meet the specific needs of local populations through the engagement of local staff and users, and the avoidance of top-down planning. PCNs will drive localised implementation plans, working under the auspices of our Place Partnerships.

2. Strategic Context

2.1 National Context

Next Steps for Integrating Primary Care: Fuller Stocktake Report, 2022

The Fuller Stocktake is the primary national reference document for the development of the new Primary Care Model with the 'essential offers' (see below) informing our vision and improvement aims;

Fuller Stocktake - Three essential offers

- Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention

The Stocktake also identifies that the cultural shifts to support *"a more psychosocial model of care"* and the *"realignment of the wider health and care system to a population-based approach*", will be hindered if there is a top-down approach to driving change and improvement, due to the impact on the development of trusting relationships with the workforce and communities. Our approach to leadership development and culture described will need to reflect this steer.

"The future of general practice", House of Commons Health and Social Care Committee, 2022

This Report references strong support for the Fuller Stocktake and provides a review of General Practice in England, using input from a number of GPs and primary care leaders. It highlights concerns relating to General Practice including a demoralised profession, people leaving as fast as they can be recruited, and patients becoming increasingly dissatisfied with access to care. There is a focus on the central role of the GP and the need for continuity of care in General Practice, ideally through individual GP lists.

The need for the GP to be core and central to a service that embraces continuity of care has shaped our new model, but in responding to this report we have had to take into account the inadequate number of GPs in Derby and Derbyshire, both now and in the foreseeable future, compared to the numbers needed to service a list-based model for the whole population. Our approach therefore incorporates the prioritisation of patients (via cohorts) for whom continuity with the same GP will be provided.

Hewitt Review – "An independent review of integrated care systems," 2023

This report was primarily focused on the development of Integrated Care Systems, but includes a section titled *"Unlocking the potential of primary and social care and their workforce."* The recommendations build upon the Fuller Stocktake and articulate the need for ICSs to play a greater role in driving primary care transformation, a point which is reflected in the Introduction to this document. This includes the need for more to be done within ICSs to facilitate integrated neighbourhood teams and to integrate care across the

whole patient pathway. It also includes recommendations on the changes needed within primary care contracting.

NHS Long Term Workforce Plan, 2023
Extracts from the Plan that relate to the primary care workforce are included below:

- *Increase the number of GP training places by 50% to 6,000 by 2031/32. We will work towards this ambition by increasing the number of GP specialty training places to 5,000 a year by 2027/28. The first 500 new places will be available from September 2025.*
- *Grow the number and proportion of NHS staff working in mental health, primary and community care to enable the service ambition to deliver more preventative and proactive care across the NHS. This Plan sets out an ambition to grow these roles by 73% by 2036/37.*
- *…extending the success of the Additional Roles Reimbursement Scheme (ARRS), which has delivered an additional 29,000 multi-professional roles in primary care. This would build extra capacity and free up available appointments by increasing the number of non-GP direct patient care staff by around 15,000 and primary care nurses by more than 5,000 by 2036/37.*

The Plan also highlights the importance of administrative automation noting that "*significant workforce benefit can be gained from the automation of administrative processes, including through AI applications such as speech recognition*" and the impact this could have on easing the time burden on General Practice staff - "*some studies have shown that over 70% of a clinician's working time is spent on administrative tasks (8) and 44% of all administrative work in general practice can be mostly or fully automated (9).*"

Whilst the commitments to additional GP training places included in the Plan are welcomed, the new Primary Care Model for Derby and Derbyshire has been designed and is expected to be implemented in a context where there is no material improvement in the net number of full-time General Practitioners for the foreseeable future, based upon the timescales stated for increasing GP training places and continuing concerns regarding retention and retirement rates. This position is supported by the data and forecasts included in the Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28 (10) (*p39*).

The assumption is also made that there will not be a material increase in non-GP staff working in General Practice or in the multi-disciplinary staff that underpin core elements of the new model in the near future. This is a balanced view based upon some recent increases in primary care staff, but also concerns raised by the King's Fund about the implementation and impact of the Additional Roles Reimbursement Scheme (ARRS) (11), the timescales included in the NHS Workforce Plan for staffing increases (2036/37), and data and forecasts included in the Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28 (*p39*) on primary care nursing numbers.

General Practice contracts
2023/24 is the final year of the current five-year framework agreement. Engagement is taking place this year, building on the Fuller Stocktake, but there is currently uncertainty about the contractual framework that will be in place from 2024/25 under which the new Primary Care Model will operate.

2.2 Derby and Derbyshire Context

Integrated Care Strategy
The Derby and Derbyshire Integrated Care Strategy (12) includes the following strategic aims;

- Prioritise prevention and early intervention to avoid ill health and improve outcomes
- Reduce inequalities in outcomes, experience, and access
- Develop care that is strengths based and personalised
- Improve connectivity and alignment across Derby and Derbyshire, to ensure people experience joined up care, and to create a sustainable health and care system

These aims have been used to inform the new Primary Care Model and the 'Improvement Goals' included in Section 6. As we implement the model the key areas of focus included in the Integrated Care Strategy (see below) will be regarded as priorities for improvement and innovation by General Practice to ensure alignment with the Integrated Care Partnership;

Key areas of focus - Derby and Derbyshire Integrated Care Strategy

Start Well

- To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness

Stay Well

- To improve prevention and early intervention of the 3 main clinical causes of ill health and early death in the JUCD population - Circulatory disease, respiratory disease and cancer

Age and Die Well

- 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 maximise a return to independence following escalations

Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28
This Plan (10) states that primary care is the cornerstone of the Derby and Derbyshire NHS' contribution to improving population health and prioritised actions will be taken to strengthen primary care, through a programme of work covering;

- *Primary care and community-based services, including social care, to deliver a model of proactive, preventative, and integrated community care built on integrated neighbourhood teams at PCN level*
- *Improving access to urgent and same day care in primary and community settings*
- *Reducing inequalities of access, outcomes, and experience associated with care*
- *Developing and making best use of JUCD resources - workforce, financial and physical*
- *Supporting the integration of pharmacy, optometry, and dental primary care services.*

The Plan includes the following guiding policies for action that "*will drive annual NHS operational planning over the next five years and guide the development of a joined up and strategic approach to the commissioning and provision of healthcare across Derby and Derbyshire - to address the challenges we face*…";

- *Allocate greater resource 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 which result in time and cost being expended 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*

The first four guiding policies are directly translatable into the aims and requirements of the Primary Care Model. The fifth is also relevant in the context of the need for high quality data and intelligence to support implementation of the model, however this is a responsibility that primarily sits with the ICB, rather than the GP Provider Board.

In developing the new Primary Care Model the following assumptions have been made, based upon the Guiding Policies;

- A higher proportion of the resources under the control of the ICB will be allocated to activities that sit under the control of General Practice and primary care
- Primary care teams will have the freedom and ability to deliver the new model in ways that best suit their local population
- Patients will experience care that is strengths based and ensures respect of patient's needs and preferences and provides them with greater control over the services they receive
- General Practice working with the wider primary care team and teams from other providers will collaboratively address activities that result in time and cost being expended without materially improving quality i.e. failure demand, and will focus on ways to ensure demand generated creates value

2.3 Culture, leadership and quality management

The national and local publications cited in this Strategic Context emphasise the importance of culture, leadership and quality management/ improvement, as key enablers to delivering their recommendations and policies, for example;

Fuller Stocktake;

- *"The key ingredient to delivering this way of working is leadership – fostering an improvement culture and a safe environment for people to learn and experiment." (p6)*

Hewitt Review;

- *"Quality improvement should be supported by system leadership and at a system level, including through the adoption of common improvement methodologies across systems... This will help ensure systems drive a learning culture in all system partners and enable future-focussed thinking."* (3.50)

Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28;

- *"The Derby and Derbyshire Health System recognises that implementing all aspects of the Fuller stocktake requires a significant change in culture and approach underpinned by strong local leadership." (p18*)

We need to build on the developing leadership infrastructure for primary care in Derby and Derbyshire, including the triumvirate of the GPPB, the Local Medical Committee (LMC), and

the GP Taskforce (GPTF) and explore the options for developing overt, system-wide approaches to culture, leadership and quality management in primary care to accompany the new Primary Care Model. These approaches need to be jointly sponsored by the ICB and implemented by all PCNs and will require flexibility and adaptation by the community provider to ensure that their approaches to quality management, leadership, and workforce development align with primary care, given the need for integrated working and care. Without such actions the expected benefits of the new clinical model will be jeopardised.

Please refer to Section 6, where we explore these issues further.

3. Current State

3.1 Strengths and successes

General Practice in Derby and Derbyshire is well organised, through the establishment of the GP Provider Board and the GPPB/LMC/GPTF triumvirate and is in a good position to provide a co-ordinated voice on service improvement and quality management. There are excellent clinical leaders and although time capacity is a constraint, the benefits of clinical leadership can be seen through the way in which key innovations have been managed, including the development of this new Primary Care Model and Team Up for example.

Service-wise General Practice has managed to accommodate a large-scale increase in GP appointments over recent years, with a 9.1% increase in appointments when comparing 2022/23 against 2019/20 (see Figure 1). Whilst it is recognised that this accommodation has likely resulted in quality being adversely affected, the ability to accommodate over half a million extra appointments, despite decreasing numbers of full-time GPs, demonstrates the resilience and service dedication of GPs and practice teams;

Figure 1 - Increase in GP appointments

	2019/20	2020/21	2021/22	2022/23	2023/24
April	486,212	340,705	485,491	580,037	471,753
May	501,570	351,229	477,121	547,579	538,841
June	475,259	435,955	535,190	511,848	568,802
July	533,015	467,423	517,602	513,401	536,175
August	467,466	413,247	482,942	522,404	
September	524,984	541,363	569,652	559,432	
October	623,133	573,364	636,625	645,236	
November	545,896	504,679	630,938	617,991	
December	489,784	487,639	510,966	531,156	
January	546,514	455,103	509,041	583,123	
February	491,491	443,532	508,256	536,546	
March	514,620	553,321	595,068	617,034	
TOTAL	**6,199,944**	**5,567,560**	**6,458,892**	**6,765,787**	

A further success story is how the Derby and Derbyshire system has the highest proportion of GP appointments that are held face to face in the Midlands (as of June 2023) – see Figure

2 below. There has been strong comparative performance against this metric for a number of months.

Figure 2 – Proportion of appointments with a GP that are face to face, by Midlands ICSs

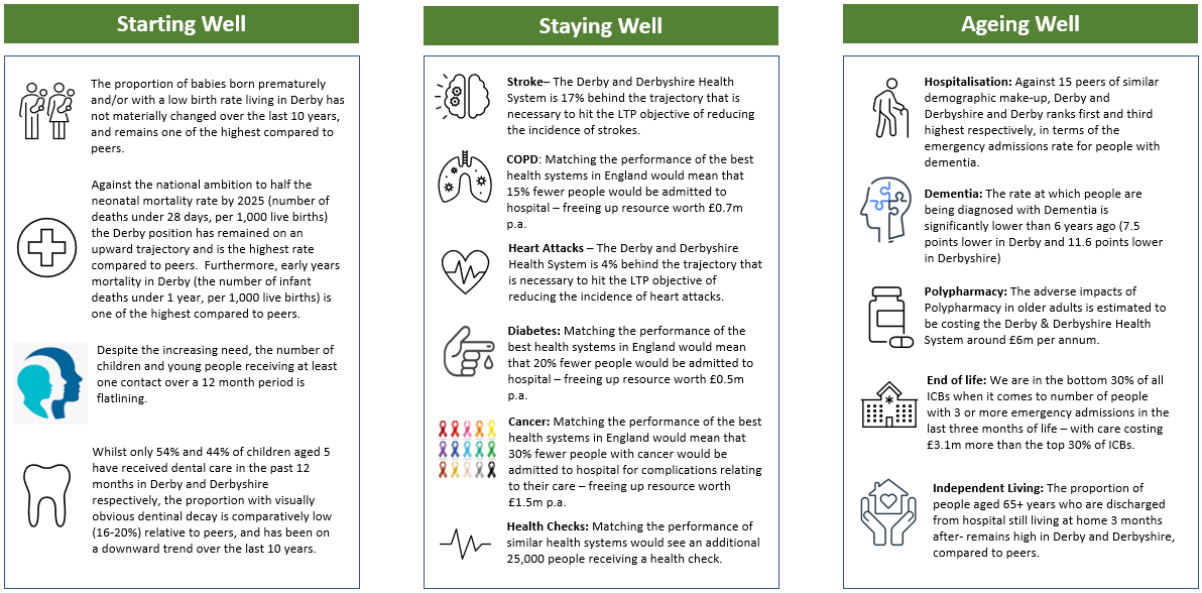
System	% Appts with a GP that are Face to Face
Birmingham and Solihull ICB	62%
Black Country ICB	64%
Coventry and Warwickshire ICB	54%
Derby and Derbyshire ICB	69%
Herefordshire and Worcestershire ICB	51%
Leicester, Leicestershire and Rutland ICB	68%
Lincolnshire ICB	60%
Northamptonshire ICB	58%
Nottingham and Nottinghamshire ICB	63%
Shropshire, Telford and Wrekin ICB	65%
Staffordshire and Stoke-on-Trent ICB	67%
Midlands	**62%**
England	**61%**

With regards to service improvement there has been a strong emphasis on strength based approaches as a facilitative method for catalysing change and improvements in primary and community based services. Champions training for a selection of acute, local authority, NHS, and VCSE staff has been arranged since December 2022, with the aim of embedding strength-based approaches in practice, improving communication / understanding across the system and exploring system risks.

3.2 Challenges

JUCD-wide

The Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28 describes in detail the challenges facing the health and care system. The following infographic taken from the Plan provides a summary of the opportunities to improve specific aspects of healthcare over the next five-years.



The Plan also cites the following as critical issues to be addressed;

- Recruitment and retention of General Practitioners and community-based nurses
- The need to change the way in which the NHS targets the conditions which drive the greatest disease burden across the Derby and Derbyshire population - cancer; cardiovascular disease, musculoskeletal disorders; mental disorders, neurological disorders, and chronic respiratory disease
- A deterioration in avoidable mortality and infant mortality in Derby and the reduction in the wellbeing of the Derbyshire population
- The growth in multi-morbidity intersected with older age requiring a fundamental shift in how the NHS in Derby and Derbyshire operates
- Financial and productivity challenges and the opportunities to reduce non value-adding activities, especially in the acute sector, including reducing acute care demand and the number of patients who are ready to go home but are in delay
- Environmental challenges

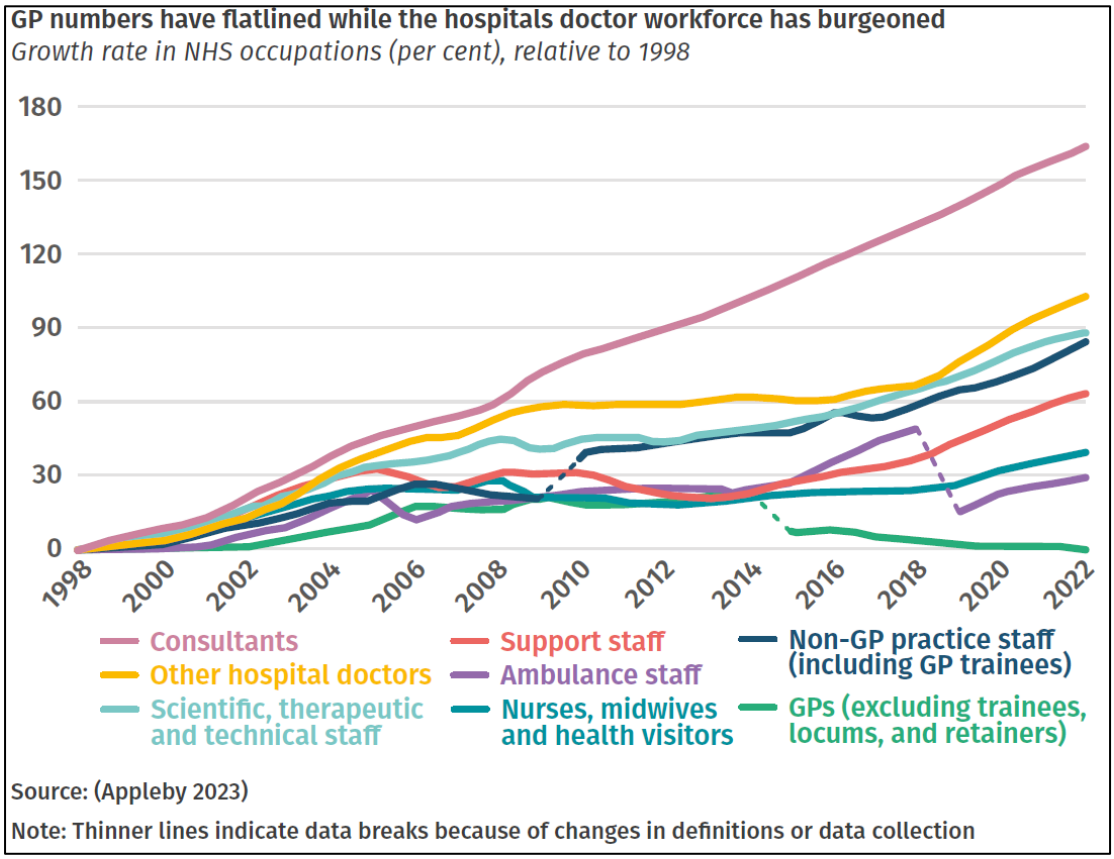
<u>General Practice specific – Demand and capacity gap</u>

The need for primary care services – This has increased significantly over the last few years and as the proportion of the population aged over 85 continues to grow (peaking in approximately 2037 at 55% greater than today (10)), the ongoing provision of primary care will become even more important to supporting the health of the population.

Increase in demand for appointments - The King's Fund recognised that between 2010 and 2014 the number of consultations in General Practice grew by more than 15% (13), and as stated in Section 3.1 there has been a 9.1% increase in appointments in Derby and Derbyshire when comparing 2022/23 against 2019/20 data. The reasons for this increase in demand are multifactorial, with long secondary care waiting, increasing prevalence of mental health problems (14) and long term conditions contributing to this position (15).

Lack of growth in fully qualified GP numbers - As noted in the Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28 the historic way that the NHS has been funded, has incentivised a greater proportion of the monies available to be invested in specialist and acute care - rather than primary and community-based physical and mental health care. This has resulted in a 163 per cent increase in hospital consultants over the past 25 years, compared to no growth in GP numbers.

Figure 3 – Growth rate in NHS occupations (per cent), relative to 1998 (16)



Without intervention, NHS workforce projections for General Practitioners show a supply versus demand gap of 1 in 2 GP posts by 2030/31 (17). The current reduction in FTE GPs in Derby and Derbyshire from 722 in March 2021 to 704 in December 2022 follows a national trend. Some of the clinical service provision has been replaced by other members of the multidisciplinary team, however the contribution of the expert medical generalist to the provision of primary care is less easily replaced.

The movement of clinical staff from other professions into primary care provides new opportunities, but these staff still require the input of the expert medical generalist to support the breadth of possible presentation, manage risk, and provide supervision (18)(19).

The increasing demand for primary care, the reduction and widening gap between GPs numbers needed and in post, and the increasingly supervisory role of expert medical generalist leads to the inference that there will be a reduction in the number of appointments with GPs. We must consider how we deliver primary care in an effective way in the face of these challenges.

The NHS Long Term Workforce Plan forecasts increasing numbers of staff and expert medical Generalists in primary care, but this will not change the existing paradigm for a number of years, and there is therefore a need to act now to safeguard care quality, by introducing a new model of care.

General Practice specific – Same day access

The current problems with same day access are recognised in both the Fuller Stocktake and the 2022 report from the House of Commons Health and Social Care Committee;

Fuller Stocktake;

- *"We should start by recognising the current system is not fit for purpose – it is fragmented and causing frustration among patients and staff"* (*p11*).

Health and Social Care Committee;

- *"As part of a broader overhaul of primary care, the NHS should dramatically simplify the patient interface. Currently patients with urgent care needs are left wondering whether to call their surgery, the out of hours service, 111 or to go to A&E. Many people are not clear about the difference between such services and the most appropriate option, further adding to the pressures on general practice."* (*para 13*)

<u>General Practice specific – Increase in list size and reduction in partners</u>

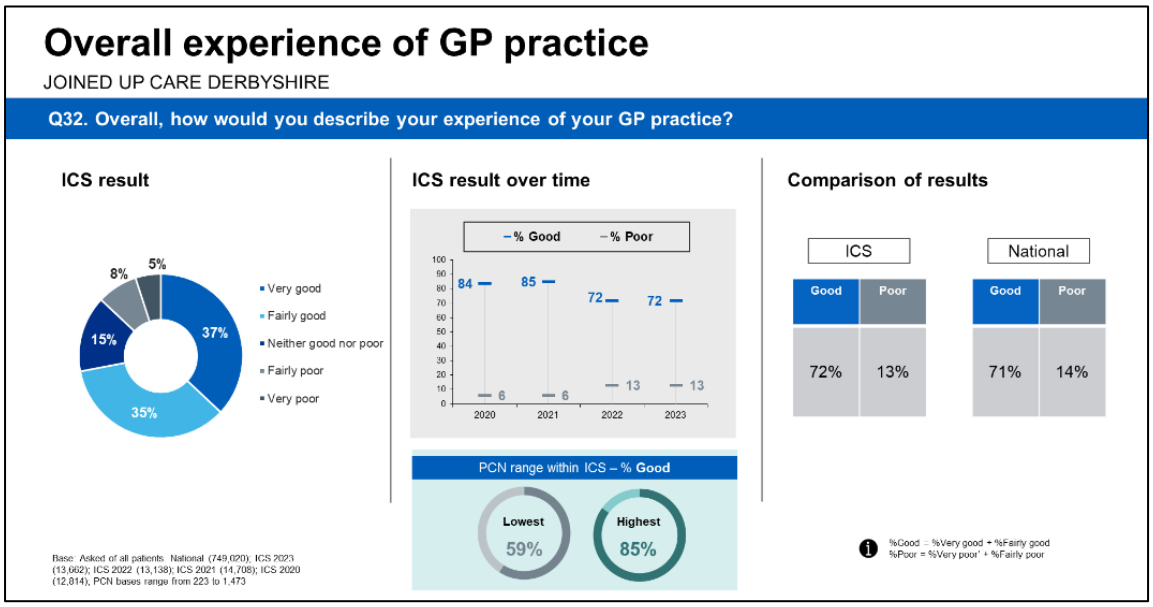
The average list size for each GP practice has increased by approximately 30% over the last seven years. This is a fundamental driver for making the current service model unsustainable (without immediate increases in funding and staffing).

This problem is exacerbated by the fall in the number of partners providing leadership expertise and capacity in General Practice, to help address this challenge and the others outlined in this section.

<u>General Practice Patient Survey – 2023</u>

The following summary infographic for Joined Up Care Derbyshire highlights a deterioration in overall experience in 2022 which has continued in 2023;

<u>Figure 4- General Practice Survey results for Overall Experience</u>



The Survey also illustrates a continued worsening in the overall experience of making an appointment (22% reported very good and 31% fairly good in 2023) but high satisfaction levels once care is accessed.

National Voices

Through insights gathered within their coalition of health and care charities, National Voices has identified nine proposals for the reform of primary care to make a significant difference for people living with health conditions and disability, and in particular people from groups that experience health inequalities, whilst also supporting the primary care workforce (20). The proposals have been signed and supported by over 50 organisations. The nine proposals are;

1. *Revamp access and triage, putting choice, personalisation and equity at the centre*
2. *Modernise and revamp communications, putting choice, personalisation and equity at the heart*
3. *Make support for people with multiple long term conditions more joined up within primary care*
4. *Develop clearer standardised processes for diagnosis of health conditions*
5. *Make it easier for people to book longer appointments in General Practice*
6. *Better equip primary care professionals to meet people's needs in holistic ways*
7. *Tackle the inverse care law for GPs and dentists in areas of socioeconomic inequality*
8. *Bring an end to wrongfully refused registrations in GPs and dentists*
9. *Work in partnership with people, communities and voluntary sector organisations for everyone's benefit*

Some of the proposals do not directly relate to the scope of the Primary Care Model, however the new model will directly support the achievement of the ambitions that sit under proposals 1,3,5 6, and 9, and in particular for patients in cohorts 2 & 3 (see next Section).

Healthwatch

Discussions have been held with Healthwatch Derbyshire to inform the model. A key consideration is how the changes to the service model with be communicated with patients and the public. There was a general agreement to tailoring the service provision to meet people's need, as described in the model.

Recent feedback from Derby and Derbyshire patients and population

The following comments are local to Derby and Derbyshire and have been taken from an unpublished Insights Report (v2) produced in early 2023 to support the development of the Integrated Care Strategy. They highlight patient concerns which include the time it takes to access a GP, and also the feeling of being rushed during appointments, both of which are issues the new model of care is seeking to tackle.

"Access: GP : Still the most common negative sentiment in Primary Care sector reports. This was around time taken to get through to the GP by telephone, lack of available appointments when a patient does get through, or how long the time is between securing an appointment and the actual day of that appointment." (p4)

"Discussion predominantly focused on primary care and thoughts were typically negative, expressing frustration with long waiting times, feeling rushed during appointments and the impact of COVID on seeing a doctor face-to-face... there were positive comments on repeat prescriptions services and the use of online services in facilitating their ease of seeing a GP." (p22)

Further specific engagement undertaken in relation to the Primary Care Model

The following organisations, groups and teams will have been engaged with in advance of this document being considered by the ICB Board in November 2023;

- ICB Board (development session)
- ICB Primary care team
- ICB Population Health and Strategic Commissioning Committee
- Integrated Place Executive
- Provider Collaborative Leadership Board
- GP Provider Board
- Primary and Community Care Delivery Board
- Transformation Co-ordinating Group
- Place Alliance Managers
- Local Medical Committee
- GP practices
- City, South and North PCN area boards
- PCN Clinical Directors and PCN Managers
- Primary Care Operations Group
- Primary Care Annual Conference 2023
- DHU Healthcare Board
- Derbyshire Community Health Services NHS FT Board
- Patient Participation Groups

Key themes that have emerged from this engagement and resulted in changes to the content of this document include:

- Increased recognition of the need for interpretation and adaptation of the Model to reflect local context
- Need to ensure the implementation of the Model is aligned with existing or emerging policy requirements in primary care to avoid confusion amongst staff and competing priorities
- A broader set of outcomes the Model will need to contribute to
- The opportunities for collaboration with system partners on implementing the Model and supporting delivery
- The need for an integrated approach with Place and community transformation
- The need to describe the changes through the positive impact it will have for patients in each cohort
- The opportunities for elevating the role of primary care in supporting the delivery of system priorities, and benefits that impact all providers

An engagement plan is currently being developed for the period following ICB approval and to accompany our Implementation Plan. This will include consideration of how best to engage with the VCSE Alliance and the Health and Wellbeing Boards, as well as further engagement with the organisations, groups and teams listed above. There will be a specific focus on public engagement and involvement in co-design of the operational aspects of the new Primary Care Model.

3.3 Opportunities to address the General Practice challenges

Role of the ICB and other sectors

As noted in the Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28 there is an opportunity for the ICB to strengthen primary care, specifically General Practice – both in terms of financial investment and clinical workforce.

It also notes the opportunity to restructure the way that clinicians are deployed across different settings of care and to combine the collective expertise of the specialist and the expert generalist within integrated clinical networks. This can include plans for aligning acute care specialists (physical and mental health) to neighbourhood teams, as recommended in the Fuller Stocktake.

Artificial Intelligence

The potential impact of artificial intelligence in the medium term is expected to be sizeable. As noted in the Strategic Context section approximately 70% of a GPs time is spent on administrative tasks, and approximately 44% of administrative tasks in General Practice are mostly or completely automatable.

Non-AI based digital triage systems have already demonstrated some opportunity to improve patient experience and increase productivity (21), and the NHS England 'Modern General Practice Access Model' identifies ways in which GP appointments can be avoided through digital telephony, making online requests 'simpler' and offering 'faster' navigation, assessment and responses for patients.

The NHS Workforce Plan notes that a number of general practices have already begun to use speech recognition technology to record clinical documentation, allowing staff to focus on patients as well as minimising manual record keeping and improving the quality of data input. The Topol Review (22) used a conservative estimate of one minute saved per patient consultation, which equates to 5.7 million hours of GP consultation time, with further savings possible should all functionalities be optimised.

Workforce

The NHS Workforce Plan also refers to changing regulation which permits a wider range of healthcare professionals to undertake tasks previously reserved to doctors, which means that the workforce model to provide care can be reimagined. This however has an inherent risk. A focus on improved access threatens the core function of primary care unless there is an equal focus on continuity, coordination and comprehensiveness.

Prevention

Prevention activities within primary care provide the greatest benefits for health improvement and a return on investment for our population. For example, improved diagnosis and management of hypertension can see a return on investment of 3.8 within a year for over 65 year olds, and within 3 years for all adults (23). Local public interventions, including those that support primary care show a return on investment of 4.1 and a cost benefits ratio of 10.3 (24). Rethinking how we capitalise on the preventative capabilities of primary care is likely to be the largest opportunity that our local health system needs to grasp.

4. Identification and Prioritisation of Needs

4.1 Introduction

The new Primary Care Model responds to needs that have been identified through a review of documented evidence, national and local strategies and plans, patient and public insights, and extensive dialogue with colleagues from General Practice, primary care, the ICB and partner organisations in Derby and Derbyshire. Please refer to Section 3.2 for the list of discussions held to date. These conversations will accelerate as we develop the implementation plan for the new Model.

4.2 What do we need to do?

The paucity in supply of General Practitioners combined with a diminishing resource allocation creates the greatest threat to the delivery of high quality primary care. A model of General Practice with a small, registered list and a stable clinical team is not a reality for most. Therefore, we must consider alternative models to augment current service provision. We need to re-consider how we target our resources in ways that ensure we have a sustainable and resilient model of primary care, which delivers optimal outcomes, including continuity for those that benefit from it the most.

When considering what we need to do it is helpful to consider the delivery of primary care within two broad facets – prevention/ proactive care and reactive care.

Prevention/ proactive care represents primary, secondary, tertiary and quaternary prevention interventions (25). Examples of prevention work within primary care include case finding for conditions such as hypertension, atrial fibrillation, COPD, diabetes, falls risk assessments, optimising medications/ reducing overmedicalisation, and anticipatory care planning. It can also incorporate improving access to lifestyle services. Prevention activities cut across the whole population from cradle to grave.

Reactive care responds to the presenting needs of people and includes a variety of urgencies that need to be dealt with. Within most settings the presenting need undergoes some form of prioritisation. Reactive care has a broad range – it might include symptom control in someone who is in the final stages of their life, a minor illness in an otherwise well individual, or someone who is concerned about their mental health.

The concepts of urgent and planned care lack relevance to General Practice. The urgency of presentation is a function of triage (initial assessment) and is relative to itself. Presenting with a breast lump may feel urgent to the person and to a diagnosis of cancer but we may not define that as urgent care. Urgent care, within General Practice, is not a distinct entity. It is part of a continuum of reactive care. It is important that we recognise this when considering how primary care provision can integrate with existing programmes of work within our system.

It is clear that the required skills, staff and services to deliver the facets of prevention/ proactive care and reactive care will vary according to the needs of the individuals who present. We must therefore develop a clinical model that allows us to differentially meet the broad range of population needs, including continuity of care for those who will benefit the most, as illustrated by the following extract from a recent report by the Institute for Public Policy Research;

"Embedding continuity for those who can benefit most does not necessitate a 'one size fits all' approach. It is clear – from wider evidence, as well as our own deliberative work – that some people will be happy with a transactional, quick appointment with the best suited professionals, while others (particularly those with long-term or complex needs) will prioritise long-term, ongoing relationships. Embedding continuity means a consistent, accessible and variable offer based on patient need and priorities." (16)

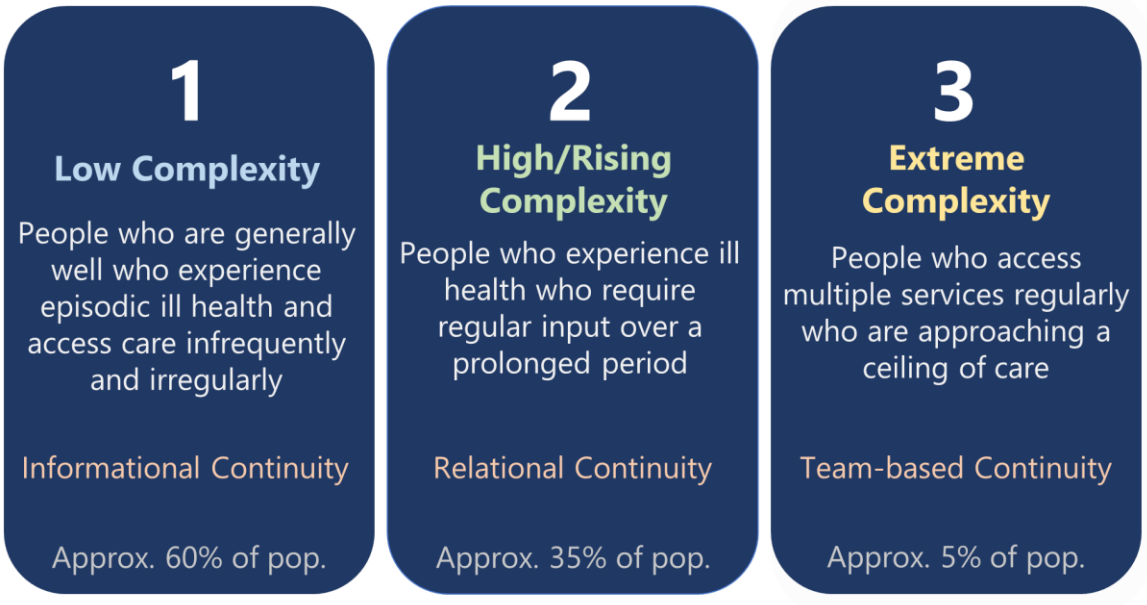
4.3 Population Stratification

Continuing to deliver high quality services as resources become increasingly constrained requires a deliberate allocation towards the needs of the population instead of demand (26). We know that approximately 5% of the population accounts for 50% of the healthcare spend (27) and that predicting health outcomes and utilisation through stratification can support tailored proactive care, and a restructuring of health care provision as well as clinical insights.

Stratifying the population according to their needs gives us an opportunity to plan and organise services in a different way. In the longer term this can lead to improved quality and reduced cost to the health system (28). Numerous population stratification tools exist for use in primary care (29), they can be summarised in numerous ways, but based on the literature and the extensive engagement undertaken to date in developing the vision and the new Primary Care Model it has been decided that the risk profile of the population can be stratified simply, and intuitively into three cohorts. These are listed below and illustrated in Figure 5;

- Low Complexity
- High and Rising Complexity
- Extreme Complexity

Figure 5 – Three population cohorts to underpin the Primary Care Model



Low Complexity

- This cohort describes people who are generally well and who typically have short lived episodes of ill health

- They may have simple to manage long-term conditions that are well controlled
- They require irregular and infrequent contact with primary care services
- There is a large opportunity for the primary prevention of ill health in this cohort
- Feedback from people within this cohort suggests that relational continuity of care is less important
- People are more willing to travel to access care and feel that convenience of access is most important
- This cohort represents approximately 60% of the population

High and Rising Complexity

- Relational continuity takes primacy in this cohort
- People within this cohort may have multiple long-term conditions that require regular input from primary care
- They may have recurrent or enduring health conditions that mean they have regular contact with their primary care team
- They may require input from several different providers to meet their needs including community and specialist teams
- Prevention opportunities sit around primary and to a larger extent secondary prevention interventions
- This cohort represents approximately 35% of the population

Extreme Complexity

- Those receiving input from multiple agencies who have reached or are approaching a ceiling in their medical care best defines this group
- Their needs are extremely complex and cross multiple agencies including (and not limited to) primary care, secondary care, community care, social care, police, drugs and alcohol, ambulance, and mental health
- Their prevention needs are most frequently tertiary prevention although there will still be the opportunity for primary and secondary prevention
- This cohort represents approximately 5% of the population

These cohorts of the population have different needs, and services must be planned and delivered around those needs to address reactive and preventative requirements. The intention of cohorting is to provide higher quality and more sustainable primary care services to the whole population.

The needs of the population are a continuous variable, and through the course of someone's life they will transition between the different cohorts as their needs change, and so whilst there will be discussion over small groups of patients that sit very close to the edge of the definitions in the second and third cohorts this does not negate the approach itself. There needs to be flexibility when applying any model of care and this is no exception, there is a key role for the expert generalist in determining which cohort a patient belongs to and when a patient needs to move between cohorts.

4.4. Point of Access

As people access or are recalled to primary care this creates a point of access. Whilst this is an exceptionally complex and detailed area, which requires a dedicated focus and plan, it is clear that there are some important features to consider, when assessing what we need to do to improve access.

It is argued that an explosion in choice has created confusion for people trying to access care with multiple avenues leading to different outputs. The Fuller Stocktake confirms that *the current system is not fit for purpose – it is fragmented and causing frustration among patients and staff*. We must also be aware that improving access in a universal way leads to an increase in health inequalities, where we see the inverse care law play out (30). Improvements to access must therefore be designed and implemented in ways that include specific arrangements for disadvantaged and more vulnerable segments of our population.

Technology is rapidly advancing. Predictive data analytics supported by AI based triage tools are currently in use internationally. There are early pilots within England emerging, particularly within out of hours settings. These shows promise in supporting the flow of people into the most appropriate services.

4.5 Culture, leadership and quality management

As referenced in the Strategic Context section we need to improve leadership and management capability and capacity and address cultural and quality management factors that currently adversely affect outcomes and contribute to failure demand in the system.

We need to ensure that primary care is fully plugged into the networks and development work taking place in JUCD on quality improvement, and that improvement science is used to support and facilitate the implementation of the new Primary Care Model, focused on the inter-locking activities of quality planning, quality control and quality improvement.

5. Vision and New Primary Care Model

5.1 Our Vision

Our vision is for a sustainable, thriving primary care system that is at the core of integrated care delivery in Derby and Derbyshire, at all levels of scale, and is instrumental in delivering JUCD priorities and wider system benefits

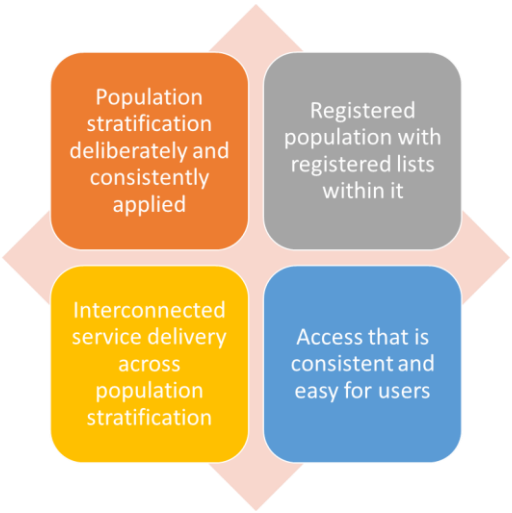
Delivering this vision requires a radical re-imagining of how primary care services are provided, with the population stratified into three cohorts – (1) low complexity, (2) high and rising complexity, and (3) extreme complexity.

There will be standardised care models for each cohort that optimise care quality within the constraints we face, providing all people with access to comprehensive, coordinated, and continuous services.

This innovative clinical model is informed by the Fuller Stocktake, feedback from users and local stakeholders, and clinical models that are operational and delivering significant benefits in other Integrated Care Systems.

Successful implementation will require joined up planning, delivery, and enabling support across the GP Provider Board, the ICB and Joined Up Care Derbyshire (JUCD) partners.

Figure 6 – Illustrating the Vision



5.2 Our aims are to;

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

5.3 New Primary Care Model

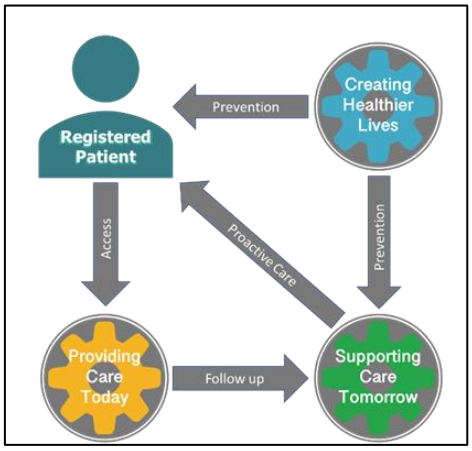
5.3.1 Overview

The new Primary Care Model is constructed around two dimensions – the facets of primary care (prevention/ proactive and reactive care) and the patient cohorts previously described.

The facets of care have been labelled as;

- Creating Healthier Lives (prevention)
- Supporting Care Tomorrow (proactive)
- Providing Care Today (reactive)

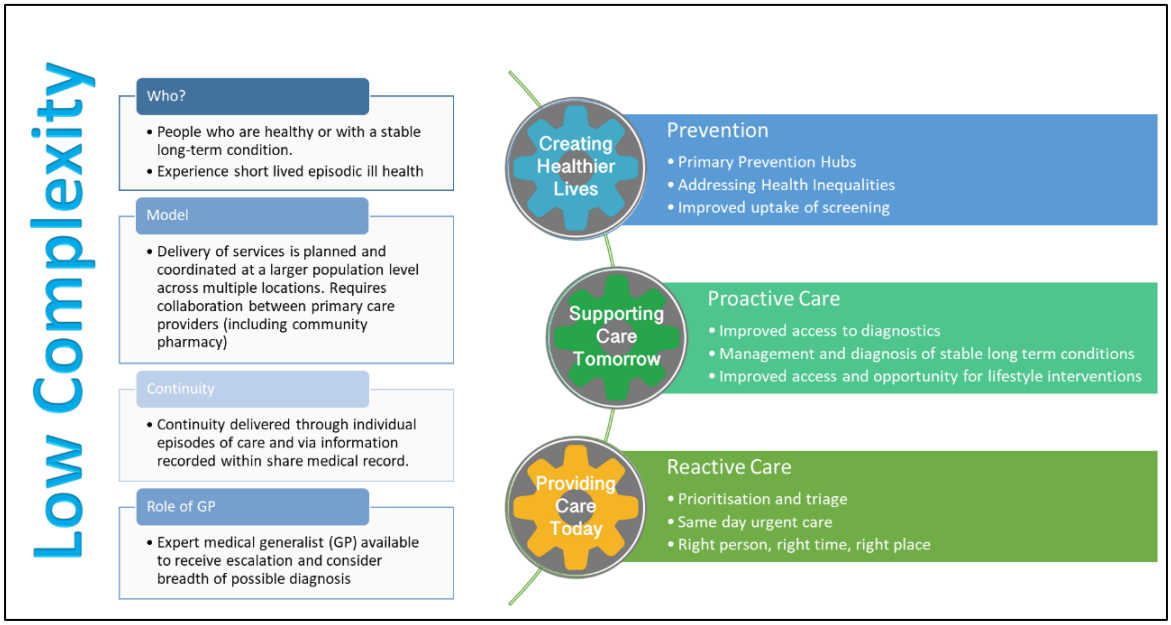
Figure 7 – Summary of how the three facets of care interrelate, around the registered patient.



The populations that sit in each cohort have similar characteristics that can be used to design and plan primary care processes, workforce and services. Some of these characteristics have already been recognised by General Practice in England resulting in a variety of different staff roles being employed to undertake a range of tasks (31). For example, we commonly see Nurse Associates and Health Care Assistants undertaking blood pressure checks and phlebotomy in the low complexity cohort; and bespoke multidisciplinary teams providing care to complex housebound patients in the second cohort. There will need to be further and ongoing developments in the workforce to meet the needs of the population in the face of increasing constraints, and to support the new Primary Care Model.

The following sections describe the new model, structured under the three cohorts.

5.3.2 Low complexity cohort



Convenience of access across all facets of care is important for people in this cohort, coupled with a willingness to travel. Service delivery for this group of people is therefore planned and coordinated at a larger population level across multiple locations and over a wider geographical area. This requires close collaboration between primary care providers and communications and system support to enable a robust triage system, recognising this is an area that practices could struggle with.

Whilst the need for relational continuity of care is less, informational continuity is very important in this group (32). A medical record that is easily shared across providers; where information can be easily extracted to support decision making, is an essential enabling requirement. There must be an effective mechanism which takes into account patient history information alongside the information gathered at contact, to help a patient see the right professional, in the most appropriate time frame that can be offered.

Under ‘Creating Healthier Lives’ this model will focus on primary prevention hubs and increasing the ease of access to preventative interventions, such as hypertension screening, as we know that making services easier to access will increase uptake rates for this cohort.

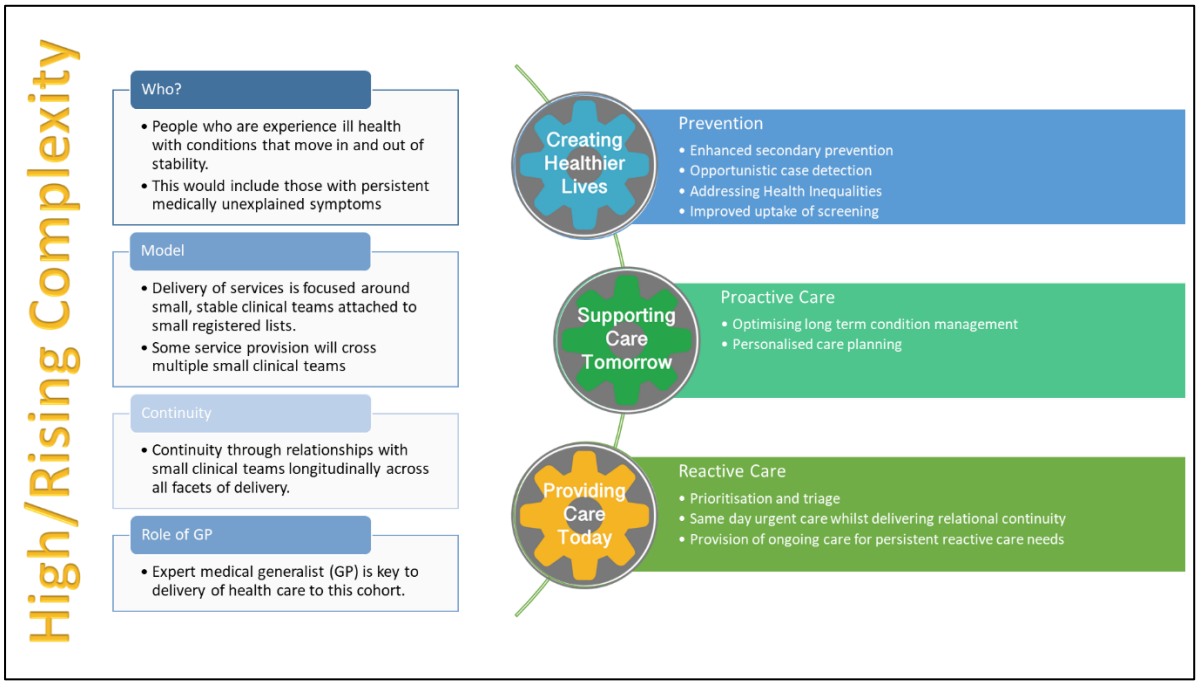
Specific interventions to reduce health inequalities, by monitoring differences in outcomes, will be developed at the population level.

Under 'Providing Care Today' there will be improved access to same day care through the larger population based services, including hub-based models for acute illness e.g. Acute Respiratory Infection (ARI) hubs.

Community pharmacy services is an essential element for this cohort. It is estimated that 6-8% of all GP consultations could be safely transferred to a community pharmacist for the management of minor illnesses. General practice referrals to the Community Pharmacy Consultation service (CPCS) include or will include conditions such as sore throat, sinusitis, shingles, UTI, impetigo, infected insect bites and otitis media. Community pharmacy is however currently facing significant capacity pressures, which will impact on the degree to which it can accommodate the transfer of activity currently dealt with by General Practice.

Expert generalism, and the role of the General Practitioner, is a central factor for this cohort, given for the breadth of possible presentations that may be seen.

5.3.3 High and rising complexity cohort



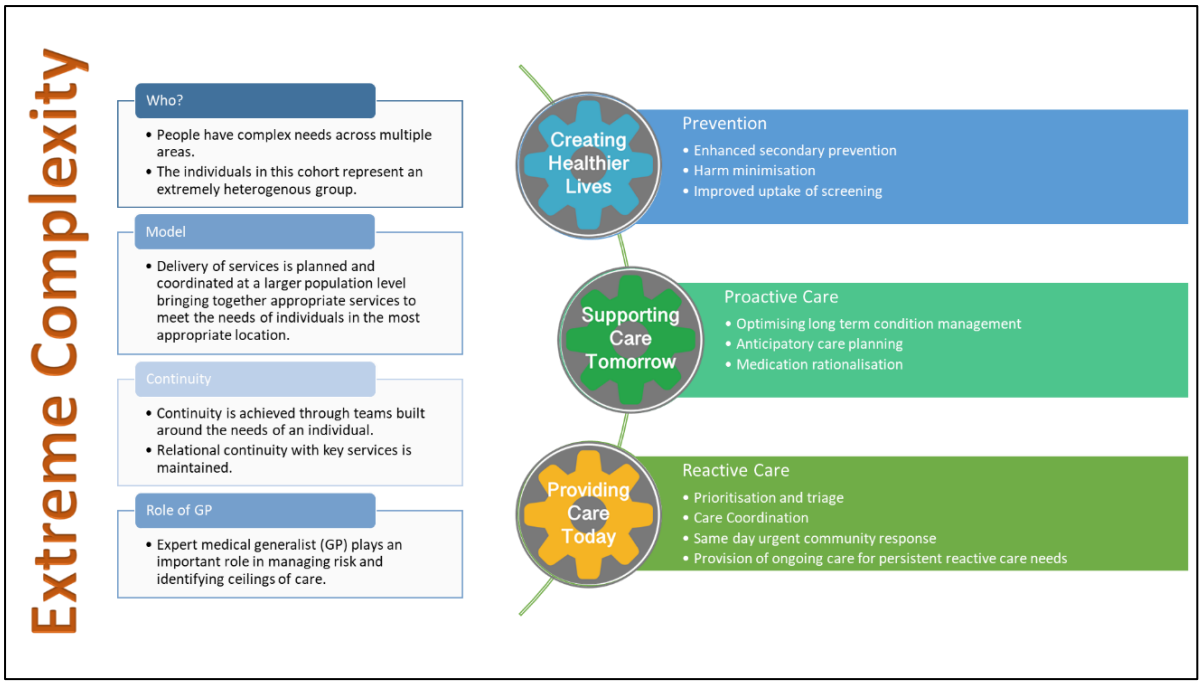
To ensure that the benefits of continuity of care are realised care will be provided by a small clinical team that gets to know the person over a long period of time (33), caring for people who experience ill health with conditions that move in and out of stability or suffer from persistent unexplained symptoms. The small, registered list provides the greatest opportunity for successful outcomes.

The care provided is generalist and personalised whilst maintaining high quality relational continuity (3). Informal networks are developed around patients to meet their needs, including input from specialist and community teams.

The delivery of this care is close to where people live and in a familiar environment. Provision covers all facets of delivery including the more urgent components of primary care. A person with an exacerbation of heart failure should be supported by a team that knows them in the same way a review of someone with significant mental health problems should be done.

Prevention work includes prescribing optimisation and improving long term condition outcomes and given the close relationship between patient and team there will be opportunities to effectively promote secondary prevention activities.

5.3.4 Extreme complexity cohort



Care for this cohort of patients will be best delivered through teams that are built around the specific needs of individuals given the very heterogenous needs.

Continuity is delivered through the three paradigms of information, relationships and team-based continuity (33). The teams are inherently multiagency because, by definition, these are people that are receiving and needing multiagency input.

A large part of the care is personalised around individual needs and is anticipatory. The care team will plan for and consider future changes to support in partnership with the patient, ensuring the plan aligns with their wishes. Care coordination plays an important role in supporting this group of people with senior clinicians with expert generalist skills (General Practitioners) being critical to managing risk and recognising ceilings of care.

It is crucial that the processes arranged for this small cohort of the population ensure the patient is appropriately and efficiently navigated to the right professional, at the right time.

5.3.5 Cohort Summary

Figure 8 – Summarising the model by cohort

Stratification	Population group	Clinical Model	Continuity	Staff Mix	Escalation/de-escalation	Activity examples
Low Complexity	~60% of population People that are stable and healthy that have health conditions that can be easily managed.	Delivery at population level (large population registered list) Multiple locations.	Delivered around episodes of care and around information. Access to medical record.	ACPs, FCPs Clinical Pharmacists, HCAs, Nursing associates, GP oversight. Comm pharmacists. Optom	Escalation up where clinical need dictates. Eg persistent unexplained symptoms. Escalation for invx should stay in service.	Reactive illness service. FCP. Mental health. NHS health checks. CVD primary prevention. Smears. CPCS. etc
Rising/High Complexity	~35% of population. Chronic conditions that move in and out of stability. Increasing frailty. Persistent and/or uncontrolled symptoms.	Delivered at small registered sub lists based within a small number of distributed locations.	Focus on relational continuity with a small team.	GPs, Practice nurses, Clinical Pharmacists, ACPs	Seeks to de-escalate where possible back to low complexity. Eg Cancer patient that achieves cure.	Reactive illness service. Medication optimisation. Structured medication reviews. Long term condition management. Care planning.
Extreme Complexity	<5% of population. Heterogenous group. Multiple complex illness combined with significant psychosocial complexity. Would include EOL and severe frailty	Delivery at population utilising an integrated, multi-agency, multi disciplinary neighbourhood teams. Delivered in the location most appropriate to the needs of the patient.	Team based continuity.	GPs, ACPs, DNs, HCAs, Physio, OT, Social worker, MH, Clinical pharmacist. Specialist input where required.	Receives escalation where multi agency approach is required. De-escalated where possible eg super users.	Personalised anticipatory care planning. Reactive service to need. SMRs focused around frailty and polypharmacy.

Illustrations of how the Primary Care Model will support patients in each cohort

Low complexity cohort

Sunita is 45 years old and thinks she may have a water infection. She had a previous infection about 2 years ago. She accesses her General Practice via a digital platform. This sends her a booking link to a remote consultation with a prescribing clinical pharmacist. There is a general practitioner available to support. It also recognises that she is overdue for her smear and provides her with booking information for multiple locations where she can have this done. The information is recorded in the medical record so that it may be used for future presentations.

High/Rising complexity

Jason is a 50 year old man who has diabetes and learning difficulties. His diabetes requires treatment with multiple medications. His General Practice contacts him to review his health, he has not been in contact for over one year, so the practice asks a Care Coordinator to speak with him and understand the issues or barriers he is experiencing. An appointment is booked for Jason to see a nurse who has known him for 10 years. During that appointment Jason also complains of some shortness of breath, so the nurse arranges an appointment with a General Practitioner who has seen him consistently over the last 5 years.

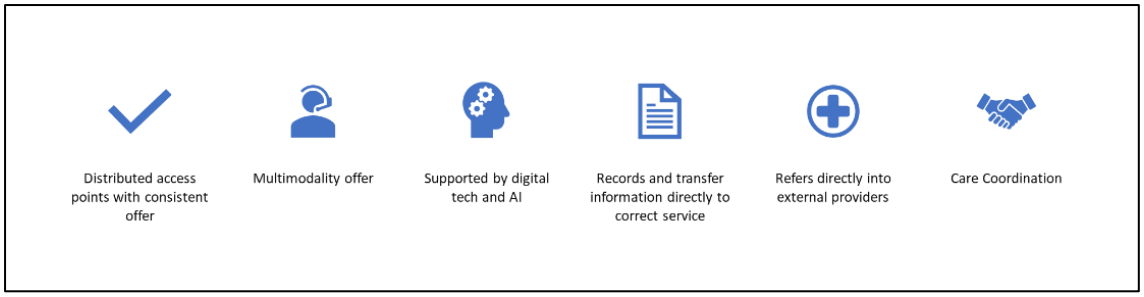
Extreme complexity
Mabel is 90 years old, and her mobility has been deteriorating. Her daughter contacts the ambulance service because she is concerned she may have an infection. After an initial triage process the ambulance service pass the information to the primary care team supporting Mabel. A Care Coordinator contacts Mabel and her daughter and arranges for a General Practitioner to visit and an occupational therapist to assess and provide support for her mobility. The contact is discussed with the multi-disciplinary team to identify opportunities for coordinating support for Mabel across multiple services.

5.3.6 Point of Access

The new service model will incorporate the following key principles in relation to access;

- Access will be multi-modal. We should not force people to online, to telephone or face to face appointments, there will be a choice. We must accept that different people need and desire different access methods.
- Information gathered will include pre-existing data from the medical record as well as information from the patient about the reason for their current contact. The information will be gathered in a consistent way to support achieving a consistent outcome.
- Based on the information gathered a decision will be made as to who, when and where there is an appropriate appointment available. The decision will take into account pressures within the system and manage the complex risk associated with triage and primary care.
- This decision will then be communicated to the professional along with the booking mechanism (including a waiting function) e.g. booking link, appointment time, warm transfer.

Figure 9 – Summarising key points in relation to access



6. Improvement goals

6.1 Introduction

This section includes an initial set of high level goals to guide how the vision and new Primary Care Model will be translated from the principles and aims described above into targeted, prioritised improvement activities. The details that sit behind the improvement activities will be developed through an Implementation Plan to be produced by the end of 2023.

Some improvement activities are already underway and in some cases well developed, whilst others need to be initiated. For some the challenge is to standardise good practice across the breadth of Derby and Derbyshire.

We want to ensure there is a strong momentum that builds on the support received to date for the vision, therefore timelines for improvement actions will be ambitious.

The improvement goals are designed to support delivery of the Integrated Care Strategy and the guiding policies for action from the Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28 and illustrate how primary care is central to the delivery of JUCD health and care system objectives.

There is also a focus in this section on the enabling functions/ actions that will be critical to the successful delivery of the improvement goals.

6.2 Our Year 1 Goals

1. Undertake population stratification and mobilise the Primary Care Model through an operating framework that maximises care quality and staff wellbeing
2. Implement a digital triage process in support of our aim for a consistent offer of primary care access for all people
3. Ensure there is access to enhanced care-coordination for all people with extreme complexity
4. Deliver primary and secondary prevention activities for circulatory disease, respiratory disease, and cancer, as prioritised by JUCD prevention and inequalities leads
5. Agree and deliver specific primary care actions that best support Age Well priority actions, releasing benefits from community services transformation including recommendations from the recent diagnostic review undertaken by Newton Europe
6. Deliver reactive and proactive care that supports key system objectives for urgent and emergency care and patient flow

1. Undertake population stratification and mobilise the Primary Care Model through an operating framework that maximises care quality and staff wellbeing

<u>Population stratification</u>

There is further work to be done to confirm the population numbers that sit within each of the stratified cohorts, building on data analysis which is currently being undertaken. This is priority work for mobilising the model.

<u>Operating framework and change management</u>

Implementing the Primary Care Model across a large, diverse geographical area consisting of 18 PCNs that range in size from 32,000 – 100,000 population, and in a way that allows for local variation, due to the differences in population needs, current workforce etc. will require a clear operating framework and intelligent change management methods that align with the GP Provider Board's (GPPB) principles and values.

There will be the opportunity to learn from other systems around the country that have partially or fully implemented similar models and potentially replicate some of their frameworks and methods, but we will also need to be assured that the approaches we use are designed around the Derby and Derbyshire system and existing operating frameworks e.g. for Community Transformation.

2. Implement a digital triage process in support of our aim for a consistent offer of primary care access for all people

The Primary Care Model will see a move away from the '8am phone call queue' and 'first come first served' process for allocating appointments.

Consistent structured information will be collected at the point of contact including about symptoms, and to allow patients to ask a question, make a request or follow up about something – with patients being able to provide this information via an online form (via the practice website and via tools like the NHS App) or to reception staff who capture the information about their needs.

Patient needs will be consistently assessed and prioritised (triaged), allowing practices to provide patients with the most appropriate care or other response, from the right member of the practice team, including signposting or referring patients to other appropriate services.

The ability to better allocate patients to the right health professional or service supports effective use of all staff time and skills and supports improved ability and capacity to provide continuity of care for those that will benefit the most, including vulnerable patients and those with long-term conditions in the second and third stratified cohorts.

The GPPB will work closely with JUCD digital leads to develop the digital triage processes for the new Primary Care Model, based upon the principles outlined above, which are taken from the "Modern General Practice" model.

3. Ensure there is access to enhanced care-coordination for all people with extreme complexity

This goal will be achieved by working alongside Derbyshire Community Health Services NHS FT and their developing approach to local navigation hubs.

Care co-ordinators are personalised care roles. They focus on what matters to individuals and support people from diverse backgrounds, including those with a range of conditions and disabilities. They co-ordinate and navigate care across the health and care system, helping people make the right connections, with the right teams at the right time. They are skilled in personalised conversations, assessing people's needs, facilitating joint working, ensuring the effective flow of information, monitoring needs and responding to change.

There is a national NHS England framework for workforce development for care co-ordinators (34) that will be used to support achievement of this Year 1 Goal. The Framework has been developed to;

- Set clear and consistent standards for care co-ordinators
- Demonstrate the benefits of care co-ordinators working in health and care
- Provide information about the training, support, supervision, and continuing professional development needed to enable care co-ordinators to succeed
- Support the development of a strong and capable workforce of care co-ordinators
- Support improved quality and consistency of care co-ordination and reduce variation in outcomes and access standards

The approach in Derby and Derbyshire will utilise this framework and integrate with the care co-ordination support already provided through Team Up to home-bound patients and as previously referenced, the ongoing work to develop local navigation hubs.

4. Deliver primary and secondary prevention activities for circulatory disease, respiratory disease, and cancer, as prioritised by JUCD prevention and inequalities leads

The Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28 identified a series of actions across primary, secondary and tertiary prevention, including under the three disease areas prioritised in the Integrated Care Strategy (Circulatory, Respiratory, Cancer) and under the 'Plus 5' priorities for reducing health inequalities.

Based upon these sources and other intelligence it is proposed the implementation of the Primary Care Model will incorporate prioritisation of the following activities in 2023/24;

Figure 10 – Proposed prevention priorities for Year 1

Circulatory diseases, including stroke and diabetes	• Increase hypertension case-finding: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke • Increase prescribing of LLT to those with elevated risk • Identification of undiagnosed AF • Increase diagnosis of heart failure prior to hospital admission • Identification of undiagnosed diabetes • Increase in number of people with diabetes receiving all care processes • Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60% • For those people who are pre-diabetic, increase the take-up of the diabetes prevention programme – with a particular focus on people living in deprived communities, ensuring the approach is adapted for our high-risk health inequality groups who require a tailored offer to support greater engagement and impact
Respiratory disease	• Increase COPD diagnoses prior to hospital admission • Increase utilisation of personalised care plans for those with Asthma and COPD • Improving vaccination uptake: reducing inequalities in uptake of life course, for COVID, flu and pneumonia vaccines
Cancer	• Increase uptake of the National Cancer Screening Programmes

	• Increase diagnoses of cancer at stage 1 and 2
Smoking	• Increase the number of referrals to smoking cessation and treatment services – including a particular focus on people living in deprived communities and people with a severe mental illness, who are four times more likely to smoke
Severe mental illness (SMI) and learning disabilities	• Ensure annual health checks take place for at least 60% of people living with severe mental illness or learning disabilities • Increase the number of people with a high BMI referred to weight management services – with a particular focus on people living in deprived communities, people with learning disabilities or Autism (who are more likely to be over or underweight due to sensory processing and associated dietary choices) and people with severe mental illness (who are more likely to have lower levels of income and may not be prioritising their physical healthcare)

5. Agree and deliver specific primary care actions that best support Age Well priority actions, releasing benefits from community services transformation including recommendations from the recent diagnostic review undertaken by Newton Europe

The specific objectives under this Improvement Goal will be agreed in conjunction with the JUCD Community Transformation Group and will seek to exploit the opportunities identified by Newton Europe in 2023 including;

- Support people proactively before needs escalate
- Supporting older adults in the community with appropriate wrap around support
- Minimising avoidable admissions to hospital, resulting in reduced de-conditioning
- Identify and mitigate causes of long waits in the acute sector

The objectives will cover opportunities to improve multi-disciplinary team working through the further development of integrated neighbourhood teams, aligned with Team Up.

6. Deliver reactive and proactive care that supports key system objectives for urgent and emergency care and patient flow

One of the aims for the Primary Care Model is to '*Support the achievement of key system objectives, through plans that are integrated with Place, the Provider Collaborative and JUCD Delivery Boards*.' As 'Urgent Care' is one of the GPPB's four priority areas it is proposed that supporting improvement in urgent and emergency care and patient flow is a priority Year 1 goal for the new model, due to the impact improvements can have on improving service quality and system efficiency including reductions in failure demand.

The specific objectives under this improvement goal will be agreed in conjunction with the Integrated Place Executive given it leads on areas where primary care is most integral e.g., system flow, discharge, intermediate care and community transformation. Connection with the UEC Delivery Board will also be made.

6.3 Enabling actions

The following sections provide a high-level overview of current thinking on enabling requirements for the Primary Care Model. The Implementation Plan that will be produced following agreement of the Model will build on this initial content.

6.3.1 Culture and Organisational Development

The development of an improvement culture across practices, hubs, PCNs and the GPPB will be critical to the success of the new Primary Care Model.

As a start point the leadership and operating principles that were developed and agreed by the GPPB (see below) will provide an excellent platform for discussions and ambitions relating to culture and organisational development (OD). Support from the System through the availability of OD expertise will be required.

- No decision about me, without me
- Transparency
- Authenticity
- Right person(s) in the right place about the right topics
- Distributed leadership

Quality Management

There is not currently an agreed, systematic approach to quality management in primary care in Derby and Derbyshire. It is recommended therefore that exploration of ways to address this gap is undertaken to support the delivery of the new Model.

One framework that could be helpful is from the Institute for Healthcare Improvement (IHI) which has long been instrumental in shaping NHS thinking on quality management. It has recently published a White Paper that proposes a holistic approach - *'Whole System Quality – A Unified Approach to Building Responsive, Resilient Health Care Systems'* (35), at the core of which is the deliberate integration of quality planning, quality control, and quality improvement activities across multiple levels of the system.

The IHI approach is consistent with NHS quality improvement approaches, both nationally through the recently launched 'NHS IMPACT' and locally through the QSIR (Quality, Service Improvement and Redesign) Programme. It could therefore build upon existing expertise and provide a joint quality management framework which can capitalise on the commitment from Derbyshire Community Health Services NHS FT to work with the GPPB to develop a consistent approach to OD, leadership development and quality management across primary and community care.

Leadership

There is a need for an enhanced focus and investment in PCN and practice leadership development to address current variability in capability and capacity.

The Primary Care Model will operate in a complex environment, and therefore effective leadership practice will need to draw on the evidence base for leading well in complexity, alongside the set of principles agreed by the GPPB. It will also be important to have an integrated approach with community services leadership development.

The Fuller Stocktake is clear on the need to avoid top-down leadership and for trusting relationships with the workforce and communities to be developed. In this context the leadership principles that underpin the Institute for Healthcare Improvement's 'Whole

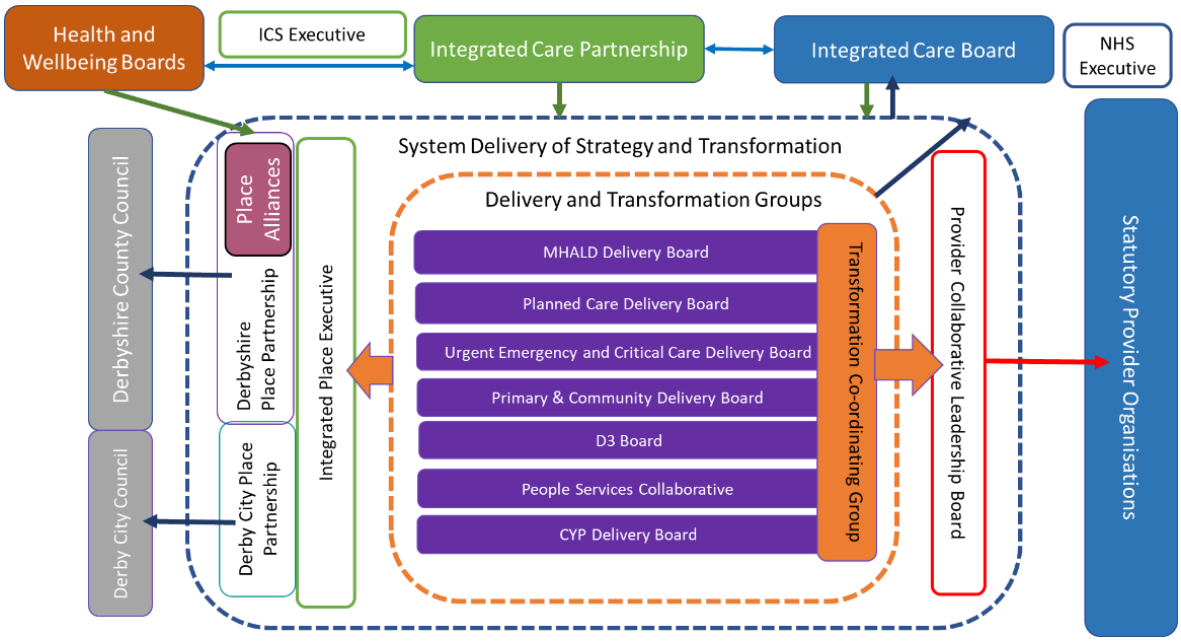
Systems Quality' approach are recommended as a good starting point for guiding a new approach to leadership development;

- Build a shared sense of purpose
- Practice systems thinking
- Engage in collective learning and dialogue
- Practice personal inquiry and reflection

6.3.2 Governance

The GP Provider Board has been asked by the ICB to lead this important piece of work and will oversee further development and implementation of the model. The GPPB will work collaboratively with JUCD partners in agreeing improvement plans and will connect into the JUCD system governance architecture (*see below*) primarily through the Primary and Community Care Delivery Board, the Provider Collaborative Leadership Board, and the Integrated Place Executive given the critical relationships between Place and the Primary Care Model and the IPE's delegated role for implementing the Derby and Derbyshire Integrated Care Strategy, and its leadership of the Community Transformation Programme.

Figure 11 - Joined Up Care Governance Architecture



Consideration will need to be given by all JUCD partners to reviewing existing system and organisational governance arrangements to ensure they reflect the role primary care needs to play at the centre of the Derby and Derbyshire integrated care system, through the new Model. It is recommended that further discussions on this subject are integral to the Implementation Plan.

6.3.3 Workforce

The workforce model for care delivery for the three population cohorts needs to be developed, building upon the initial outline requirements as summarised below;

Figure 12 – Outline staff mix requirements by cohort

Stratification	Staff Mix
Low Complexity	ACPs, FCPs Clinical Pharmacists, HCAs, Nursing associates, GP oversight. Comm pharmacists. Optometrists
Rising/High Complexity	GPs, Practice nurses, Clinical Pharmacists, ACPs
Extreme Complexity	GPs, ACPs, DNs, HCAs, Physio, OT, Social worker, MH, Clinical pharmacist. Specialist input where required.

Detailed workforce planning will need to be undertaken and this will need to be integrated with JUCD-wide workforce planning and with Team Up, given the inter-relationships. The plans will need to consider broader requirements including training, education and development, supervision, and staff wellbeing support.

The availability of a sufficiently capable workforce will be a key determining factor in how quickly the Model can be rolled out across all locations.

6.3.4 Digital/ AI and data

Digital capability will be a key determining factor for the pace at which the Primary Care Model can be rolled out, with a first priority being to deliver the Year 1 Goal 'Implement a digital triage process'. There will need to be dedicated digital support provided, funded by the System, given there is not the capability within existing GPPB or PCN resources to facilitate the scale of work required.

In relation to data requirements the Fuller Stocktake states the need for business intelligence tools and timely data to be made readily available to practices and neighbourhood teams in easy-to-use formats, supported by the development of real-time data visualisation and standardisation of approaches to data to enable comparability tools, with support to be provided by NHS England working with ICSs and IT suppliers.

6.3.5 Estates

The JUCD Estates Strategy will be central to creating coherence across services and sectors, and it should help drive the transition to a modern, fit-for-purpose primary care estates offering – including future development of hubs within each neighbourhood and places to co-locate integrated neighbourhood teams, as well as linking into the wider rollout of community diagnostic hubs, for the provision of more integrated services.

Work will take place through the Implementation Plan to establish estates-related priorities for roll out of the Model, with discussions and plans aligned across community and primary care and other sectors, to ensure all potential opportunities for co-location are explored.

6.3.6 Engagement and Communications

<u>Engagement</u>

The implementation of the new Primary Care Model and how patients can receive most benefit will be subject to a planned approach to public engagement led by the ICB given its duties in relation to primary care services.

Involvement

It will be critical to involve the public and the voluntary sector in the detailed design and implementation of the Model to ensure services are reflective of lived experience. This involvement will need to include representation for each of the three cohorts. The JUCD engagement model will be used and support from the ICB will be required to help organise and deliver this involvement over what is likely to be an extended period of time.

Communications

Materials are currently being developed to help communicate the new Primary Care Model across a wide variety of constituents, including the general population, patients and existing representative groups, general practice, community, social care, other JUCD organisations and the voluntary sector. The ICB Communications Team is supporting this work.

7. Outcomes and Evaluation

7.1 Sentinel measures

The following high-level sentinel measures have been developed to provide clarity on the key benefits we expect the Primary Care Model to deliver.

1. Improve patient experience
2. Improve staff wellbeing
3. Improve productivity by reducing failure demand
4. Improve quality of care provided
5. Improve value for money to the whole system

7.2 Outcome measures framework

Figure 13 incudes a suggested list of outcome domains for measuring the impact of the Primary Care Model. These are informed by the USA Institute for Medicine definition of quality domains (safe, effective, patient-centred, timely, efficient, equitable) (36), the strategic aims for the Derby and Derbyshire Integrated Care Strategy, key NHS and ICS policy requirements, and the need for a specific focus on General Practice and primary care.

Example outcome measures are included to illustrate the domains, the actual measures will be agreed as part of the Implementation Plan, through engagement with primary care staff, wider stakeholders and the public.

The framework will help to illustrate progress against the sentinel measures referenced in Section 7.1, and broader requirements such as increasing social value and General Practice resilience.

Figure 13 - Suggested list of outcome domains and example outcome measures

Domain	Summary description	Example outcome measures
Safe	Avoiding harm to patients from care that is intended to help them	• Clinical incidents • Near misses
Effective	Providing services based on evidence and which produce a clear benefit	• Relevant QoF indicators
Personalised	Providing care that is strengths based and ensures respect of patient's needs and preferences and ensures people experience joined up care	• Patient experience indicators
Timely	Reduces waits and sometimes harmful delays	• Access standards
Proactive	Prioritises prevention and early intervention to avoid ill health and improve outcomes	• Measures aligned to agreed prevention priorities - *as agreed through the Integrated Place Executive for the implementation of the Integrated Care Strategy*
Efficient	Avoiding waste	• Productivity measures
Social value	Adds value to wider community, including anchor institution measures	• Population sickness levels related to absence from work • Employment opportunities for local people in primary care
Equitable	Reduce inequalities in outcomes, experience and access	• Health inequality specific measures aligned to the agreed prevention priorities
Non-clinical patient impact	Minimising additional journey times	• Travel costs
Staff	Improves staff working lives	• Staff survey indicators • GP recruitment and retention rates • Practice staff recruitment and retention rates
Structural	Ensure strong, sustainable primary care services	• Reduction in practice closures

7.3 Evaluation

An evaluation approach, based upon the agreed outcome domains and measures will be developed as part of the Implementation Plan for the new model.

8. Next Steps

The GPPB will oversee production of an Implementation Plan by December 2023 which will inform the 2024/25 JUCD Operational Plan from a General Practice and primary care service perspective.

As referenced in Section 6 the Implementation Plan will build upon the initial content included in this document and on the improvement plans for each Year 1 goal and key enabling actions.

There will need to be SMART objectives agreed that align with 2024/25 ICP and JUCD goals, and a reflection of the further engagement activities that will take place between now and the production of the Plan.

Further areas for inclusion within the Implementation Plan are;

- Further development of outcomes framework with high-level evaluation methodology
- Risk management framework **–** Including initial risk and issues logs.
- Communications and engagement plan
- Resource requirements for programme management and delivery of the Plan
- Governance arrangements for overseeing implementation
- Roll-out methodology and timescales

As referenced at the start of this document for the Primary Care Model to be fully effective it will need to be adopted across all neighbourhoods in Derby and Derbyshire, but with adaption to meet the specific needs of local populations identified through the engagement of local staff and users**.**

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NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 101

Report Title	System-Level Primary Care Access Improvement Plan							
Author	Emma Prokopiuk, Assistant Director of GP Commissioning & Development							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer / Deputy Chief Executive Officer							
Presenter	Clive Newman, Director of Primary Care							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 – System-Level Primary Care Access Improvement Plan Appendix 2 – System-Level Primary Care Access Improvement Plan Presentation Slides							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Primary Care Sub Committee – 10.10.2023 Population Health and Strategic Commissioning Committee – 9.11.2023							

Recommendations

The ICB Board is requested to **APPROVE** the System-Level Access Improvement Plan.

Purpose

As part of the national Primary Care Access Recovery Plan, ICBs are required to take a System Level Primary Care Access Improvement Plan through their ICB Public Boards in October / November 2023 with a further update in March 2024.

Background

A joint NHS and Department of Health and Social Care plan was published on 9th May 2023. The Primary Care Access Recovery Plan (PCARP) focuses on recovering access to general practice and supports two key ambitions:

1. **To tackle the 8am rush and reduce the number of people struggling to contact their practice.** End to patients 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**

    a) If their need is clinically urgent it will be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their practice in the afternoon they may be assessed on the next day, where clinically appropriate.

b) If their need is not urgent, but it needs a telephone or face-to-face appointment, this will be scheduled within two weeks.

c) Where appropriate, patients will be signposted to self-care or other local services (e.g. community pharmacy or self-referral services).

The GP Commissioning & Development Team have produced a System Level Access Improvement Plan with the support of wider system colleagues including GP Provider Board.

Report Summary

The report outlines the key asks of the national PCARP and describes the local actions we are taking to implement this.

In summary the report describes:

1. Derby and Derbyshire and our GP practices
2. National Context - Delivery Plan for Recovering Access to Primary Care
3. Our long-term vision for access in Derby & Derbyshire
4. How we will deliver the Primary Care Access and Recovery Plan
5. How we will organise ourselves to deliver and govern the plan
6. How we will help those who need help the most – managing inequalities
7. How we will invest local and national funding to deliver the plan
8. How we will involve patients and communicate our work
9. How we will manage risks to the delivery of our plan

The report has already been presented to the Primary Care Subgroup (10.10.2023), Primary Care Operational Group (10.10.2023), DDICB Executive Team (25.10.2023) and Population Health & Strategic Commissioning Committee (09.10.2023). Useful feedback was received from all groups and has been incorporated into this report.

For ease the appendices to the System-level Primary Care Access Improvement Plan have not been included in the paper to the Board however they are available on request.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

No further risks identified.

Financial impact on the ICB or wider Integrated Care System		
Yes ☐	No☒	N/A☐
Details/Findings The PCARP plan is a nationally funded programme of work – section 7 of the plan details the funding streams and how it is being used in the ICB.		**Has this been signed off by a finance team member?** Section 7 of the plan relating to funding was produced by Rebecca Monck, Assistant Chief Finance Officer.

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:** Plan was produced in collaboration with Primary Care Colleagues. The plan has also been presented to Health Watch AGM and the feedback is enclosed at Appendix 1.

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

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

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

Derby and Derbyshire
Integrated Care Board

System-level Primary Care Access Improvement Plan

October/November 2023

Final draft V5

1. Introduction

This is Derby & Derbyshire Integrated Care Board's (ICB) response to the national Delivery Plan for Recovering Access to Primary Care (PCARP).

Our plan sets out:

1. Introduction
2. Description of Derby and Derbyshire and our GP practices
3. National Context - Delivery Plan for Recovering Access to Primary Care
4. Our long-term vision for access in Derby & Derbyshire
5. How we will deliver the Primary Care Access and Recovery Plan
6. How we will organise ourselves to deliver and govern the plan
7. How we will help those who need help the most – managing inequalities
8. How we will invest local and national funding to deliver the plan
9. How we will involve patients and communicate our work
10. How we will manage risks to the delivery of our plan

The plan is a 'work in progress'. It is not intended as a definitive final statement but is the summary of discussion to date and the starting point for further discussion with General Practice and other providers. The focus is on the immediate actions up to 31st March 2024, though work will continue beyond that.

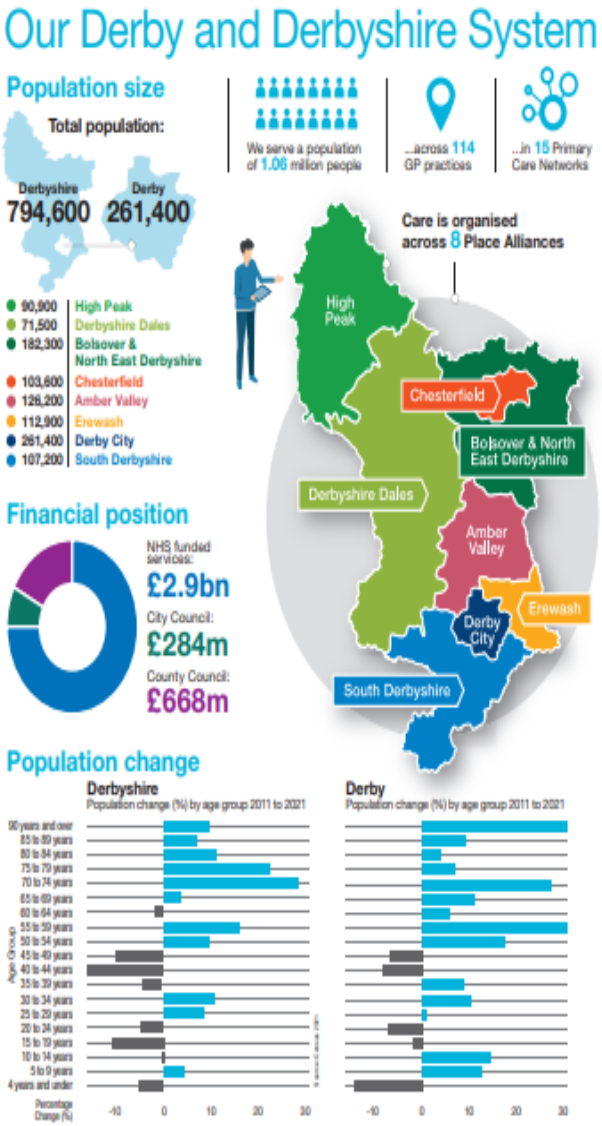
This plan should be read alongside the other plans that we have developed. Our planning assumptions and outcomes have been aligned to and are interdependent with:

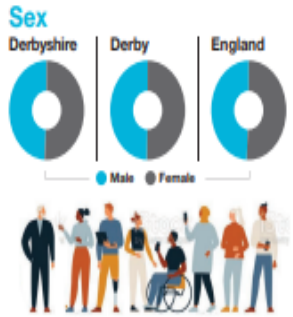
- Fuller Report
- Derby & Derbyshire ICB Joint Forward Plan
- Derby & Derbyshire ICB Integrated Care Strategy
- Derby & Derbyshire ICB Operational Plan 23/24
- Recovery Plan for Urgent & Emergency Care
- Recovery Plan for Planned Care

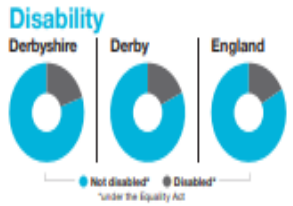
The primary interdependency is with the Primary Care Clinical Model for Derby & Derbyshire which is being developed by the GP Provider board. This plan should be considered as an adjunct to that strategy and this is described in section 4.

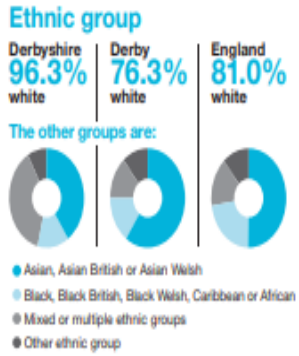
2. Derby and Derbyshire ICB and our GP practices

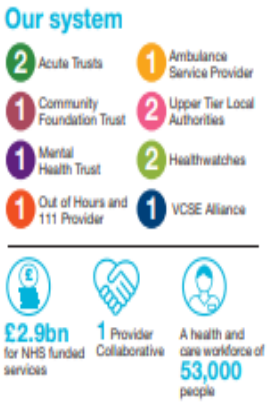
Derbyshire is a diverse county, with a population of over 1m people, 261,400 of which live in Derby. Our most deprived wards are largely in the city and the east of the county. We spend nearly £4b a year in health and social care and employ 53,000 people.

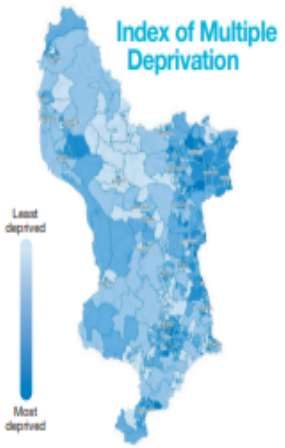












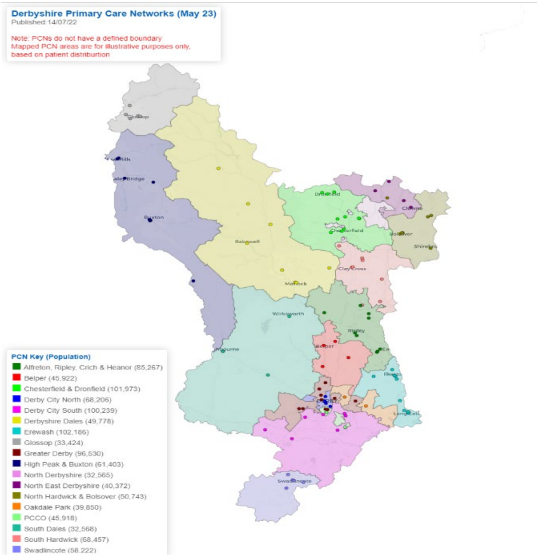
Derby and Derbyshire's Practices and Primary Care Networks

Primary Care Networks (PCN) were formed in 2019, as a key building block of the NHS Long-term Plan and 5-year framework for GP core contract.

PCNs bring together practices to work at scale without creating new statutory bodies. They were set up as a vehicle for delivering the Long-Term Plan and providing a wider range of services to patients.

They have played a role in stabilising general practice and aim to support integrated care and reduce health inequalities.

There are 18 PCNs (113 practices) in Derby and Derbyshire, ranging in size from 32,000 – 100,000 population. The map illustrates the location and size of our PCNs in Derby & Derbyshire.



The last three years have seen unprecedented demand on health and social care services. General Practices have had to make significant changes to the way they deliver services to adapt and respond to the COVID-19 pandemic. Our PCNs delivered the majority of the covid vaccination programme in Derbyshire, responding very rapidly to set up and administer vaccines within our communities.

As we moved out of the pandemic response, we are now faced with a number of challenges including a significant increase in the demand for General Practice. In 2022 we provided over 6.5 million appointments to our population. In January 2021 general practices provided 468,632 appointments increasing to 583,123 in January 2023, an increase of 24.4%. This increase in activity was delivered with a diminishing workforce and during one of the most challenging periods in the NHS.

Many practices are heading into the autumn period in a more precarious position than previous years. This is down to a combination of factors including but not limited to increasing workload, increasing demand, fatigue and increased financial pressures.

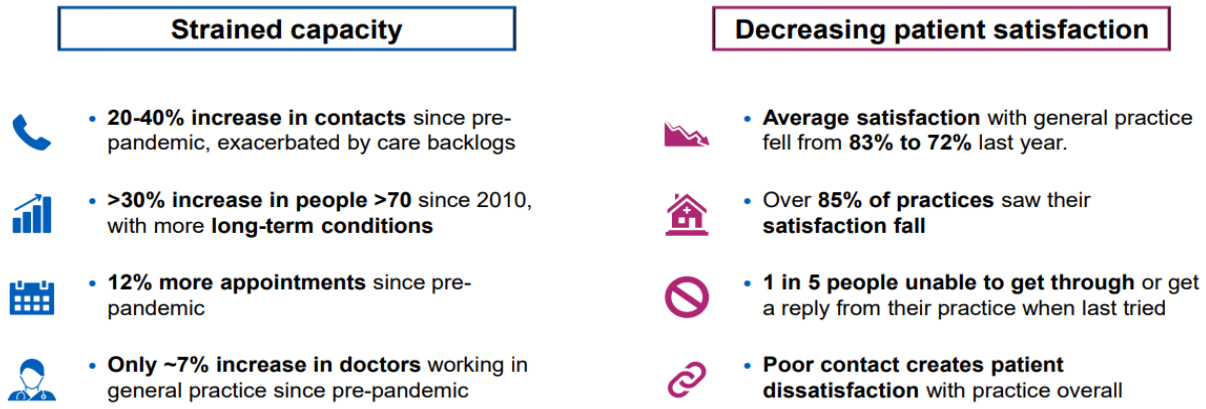
3. National Context - Delivery Plan for Recovering Access to Primary Care

This section describes the national plan for recovering access to primary care, why it was brought in and what it aims to do. This plan describes how we will locally implement that national plan, with the detailed response in section 5.

Why was the national plan developed – drivers for change?

Like many parts of the NHS, general practice is under intense pressure. Where demand is greater than capacity it means general practice cannot always be effective, and patient experience and access are negatively impacted.

The diagram below describes the situation general practice has found itself in with strained capacity and a decrease in patient satisfaction.



These patient experiences sentiments are also echoed on a local level. They are highlighted in the Insight theming document that was developed for the ICS strategy. This document looked at 2 years of patient experience reports mainly from the Derby and Derbyshire system and their key messages. Primary Care access was a key theme throughout the document around decreasing patient satisfaction. Here is the full document.

In May 2022, the Next Steps for Integrating Primary Care: Fuller Stocktake Report[1] was published. This was commissioned by Amanda Pritchard (NHS England CEO) and outlines a new vision for primary care that reorientates the health and care system to a local population health approach through building integrated neighbourhood teams, streamlining access and helping people to stay healthy.

This key report provides practical steps that integrated care systems (ICS) and national leaders need to take to create this shift through locally driven change. The report was published prior to formation of ICSs and provides specific and practical advice on how they should accelerate the implementation of integrated primary care. All ICS Chief Executives were signatories to this report.

[1] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

In October 2022, The Health and Social Care Select Committee published a report exploring the future of NHS general practice[2]. The inquiry examined the future challenges facing general practice in the next five years as well as the current and ongoing barriers to access. The report outlines a challenging picture of general practice in crisis, with the government and NHS England neither acknowledging nor remedying the situation. The crisis is caused by a depleting GP workforce and ever-increasing demands on services from an ageing, more clinically complex population, resulting in the increased use of expensive locum doctors. The report includes a number of recommendations focused in four areas: access to general practice; continuity of care; general practice and new NHS organisations; and the GP partnership model.

What are the main elements of the national plan?

To try and address the challenges being faced NHS England published the Delivery Plan for Recovering Access to Primary Care in May 2023(PCARP). The plan has two central ambitions:

1. To tackle the 8am rush and reduce the number of people struggling to contact their practice. Patients should no longer be asked to call back another day to book an appointment, and we will invest in general practice to enable this.

2. For patients to know on the day they contact their practice how their request will be managed.

a) If their need is clinically urgent it should be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their practice in the afternoon they may be assessed on the next day, where clinically appropriate.

b) If their need is not urgent, but it requires a telephone or face-to-face appointment, this should be scheduled within two weeks.

c) Where appropriate, patients will be signposted to self-care or other local services (e.g., community pharmacy or self-referral services).

The plan seeks to support recovery by focusing this year on four areas:

- Empowering patients
- Implementing Modern General Practice Access
- Building capacity
- Cutting bureaucracy

To deliver the central ambitions of the national plan there needs to be a sustained focus on the 4 areas mentioned above. NHS England have identified specific initiatives against each of these to support delivery of the plan. They are:

[2] https://committees.parliament.uk/publications/30383/documents/176291/default/

Empowering patients

Empower patients to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy. This will relieve pressure on general practice. By rolling out tools patients can use to manage their own health, and invest up to £645 million over two years to expand services offered by community pharmacy.

1. Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024.
2. Ensure integrated care boards (ICBs) expand self-referral pathways by September 2023, as set out in the 2023/24 Operational Planning Guidance.
3. Expand pharmacy oral contraception (OC) and blood pressure (BP) services this year, to increase access and convenience for millions of patients, subject to consultation.
4. Launch Pharmacy First so that by end of 2023 community pharmacies can supply prescription-only medicines for seven common conditions. This, together with OC and BP expansion, could save 10 million appointments in general practice (nationally) a year once scaled, subject to consultation.

Implementing Modern General Practice Access

The plan is to change how practices work by implementing the 'Modern General Practice Access' programme. This aims to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another time. The aim is that patients know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online message. Nationally the NHS is re-targeting £240 million, with much of that funding to move practices from analogue to digital phone systems.

5. Support all practices on analogue lines to move to digital telephony, including call back functionality, if they sign up by July 2023.
6. Provide all practices with the digital tools and care navigation training for Modern General Practice Access and fund transition cover for those that commit to adopt this approach before March 2025.
7. Deliver training and transformation support to all practices from May 2023 through a new National General Practice Improvement Programme.

Building Capacity

The national plan aims to build capacity to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed. So practices can offer more appointments from more staff than ever before.

8. Make available an extra £385 million in 2023/24 to employ 26,000 more direct patient care staff and deliver 50 million more appointments by March 2024 (compared to 2019).
9. Further expand GP specialty training – and make it easier for newly trained GPs who require a visa to remain in England.
10. Encourage experienced GPs to stay in practice through the pension reforms announced in the Budget and create simpler routes back to practice for the recently retired.
11. Change local authority planning guidance this year to raise the priority of primary care facilities when considering how funds from new housing developments are allocated.

Cut Bureaucracy

The national plan aims to cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practice have more time to meet the clinical needs of their patients. The aim is to give practice teams more time to focus on their patients' clinical needs.

12. Reduce time spent liaising with hospitals – by requiring ICBs to report progress on improving the interface with primary care, especially the four areas we highlight from the Academy of Medical Royal Colleges report, in a public board update this autumn.
13. Reduce requests to GPs to verify medical evidence, including by increasing self-certification, by continuing to advance the Bureaucracy Busting Concordat.
14. Streamline the Investment and Impact Fund (IIF) from 36 to five indicators – retarget £246 million – and protect 25% of Quality and Outcomes Framework (QOF) clinical indicators.

4. Our long-term vision for access in Derby & Derbyshire

As referenced at the start of this document, the GPPB are working on developing a 'Sustainable Clinical Model for Primary Care in Derby & Derbyshire'.

The core purpose of the work is to support the development of a new, sustainable Primary Care Model for Derby and Derbyshire. The aim is to give people hope, by demonstrating how we can mitigate the crisis facing primary care, through a shared vision for improving quality of care and staff working lives. In doing so we will build on improvement work already in train and the considerable strengths of our current services.

The core scope of this document is the care that is delivered or overseen by General Practices and Primary Care Networks (PCNs). However, the new model is consistent with and will inter-relate with the Joined-Up Care Derbyshire (JUCD) approach for transforming community services, including the Team Up service, reflecting the critical role community services have in supporting primary care. The model also assumes co-ordinated input from mental health, secondary, local authority funded and VCSE provided care, and other elements of primary care - community pharmacy, optometry, and dentistry services.

The vision is for a sustainable, thriving primary care system that is at the core of integrated care delivery in Derby and Derbyshire, at all levels of scale.

Delivering this vision requires a radical re-imagining of how primary care services are provided, with the population stratified into three cohorts – (1) low complexity, (2) high and rising complexity, and (3) extreme complexity.

There will be standardised care models for each cohort that optimise care quality within the constraints we face, providing all people with access to comprehensive, coordinated, and continuous services.

This innovative clinical model is informed by the Fuller Stocktake, feedback from users and local stakeholders, and clinical models that are operational and delivering significant benefits in other Integrated Care Systems.

Successful implementation will require a joined up approach to ensure there is alignment with existing primary care developments and policy asks, and enabling support from across the GP Provider Board, the ICB and Joined Up Care Derbyshire (JUCD) partners.

To be fully effective the Primary Care Model will need to be adopted across all neighbourhoods in Derby and Derbyshire, whilst recognising the need for adaptation to meet the specific needs of local populations through the engagement of local staff and users, and the avoidance of top-down planning.

This strategy is led by the GPs themselves, through Derbyshire's GP Provider Board. It is in the context of this vision that we are delivering our Primary Care Access Recovery Plan

The aims are to;

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

A summary table of the new model is detailed below:

Stratification	Population group	Clinical Model	Continuity	Staff Mix	Escalation/de-escalation	Activity examples
Low Complexity	~60% of population People that are stable and healthy that have health conditions that can be easily managed.	Delivery at population level (large population registered list) Multiple locations.	Delivered around episodes of care and around information. Access to medical record.	ACPs, FCPs Clinical Pharmacists, HCAs, Nursing associates, GP oversight. Comm pharmacists. Optom	Escalation up where clinical need dictates. Eg persistent unexplained symptoms. Escalation for invx should stay in service.	Reactive illness service. FCP. Mental health. NHS health checks. CVD primary prevention. Smears. CPCS. etc
Rising/High Complexity	~35% of population. Chronic conditions that move in and out of stability. Increasing frailty. Persistent and/or uncontrolled symptoms.	Delivered at small registered sub lists based within a small number of distributed locations.	Focus on relational continuity with a small team.	GPs, Practice nurses, Clinical Pharmacists, ACPs	Seeks to de-escalate where possible back to low complexity. Eg Cancer patient that achieves cure.	Reactive illness service. Medication optimisation. Structured medication reviews. Long term condition management. Care planning.
Extreme Complexity	<5% of population. Heterogenous group. Multiple complex illness combined with significant psychosocial complexity. Would include EOL and severe frailty	Delivery at population utilising an integrated, multi-agency, multi disciplinary neighbourhood teams. Delivered in the location most appropriate to the needs of the patient.	Team based continuity.	GPs, ACPs, DNs, HCAs, Physio, OT, Social worker, MH, Clinical pharmacist. Specialist input where required.	Receives escalation where multi agency approach is required. De-escalated where possible eg super users.	Personalised anticipatory care planning. Reactive service to need. SMRs focused around frailty and polypharmacy.

Community Pharmacy

Community pharmacy remains a critical partner in primary care. Across Joined Up Care Derbyshire community pharmacies dispensed 6,450,329 medicines, 7,057 CPCS referrals, 1391 discharge medicines reviews, 50959, new medicines service reviews over the last year, as well as providing contraception services, smoking cessation consultations hypertension case finding.

The Fuller stocktake highlighted that the wider primary care team could also be much more effectively harnessed, specifically the potential to increase the role of community pharmacy, dentistry, optometry, and audiology in prevention, working together to 'make every contact count' into more services. Examples include in cancer diagnosis pathways, where community pharmacy plays a more active role in signposting eligible people to screening and supporting early diagnosis, building on a number of successful pilots such as those from the Accelerate, Coordinate, Evaluate (ACE) programme.

Community pharmacy embedded into ICB's provides future opportunities to deliver clinical services at locations that are readily accessible where people can reach them through a variety of transportation means by professionals who are highly skilled to deliver these. This was seen during the COVID pandemic with access to community pharmacies at easy to reach locations. A move toward a service-based contract with opportunities with independent prescribing and a greater use of technologies.

The Nuffield Trust and Kings fund publication October 2023 sets out a vision and strategy for Community Pharmacy in England over the next ten years.

Community pharmacies already provide essential support to patients through medicines supply and delivering a number of the nationally and regionally commissioned services e.g. CPCS, DMS, NMS, contraception, smoking cessation and flu and COVID vaccinations, but there is variation across the pharmacy sector in terms of capacity and capability.

The vision is to increase the capability and capacity to all pharmacies offering services including:

- Help with common illnesses with implementation of pharmacy first.
- Prescriptions for certain conditions, making use of pharmacists' independent prescribing skills (JUCD is already participating in the community pharmacy independent pathfinder which is due to commence in four sites across JUCD at end November /December 2023.
- Smoking cessation and weight management
- Targeted health checks, e.g., blood pressure and lipids.
- Support in managing some long-term conditions, e.g., CVD, Asthma, COPD, Diabetes
- A wider range of vaccinations and other public health services.

Community pharmacy continues to play an important part in communities and there is a real ability to deliver population health needs, play a vital role in primary and secondary prevention priorities and address meeting the needs in CORE20PLUS5.

Community pharmacy transition into ICB's and supporting the development of their capability can support a sustainable clinical model for the low complexity patients. The increased skills with independent prescribers and incorporating community pharmacy into clinical pathway services could support those with rising complexity as part of this plan.

5. How we will deliver the Primary Care Access Recovery plan

In the previous section we talked about the transformation to General Practice in Derby and Derbyshire and how that will change and improve how patients access services. In this section we're going to talk about the immediate plans to deliver the national access recovery plan for Primary Care.

Our approach

The NHSE Capacity, Access and Improvement Plan (CAIP) guidance states that for PCNs to receive the 30% CAIP funding, the ICBs will make an assessment based on the local improvement across the three key areas detailed in the guidance.

THE CAP CONSISTS OF TWO PARTS:	
National Capacity & Access Support Payment (CASP) **70% Payment**	**Local Capacity & Access Improvement Payment (CAIP)** **part or all of 30%**
• The Capacity and Access Support Payment for the period 1 April 2023 to 31 March 2024 is calculated as £2.765 multiplied by the PCN's Adjusted Population. • This funding will be unconditionally paid to PCNs, proportionally to their Adjusted Population • Paid via PCSE **1 in 12 equal payments over the 2023/24 financial year**	• The maximum a PCN could earn is £1.185 multiplied by the PCN's Adjusted Population as of 1 January 2023. • The commissioner will instruct PCSE Online to make the appropriate payment to the Nominated Payee of the PCN by no later than **31 August 2024.**
DD total funding £3,061,941	**DD total funding £1,312,260**

We have worked with our 18 PCNs to develop their CAIPs earlier in the year. As part of those plans they incorporated all of the requirements of the PCARP with the ambition to achieve or work towards the target where appropriate.

The plans were signed off by the Access Working Group following feedback on the draft plans submitted. We are holding mid-year reviews with the PCNs to assess their progress against the targets and provide support where necessary.

A summary of PCN plans

- Collaboration with PPGs and working towards and improvement against a 5 patient survey questions relating to ease of access
- Develop bespoke in-house surveys to engage with patients to support the results of the patient survey
- Facilitated learning time for practices on care navigation and awareness of services to enable the ability to support getting people to the right place, first time (use of QUEST sessions)
- Increase in onboarding and usage of CPCS services
- Review of websites website to ensure fit for purpose
- Development of hubs in the PCN to deliver services from
- Segmentation of population
- Triangulation of CBT / Online consultation data – addressing demand/capacity and staff management
- Integrated working with partners / voluntary organisation

Detailed Action Plans

The tables on the next pages describes the key actions from the national recovery plan, actions we are taking to achieve them, how we are going to measure them and who is responsible for delivery.

Progress to date against the key deliverables of the workstream is also included. This detail also forms a monthly highlight report that is shared through the governance structure for this programme of work.

Commitment	What do we want to do (ambition)	Actions to get there	How will we track progress (indicators)		Who's responsible
			Indication	**RAG**	
Improving information and NHS App functionality	All Practices to have enabled all four NHS App functions for patients. 1. Apply system changes or manually update patient settings to provide prospective record access to all patients **by 31.10.23** 2. Ensure directly bookable appointments are available online **by 31.07.23** 3. Offer secure NHS App messaging to patients where practices have the technology to do so in place - **ongoing** 4. Encourage patients to order repeat medications via App supported by comms toolkit - **ongoing**	All PCNs have included in their Capacity & Access plans and improvement in the use of the NHS App for the 4 functionalities.	POMI % of practices that have enabled prospective records, repeat prescriptions, secure messaging, and managing appointments) multiplied by % of population with app		Head of Digital
Increasing self-directed care where clinically appropriate	Expand self-referral routes as set out in 2023/24 operational planning guidance by **30.09.23.** 1. Falls services 2. Musculoskeletal services 3. Audiology for older people including loss of hearing aid provision 4. Weight management services 5. Community podiatry 6. Wheelchair and community equipment services ICBs should also note operational planning action to expand direct access where GP involvement is not clinically necessary.	We will continue to review and work with providers to build self-referral pathways in the few services where this is not yet available unless routes are not in place due to clinical reasons.	Our baseline self-referrals is: **1,100** Our target (50% increase from baseline): **1,650**		Assistant Director of Community Services
Expanding Community pharmacy services	Build on the success so far of the increasing role of pharmacies and expand the services offered, increasing convenience for the public by: 1. Introducing a Pharmacy First service for patients **by end of 2023** that enables pharmacists to supply prescription only medicines including – antibiotics and antivirals where clinically appropriate, to treat (sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women) 2. Expand blood pressure check and oral contraceptive services 3. Invest to improve the IT system connectivity between CP & GP 4. We will build on work already underway with regards to the CPCS service to promote community pharmacy capacity	1. National roll out expected early 2024 and webinar along with national comms plan and patient facing material. 2. Roll out BP check and contraception services 3. Digital planning 4. On-going engagement with PCN's to support increasing engagement and implementation	1. Implementation of Pharmacy First 2. Increase in blood pressure checks and oral contraceptive services – awaiting data 3. Improved connectivity 4. Increase in CPCS referrals		Director of Medicines Management

Implementing Modern General Practice Access

Commitment	What do we want to do (ambition	Actions to get there	How will we track progress (indicators)		Who's responsible
			Indication	**RAG**	
Better digital telephony	Ensure all practices who need to move from analogue to digital telephony do so **by 31/12/23 and the remainder by 31/03/24**	1. Co-ordinate access to specialist procurement support through NHS England's commercial hub 2. Determine whether ICB wants to follow scale approach to telephony 3. Use peer networks and demonstrations with practices/PPGs/PCNs to help practices and PCNs identify and adopt digital telephony	All practices on CBT		Head of Digital
Simpler online requests	Ensure that all practices are providing the contractual requirement of providing online access. A new digital framework will be provided by NHS England in December 2023	ICBs will work with PCNs and practices to decide which tools will best enable them to shift to the Modern General Practice Access model	All practices delivering online access and working towards 260/1000 referrals		Head of Digital
Faster navigation, assessment and response	Make it easier for people to contact their practice and to make getting a response the same day the norm, so patients know how their request will be dealt with.	ICBs will work with PCNs and practices to decide which tools will best enable them to shift to the Modern General Practice Access model All practices to nominate 1 member of staff to attend the Care Navigation Training and share the learning with their practice	All digital tools in place to support Modern General Practice Access Every practice has had a member of staff attend the training.		ICB/PCNs ICB/Practices

Building capacity

Commitment	What do we want to do (ambition)	Actions to get there	How will we track progress (indicators)		Who's responsible
			Indication	**RAG**	
Larger Multi-Disciplinary Teams	Continue to grow the practice team, especially roles with responsibility for direct patient care which can be part of larger MDTs. Support the Manifesto commitment of 26,000 additional FTE direct care staff in General Practice	Support PCNs to use their full ARRS budget (£26,340,697 by end of March 2024) and report accurate complement of staff using NWRS portal	100% ARRS budget spent by March 2024 Recruit to 670.47 WTE		Assistant Director of GP Commissioning (transformation)
More Doctors	We want to continue to have more new doctors in general practice by training more GPs and supporting other doctors to transition to general practice. From autumn 2023 government will introduce an additional four months at the end of a visa for newly trained GPs to remain in the UK.	Addressing pension challenges and annual and lifetime allowances Make the GP Return to Practice and International Induction programmes easier and more attractive	Data automatically collected via NWRS		NHS England
Retention and return of experienced GPs	Encourage GPs to return to general practice or to support NHS 111 In flexible roles where, for example, working from home is possible as described in the UEC recovery plan	Practices/PCN's review and take up local offers for retention Utilise full allocation of GP retention funding by March 2024	October 23 – 22 GP retainers funded. Full allocation spend of £346k		GPTF
Higher priority for primary care in housing developments	Ensure new developments are accompanied by primary care infrastructure, and that this is supported by the planning system.	ICBs have delegated responsibility to ensure that the population has adequate primary medical services. As part of normal planning processes, ICBs should work with local stakeholders and take account of areas where housing developments are putting pressure on existing services.	Link to local estates strategy		NHS England

Commitment	What do we want to do (ambition)	Actions to get there	How will we track progress (indicators)		Who's responsible
			Indication	**RAG**	
Improving the primary – secondary care interface	ICB Chief Medical Officers to establish a local mechanism, which will allow both general practice and consultant-led teams to raise local issues, to jointly prioritise working with LMCs, and to tackle the high-priority issues including those in the AoMRC report. In addition, ICBs must address four areas outlined below.	Alliance for Clinical Transformation (ACT) group (senior GP/consultant group) well established. It has developed a concordant for use across the interface. It identifies problems and develops solutions. Additional capacity required to support continued development. Recommendations go for sign off by system Clinical Professional Leadership Group (CPLG) and implementation by providers via the Provider Collaborative Leadership Board (PCLB)	ACT group established, discussing issues and generating solutions ICB CMO attending and supporting Recommendations going to CPLG and PCLB for sign off and implementation Standing agenda item at CPLG led by ICB CMO, with input from GPPB and LMC CPLG working through list of issues prioritised by ACT		ACT; GPPB; LMC; acute MDs ICB Chief Medical Officer CPLG
Improving the primary – secondary care interface	**Onward referrals**: if a patient has been referred to secondary care and they need another referral, for an immediate or a related need, the secondary care provider should make this for them, rather than sending back to General Practice which causes a further delay.	Refresh existing consultant to consultant referral policies with input from primary care. Review and optimise use of advice and guidance between consultants within hospital	Consultant to consultant policies updated and signed off by CPLG and PCLB Consultant to consultant A&G reviewed and updated		ICB Chief Medical Officer overseeing work by Acute Trusts with GPPB and LMC input

Improving the primary – secondary care interface	**Complete care (fit notes and discharge letters)**: trusts should ensure that on discharge or after an outpatient appointment, patients receive everything they need, rather than leaving the patients to return prematurely to their practice. **By 30th November 2023**, provider of NHS-funded secondary care services should have implemented the capability to issue a fit note electronically.	Discharge policies already include requirement for patients to have what they need on discharge (including fit notes) Further work needed to develop IT infrastructure to support acute trusts to issue electronic fit notes E-prescription roll out due for summer 2024	Programme of review and audit of discharges to ensure that patients have what they need Electronic fit notes issued by hospitals E prescription rolled out		Acute hospital leads Assured by ICB CMO
Improving the primary – secondary care interface	**Call & recall**: for patients under their care, NHS Trusts should establish their own call/recall systems for patients for follow-up test or appointments meaning patients will have a clear route to contact secondary care and not have to ask their practice to follow up on their behalf.	Acute Trusts have range of call/recall options including patient initiated follow ups and open appointments Clinics communicate direct points of contact for patients, though this is not yet fully standardised Acute Trusts to roll out monthly calls to patients on waiting lists as touch point and reassurance and to check appointment still required Optimise use of 'my planned care' to increase take up and provide more accurate indicative waiting times	Audit %age of GP work that relates to acutes. Currently estimated at c23%. Aim to reduce. Standardise comms to patients with clear direct contact points for patients Roll out of monthly calls – commencing October 23 Improved accuracy of waiting list times on MPC Higher patient take up and use Winter priority/opportunity to support GenP resilience by releasing 20% of daily contacts related to management of patients on waiting lists.		Acute hospital leads Assured by ICB CMO

Improving the primary – secondary care interface	**Clear point of contact**: ICBs should ensure providers establish single routes for general practice and secondary care teams to communicate rapidly e.g., single outpatient department email for GP practices.	Optimise and standardise use of 'advice and guidance' Optimise use of consultant connect Ensure standard and straightforward comms point for GP practices to reach acute clinical teams and vice versa	Standard and optimised uptake of A&G and Consultant Connect – monitored through audit with feedback loop in place to support use 'Backdoor' phone and email contact points for GP & acute teams with agreement on how they will be used		Acute hospital leads Assured by ICB CMO
Building on the Bureaucracy Busting Concordat	Reduce the demands on practice time from unnecessary or low value asks and improve processes for only the most important requests for medical evidence.	Annual audit of primary secondary care contract requirements and action plan Continue to reduce medical evidence requests and increase self-certification	Annual audit and implementation plan in place Reduction in medical evidence requests and increase self-certification		ICB commissioning team to co-ordinate overseen by CMO, with input from LMC & GPPB

Cloud-based Telephony

National support is available to enable 1,000 practices to transition to digital telephony by December 2023. The expectation is that all remaining analogue practices will move to digital telephony by March 2024. Of the 113 practices across Derbyshire, DDICB has **34** practices who are listed by NHSE as critical and need to migrate to Cloud-based Telephony (CBT) by 31 March 2024. One practice has reached an agreement with their chosen provider and is on track with their migration.

Progress against this deliverable is tracked monthly with the NHSE/I Procurement Hub who can assist with any issues.

NHS App

To make better use of data and digital technology practices are to utilise the new NHS App as a digital 'front door'. As of August 2023, 98.2% of practices were offering the book and cancel appointment's function and all practices are offering the repeat prescriptions within the NHS App. The two practices that are not currently offering the appointments function have all been contacted to understand any issues with enabling this function.

Work is ongoing with practices to ensure full functionality within the NHS App, including secure app messaging.

Online Consultations

Whilst national level engagement with the market continues, and the timeline for the launch of the framework is confirmed, DDICB will work with practices to fully understand the contracting position for their online consultation solutions currently in use.

As of August 2023, 48 practices were on track to achieve the Online Consultation Usage target (although not contractual) of 260 per 1000 registered patients per annum, and 24 practices are already surpassing the target. There are a small number of practices that have none or very low numbers of online consultations. However, there are national issues with retrieving data from the footfall platform resulting in data quality issues. Work is taking place to rectify these issues, so DDICB has an accurate picture of performance.

Engagement with PCN Operation Managers to encourage increased uptake of Online Consultation is ongoing and will be discussed with PCN's during their PCARP mid-year review meetings.

Digital Framework

DDICB are awaiting the release of the national digital framework. In the meantime, our PCN Managers have been working together to develop a specification of requirements for a front end triage tool to support navigation. They are currently engaging with staff and patients regarding options.

General Practice Appointment Data (GPAD)

GPAD category mapping was introduced by NHSE in 2021/22. Practices were incentivised to map all active appointment slots by 30 June 2021 to the new set of national appointment categories via the Investment and Impact Fund, as part of the Primary Care Network Contract DES. One of the specified GPAD categories is percentage of appointments seen within 14 days from booking.

As of August 2023, 60 practices are seeing at least 85% patients within 14 days of booking an appointment, with more than half of these are seeing 90%+ patients within 14 days. We expect this figure to improve once the exemption flags are operational within the clinical systems, which will allow practices to indicate whether the appointment is a follow-up/patient choice and not required to be seen within the 14 days.

Data is shared on a regular basis with PCNs to support them to achieve this target and DDICB will continue to work with the practices who are outliers.

Care Navigation Training

This training is being offered by NHSE and plays a crucial aspect of implementing modern general practice access and is aimed at reception staff. To date, 54 practices have signed up to participate in the national Care Navigation Training.

DDICB will continue to communicate out to PCN Operation Managers to encourage uptake of the training. This will also be discussed with PCN's during their PCARP mid-year review meetings.

General Practice Improvement Programme (NGPiP)

This national programme includes Universal, Intermediate, Intensive and Local levels of support. Programmes focuses on implementing 'modern general practice' operating models and introduces the Support Level Framework (SLF) tool. DDICB have 35 practices signed up to NGPiP and one PCN. We are awaiting details from NHSE/I regarding the number of practices who have signed up to participate in the Leadership element of the programme.

Offer type	Confirmed spaces	% of practices
Practice Intensive	15	13.2%
Practice Intermediate	20	17.7%
PCN Intermediate	1	5%
Leadership	TBC	TBC

Following participation in the NGPIP these practices will be implementing the Modern General Practice Access Model and will therefore be ringfenced for Transition Funding to make these changes.

Local Improvement Offer

The Access Working Group have designed a process for accessing funding for those practices who are implementing the Modern General Practice Access Model during 2023/24 but not taking part in the NGPiP. The criteria for application is based on the NGPiP and the outcome measures also reflect what is required as part of the national programme. We are keen to implement a 'train the trainer' model working with out GP Task Force to support this.

GP Community Pharmacy Consultation Service (GP-CPCS)

The General Practice Community Pharmacist Consultation Service is a pathway general practices use to refer patients with minor illness or low acuity conditions to a community pharmacist. Launched by NHSE in October 2019, it aims to facilitate same day appointments with a community pharmacist for minor illness or an urgent supply of a regular medicine, improving access to services and providing more convenient treatment closer to patients' homes.

All DDICB practices are engaged with the GP-CPCS scheme. Locally, we have made the decision to include the scheme within the PCARP with the aim of increasing the number of referrals into the service by the end of March 2024.

Stage	Stage 1: Pre-engaged	Stage 2: Engaged	Stage 3: Live
Number of practices	12	27	74
% of practices	11%	24%	65%

However, despite the engagement there are several challenges with this scheme. Three of our PCNs are making low or no referrals into the scheme and have requested support from DDICB to discuss the difficulties they are experiencing.

The GP-CPCS Steering Group and GP-CPCS Operational Group are held monthly, and any issues/next steps are discussed and agreed between these groups. DDICB will continue to focus on the practices in stage 1, using information from the PCARP to identify practices.

Support Level Framework (SLF)

The Support level framework (SLF) is a tool to support practices in understanding their development needs and where they are on the journey to embedding modern general practice. The SLF has been co-produced with general practice teams and clinically developed based on knowledge and experience, research, and best practice, where available.

As part of the SLF, visits will be undertaken by NHSE. Of the 33 practices signed up to NGPiP, **3** have already had their visits completed by NHSE. DDICB have not started undertaking visits yet but are engaging with practices to encourage them to sign up to the NGPiP programme. A bulletin has been circulated to all other practices explaining the programme and its benefits. Whist it is not a contractual requirement, as an ICB we are recommending that practices take advantage of this offer. A small working group has been established focusing on uptake and our approach.

GP Registration Service

The Register with a GP surgery service gives all GP practices in England a standardised way of taking registrations online. Currently, DDICB have the lowest sign-up rate, 16.8%, compared to other ICB's in the Midlands region, who have achieved 25.1%. NHSE have set a target of 33% for the region to be achieved by 31 December 2023.

DDICB are promoting all upcoming webinars to practices and are considering arranging a local webinar to be delivered by NHSE to encourage practice sign up.

Self-referral Pathway

The clinical development and promotion of self-referral pathways for professionals and service users is key to managing demand and preserving access to general practice in Derbyshire. This will mean patients do not need to contact their practice, or will provide another, clinically appropriate, alternative care option.

DDICB have undertaken the initial national self-assessment, with a second self-assessment completed in late September. Our baseline figure for self-referrals is 1,100 and our target is 1,650, which is a 50% increase from baseline.

We will continue to review and work with providers to build self-referral pathways into the few services where this is not yet available, unless clinically inappropriate. We are awaiting data outlining the levels of self-referrals that have been delivered so we can accurately understand our position against the 1,650 target. Once available, the data will be built into our community performance.

Empowering patients to safely utilise self-referral pathways, and supporting our practices to empower their patients, is a key strand of our Recovery Plan Communications strategy.

GPN Workstream

General Practice Nursing is a key component of delivering proactive and reactive care in line with the Access Improvement Plan, yet it remains an incredibly vulnerable area of the workforce. A significant proportion of our workforce is > 40 with approximately 33% of Derbyshire GPNs over the age of 55. Whilst there has been support for advanced practice and nursing associate roles via ARRS, the core workforce has not received the same spotlight.

With GPN numbers teetering on a cliff edge, and in line with the 2021 Sonnet Report, a significant amount of work, led by The Hub Plus, is underway to elevate the GPN role, strengthen GPN leadership and fundamentally support and retain our nurses.

Practice Management

Practice Managers are the linchpin of a strong general practice, playing a key role in maintaining quality care and ensuring a practice is future ready. The role can feel relentless and isolating. As a system we appreciate how important accessible, responsible, and relevant training is for busy practice mangers. It is also imperative we foster a strong pipeline of future practice managers. The ICB is supporting The Hub Plus to continue to deliver their successful Practice Manager Induction Programmes and Step UP.

Staff wellbeing

With plans to build capacity and improve access we must be cognisant of our responsibility to 'look after our people'. Lessons learnt over the pandemic and ongoing post-pandemic recovery have emphasised the need to provide and promote a catalogue of wellbeing offers for both individuals and organisations. Since 2020 we have had a dedicated Primary Care wellbeing workstream which works alongside the Joined-Up Care Derbyshire Wellbeing team. Whilst funding for these workstreams is no longer provided centrally it remains a local priority to ensure service delivery changes are delivered by a supported and well workforce, building on the principles of the NHS People Plan.

Fellowships (GP & nurses)

Provision of fellowship schemes that offer a two-year programme of support, to all newly qualified GPs and nurses, including new to practice nurses, working substantively in general practice – with an explicit focus on working within and across PCNs. Participants will receive funded mentorship and CPD opportunities and rotational placements within or across PCNs of up to one session per week, to develop experience and support transition into the workforce.

Supporting Mentors Scheme

Provision of opportunities for experienced GPs working in primary care, to support less experienced GPs through high quality mentoring. With a key aim of increasing retention of experienced GPs through access to mentor training and opportunities, and increased retention of less experienced GPs through high quality mentoring support, leading to increased GP FTE.

Local GP Retention

Provision of continued support through the scheme to encourage and support local action to minimise attrition of the GP workforce. To work with local practices and networks to develop a local action plan to support the retention of GPs within the workforce, aiming to:

a. retain GPs at points of transition in their career (e.g., nearing retirement or seeking to return from a career break);
b. support new ways of working and embed flexibility for GPs

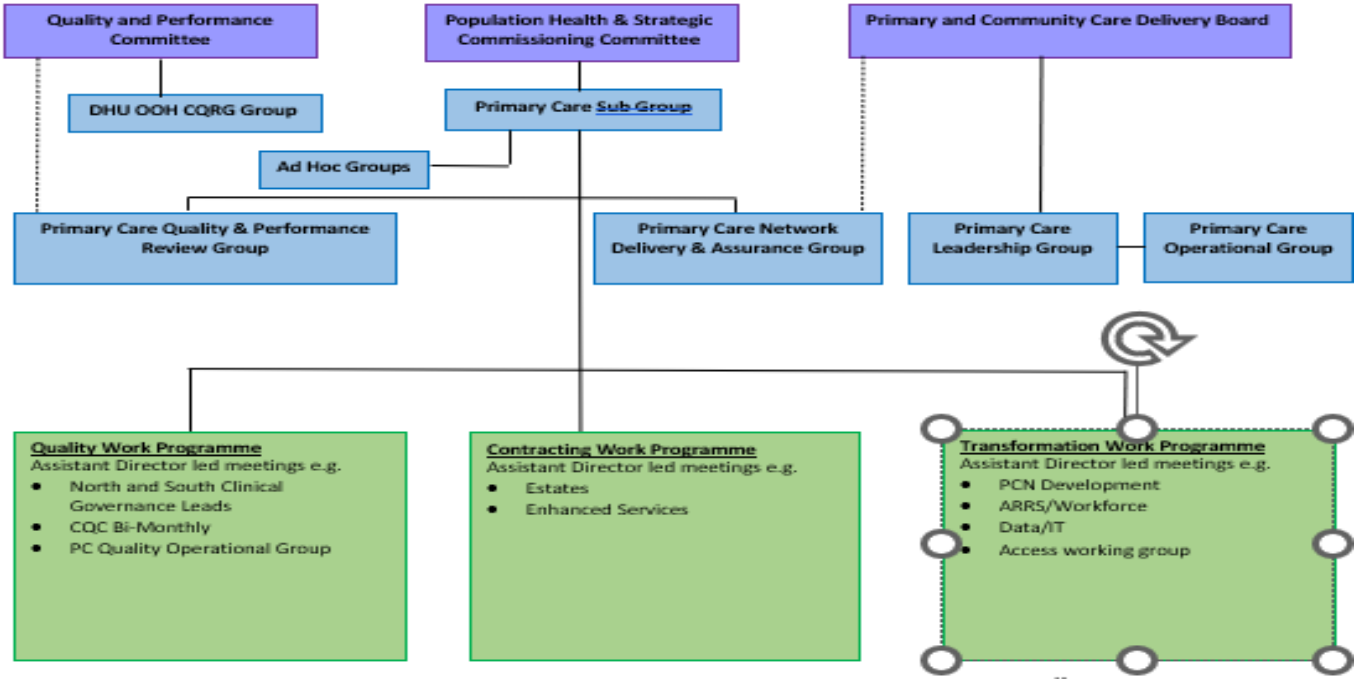
6 How we will organise ourselves to deliver and govern the plan

The Primary Care access recovery work is overseen by Clive Newman, Director of Primary Care (SRO). The ICB work collaboratively with other partners on this programme of work including, but not limited to the following:

- Primary Care Networks – this is with both Clinical Directors and PCN managers.
- GP Provider Board who provide a collaborative voice for developing the future of general practice provision within the Derby & Derbyshire health and care system.
- Derby & Derbyshire Local Medical Committee
- General Practice Task Force (GPTF) who now deliver the Training Hub for Derby & Derbyshire amongst many other things including System Development Fund schemes.
- Community Pharmacy Derbyshire (formally LPC)

The PCARP programme of work is managed via the Access Working Group which is a subgroup of the Primary Care Network Delivery & Assurance Group that oversees the PCN DES. The group has representation from the ICB, GP Provider Board, LMC & GPTF. The group meet monthly to discuss progress against the plan and advise on any issues/barriers that are being met. Overall accountability (particularly financial) for the work sits with the Derby & Derbyshire Primary Care Subgroup. Assurance of delivery for the programme of work is also provided by the Primary & Community Care Delivery Board that comprises of stakeholders from multiple other organisations in the Derby & Derbyshire system. The diagram below illustrates the governance for the programme of work.

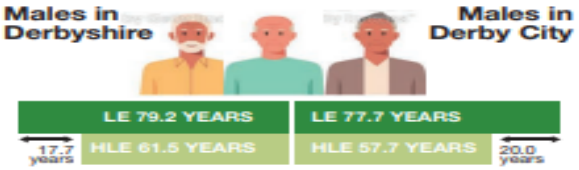
It is important to note that whilst this is a general practice plan it needs to be owned by the system. There are a number of things within the action plan are outside the control of general practice and will require the commitment of system partners.



7. How we will help those who need help the most – managing inequalities

Many people in Derby and Derbyshire live for a long time with long-term and often multiple conditions and there are stark differences in rates of healthy life expectancy between populations. There are similarly striking differences in life expectancy rates when comparing the least and most deprived populations.

Life expectancy



Life expectancy was significantly **worse** for women compared to England. Life expectancy for men was **similar** to England. Healthy life expectancy for both men and women was **significantly worse** compared to England.

Life expectancy was significantly **worse** for both men and women compared to England. Healthy life expectancy was **significantly worse** for men compared to England Healthy life expectancy for women was **similar** to England.

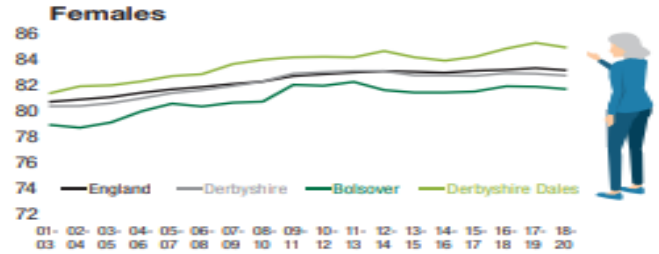
LE = Life expectancy **HLE** = Healthy life expectancy

Public health profiles - OHID (phe.org.uk) accessed 31/03/2023

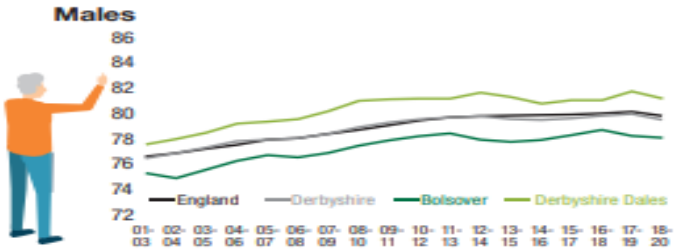
Cost of Living Vulnerability Index

Local Authority	Rating	Ranking*
Derby City	1193	78
Bolsover	1181	83
Chesterfield	1035	119
Amber Valley	1003	126
Erewash	955	144
High Peak	912	152
North East Derbyshire	656	219
Derbyshire Dales	640	222
South Derbyshire	522	252

*Ranking (out of 307). 1 = most vulnerable.

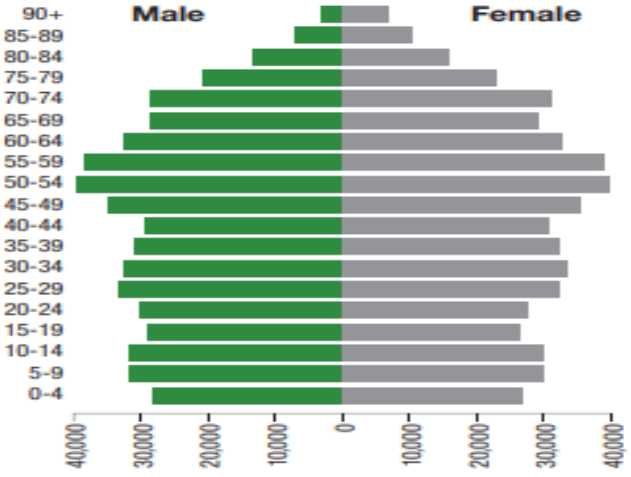


Bolsover had a significantly worse life expectancy compared to the average for England.



Bolsover had a significantly worse life expectancy compared to the average for England.

Population Pyramid

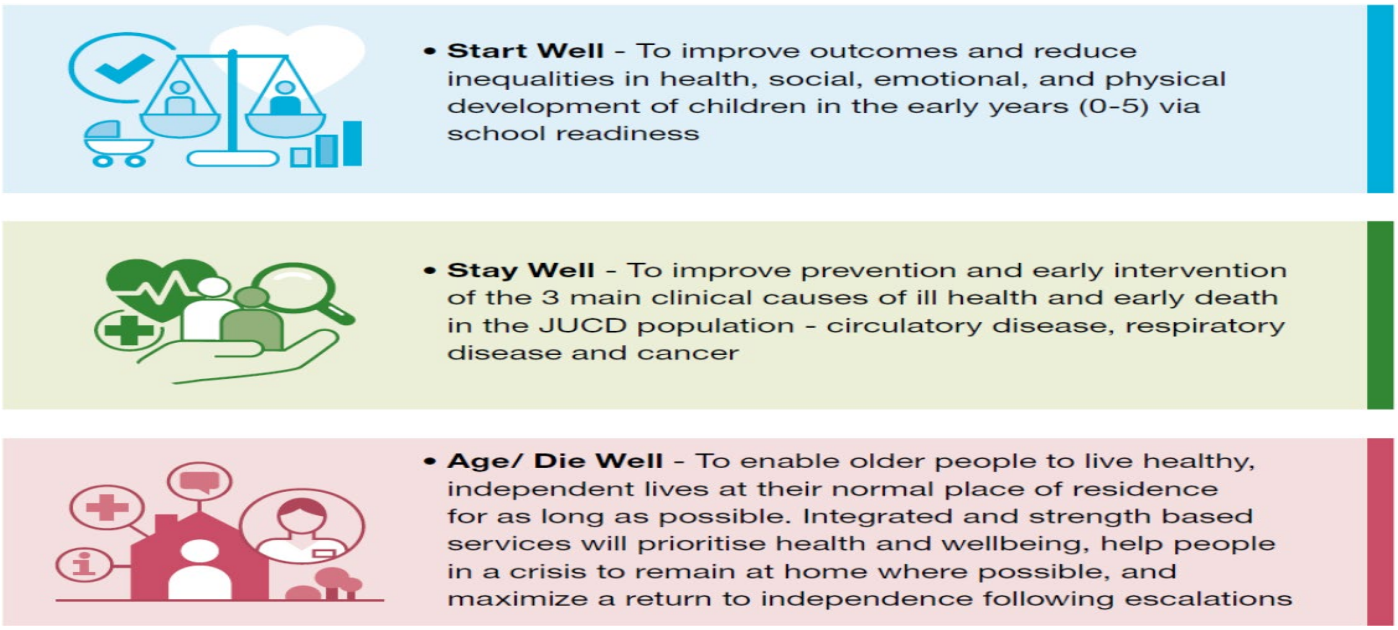


Source: SHAPE atlas accessed 31/03/2023

Population outcomes

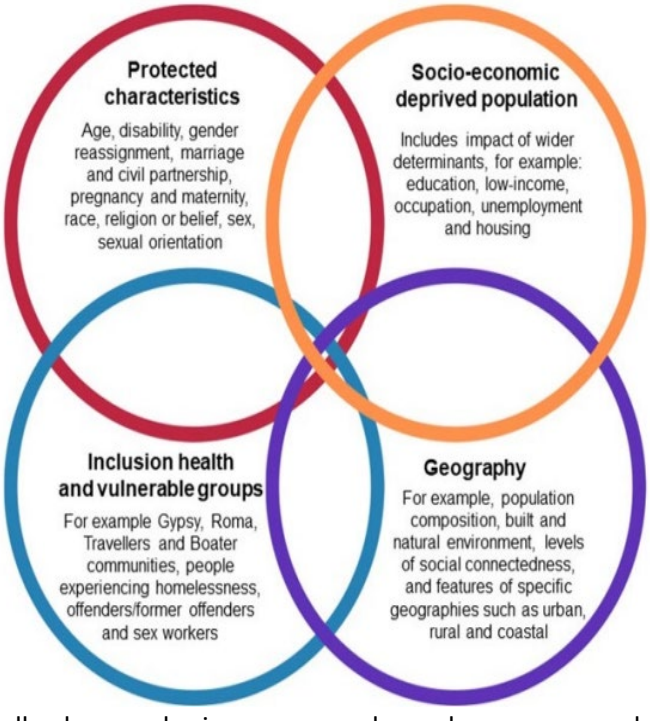
Work has been undertaken by JUCD System colleagues to develop a set of priority population outcomes and key indicators (known as Turning the Curve indicators) based upon the Derby and Derbyshire Joint Strategic Needs Assessments (JSNAs). These focus on increasing life expectancy, increasing healthy life expectancy, and reducing inequalities.

The following statements have been developed by the JUCD System to describe if the population was living in good health, it would be experienced as follows:



Health Inequalities

'Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions, or determinants, influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing' (Addressing health inequalities through collaborative action)



Local patient and public insight: The ICS theming document has sub-section on health inequalities. This looks at experiences and key barriers from people with protected characteristics, vulnerable groups and areas of high deprivation. Derby Health Inequalities Partnership (DHIP) conducted a Community Consultation in Derby City in 2021/22. Seven overarching themes were identified from the thematic analysis: health issues, community, health services, health behaviours, information, service issues and the need for action. The report highlighted in-depth feedback around primary care and gave key recommendation. Here is the full report.

Fig: (Addressing health inequalities through collaborative action)

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Health Inequalities leads

All 18 our PCNs have named Health Inequalities leads who are the visible leads for health inequalities in the PCN. The table below indicates the chosen area of health inequality that the PCN are focusing on.

PCN	Lead	Target Population
C. & Dronfield	Dr Upendra Bhatia	Identify PCN Spirometry Service & bookings ongoing –Increase Childhood Immunisations, cytology, identify frail & isolated over 85's are being reviewed – Planning to be updated
N.Hardwick & Bolsover	Dr McMurry/Nicola Gerrard	Diabetes – highest levels of inactivity and obesity in the country – local programme in place focusing on this area
Derbyshire Dales	Mark D'Apice/Rich Gooch	Target rural areas with few or no existing links to support services – Currently reviewing
Erewash	Sara Bains	Involved in the population health improvement 22 wk programme initially – Sara working with the wider Derbyshire system
Greater Derby	Dr Gillian Davidson (Dr Drew Smith – City Lead)	Derby city wide approach – Dr Drew Smith & Madeleine Corbyn City Lead contacts - communication barriers, learning disabilities, hard of hearing and sight, PSA tests for black men across the City*
DCN	Dr Drew Smith	Derby city wide approach - * Dr Drew Smith & Madeleine Corbyn City Lead contacts
Oakdale Park	Fiona Bolstridge (Dr Drew Smith – City Lead)	Derby city wide approach - * Dr Drew Smith & Madeleine Corbyn City Lead contacts
PCCO	Dr Mahya Johnson & Dr Sophie Harvey (Dr Drew Smith – City Lead)	Derby city wide approach - * Dr Drew Smith & Madeleine Corbyn City Lead contacts
South Hardwick	Dr Dan Stinton	Socioeconomic deprivation - focussing on the over-prescription of opioids and gabapentinoids for non-cancer pain.
Belper	Rebecca Eve	Previous leads have left which has impacted the PCN and plans are now being reviewed
NED	Dr Naveen Jayadev	TBA – Awaiting update from PCN
Swadlincote	Dr Sue Clover	Lack of a walk in centre or GP lead OOH service - ongoing work with support from wider system colleagues to implement & embed inequalities plan
ARCH	Dr Justine Reid	Change of PCN Business lead – require guidance
DCS	Dr Eshan Peiris / Sam Harper (Dr Drew Smith – City Lead)	Derby city wide approach - * Dr Drew Smith & Madeleine Corbyn City Lead contacts (DCS PCN -targeted a wide range of different populations dependant on geography and also the specific area of medicine eg those who don't speak English and/or use sign language (Social Prescribing); patients who are not digitally literate (access)
High Peak	Dr Chris Harvey (interim)	Military Veterans - with a plan around sharing best practice, achieving Veteran Friendly status and working with PLACE/lay colleagues
South Dales	Alexa Kay	Rural with few or no existing links to support services – reviewing plan
Glossop	Dr Alan Down & Sharon Snape	RUN project (reaching the unreachable; those patients that have not visited practices between 3-5 years) with a higher prevalence of cancer, COPD and depression than national average, working on prevention in these areas & developing a risk register with this project
North Derbyshire	Dr Peter Scriven	Reviewing plan TBC – New lead starting December

Support to practices in areas of deprivation

During winter 22/23 an additional £400k was used to support the top 20% of practices (23 in total) with the highest deprivation scores in Derby & Derbyshire was provided. This additional funding allowed these practices to deliver a further 2,000 appointments from November through to March.

NHS England Frameworks published to help systems reduce health inequalities

NHS England has published two new frameworks to support work to reduce health inequalities: The Digital Inclusion Framework supports work to design and implement inclusive digital approaches and technologies; while the Inclusion Health Framework provides practical information to support NHS systems and their partners to take practical action on reducing health inequalities for inclusion health groups, such as people experiencing homelessness and Gypsy, Roma, and Traveller communities.
Digital Inclusion Framework

Inclusion Health Framework

We will encourage our practices to utilise these frameworks to ensure that they are working towards reducing health inequalities.

Following feedback at Population Health Strategic Commissioning Committee (9.11.23) from the Public Health Team at the Local Authority we will explore opportunities with local libraries to support people to learn about how the can access digital services in Primary Care.

8. How we will invest local and national funding to deliver the plan

The table below sets out how the funding that has been identified as part of the GP improvement plan will be used and maximised in each area.

The ICB will ensure that funding is spent in year with practices and PCN's across Derbyshire, with the deliverables being closely monitored against the funding envelopes given. Funding will be paid in a timely way, per the ICB's agreement with the providers utilising the payment mechanisms that are already in place and working well.

The funding has been split out into the categories below and therefore, there is assurance that the funding to support primary care is being used in addition to existing funding for it's intended purpose. Derby and Derbyshire ICB are aware of the amount of existing funding being spent across primary care, how this splits across different schemes and how this benchmarks in the midlands systems. This provides a baseline for current spend which can be monitored to ensure that this continues to be in line going into future years.

Additional funding for primary care in 23/24	£	**How will funding be used and maximised to deliver the plan?**
Transition cover and transformation support funding	785,000	33 practices going through the national GPIP programme will require transition funding. The remaining will be used on a application basis for the local improvement programme
Cloud based telephony transfer funding	918,000	Funding used to support 29 practices that are required to make the transition to cloud based telephony, working with NHSE procurement to negotiate transitions
Digital 0.93p per weighted patient	1,080,539	Online consultation, messaging and front-end triage
Capacity and access support payment (guaranteed element 70%)	3,061,941	Examples of spend against this budget detailed below. **Note** – this is not 'new' money this was IIF funding in previous years but has been recycled to support Access in 23/24
Capacity and access improvement/ incentive payment (based on achievement of indicators 30%)	1,312,259	An end of year assessment against CAIP plans will be made. **Note** – this is not 'new' money this was IIF funding in previous years but has been recycled to support Access in 23/24
ARRS (additional value for 23/24 per allocation given)	6,814,000	Funding being monitored closely in line with PCN recruitment plans, working to ensure the maximum number of staff can be employed through this funding stream in line with guidance
ARRS (funding required from ICB in line with contracts without national funding to support, high risk)	1,135,697	This funding is the difference between the ARRS allocation given and the contractual amount per the PCN DES. This would have to be funded from the ICB core funding, which would worsen the current reported position. This funding would need to be given to the ICB in addition to the £6.8m above to ensure contacts are fulfilled.
TOTAL	**15,107,436**	

Appendix 1

Money as part of the improvement plan, not 'new' for 23/24 onwards		
System development funding	2,259,000	
Enhanced access	8,391,824	
Leadership and Management	757,457	
IIF	1,059,168	
ARRS (funding allocated against costs in 22/23)	18,391,000	Funding which is supporting staff already in post as part of the ARRS, monitored through the workforce portal.
TOTAL	**30,858,448**	
Overall total national funding for PC improvement plan	**44,830,187**	
Overall total funding required from DDICB for PC improvement plan	**1,135,697**	

As part of the Capacity and Access Improvement plans developed at a PCN level the PCN received 70% of their funding unconditionally to support improving access. Below are just some examples of how this funding has been spent so far:

PCN	70% CAIP Funding Spend Examples
Glossop	1. Those with cloud telephony – but not got facilities for example queue booster have contacted their providers and are in the process of adding these facilities and utilising the funds to cover the additional costs of adding these extra facilities to their existing systems 2. Run and continue to push joint campaigns around Friends and Family utilising QR codes, NHS app knowledge etc utilising QR codes to improve uptake across the 5 practices using social media, waiting areas, websites etc 3. Released staff to attend Care Navigation training along with the advance care navigation training - Back fill funding to enable release of these staff 4. Release care navigation champions from each practice to meet and share their knowledge and start to work to compile a standardised care navigation template that can be shared as a cross organisational template within all the 5 practices – each manager and a clinician from each practice will then input and support this work to ensure we can implement this going forward. 5. We also plan to get our care navigation champions to compile a training module which will include how to use the care navigation tool/template they will have designed, so that we can then share and set up training for all our front line staff to ensure all working collaboratively and to a s well-structured and standardised way. 6. In the absence of being able to employ salaried GPs, one of our larger practice and a smaller practice as utilised some of their funding to provide more Paramedic and ANP hours in order to cope with the current demand and reduce pressure on the current GPs. 7. Another smaller practice as used some of the funding to employ extra services for example GP , phlebotomy and HCA hours to help with the current demand and pressures faced within primary care
Derbyshire Dales	1. Derbyshire Dales PCN plan to use the funding to support waiting room machines that are integrated with Systmone. This will free up time to deal with winter pressures, and will also offer ongoing time saving to be able to react to extra pressures.

	2. Derbyshire Dales are re engineering their appointments system (trial run 3/10/2023) to provide immediate GP access and additional appointments
ARCH	1. ARCH PCN have appointed clinical leads into the PCN using some of the 70% capacity/access funding. They lead on Mental Health, Pharmacy, CVD, Health inequalities, Cancer, Practice nurse support and development (ANP and a practice nurse)
Swadlincote	1. All 5 practices within Swadlincote PCN are participating in NGPIP and will utilise the funding to support the change to Modern General Practice Access Model 2. Work is underway to form a PCN PPG with member representation invited from each surgery PPG 3. Define frequent attenders and look at data to develop care plans to support those identified with a view to reducing contacts whilst achieving a positive outcome
PCCO	1. Looking to purchase extra BP Machines to facilitate extra BP clinics 2. Have new check in systems to facilitate easier booking in 3. Purchasing the Stay Safe app for staff to go out into community/ home visits more safely 4. Have purchased Teamnet.

9. How we will involve patients and communicate our work

Engagement with patients, public and primary care workforce to deliver the PCARP is essential so that they have the opportunity to feed into the development of transforming General Practice within Derby & Derbyshire.

As a system we need to ensure that robust mechanisms are embedded to receive information and feedback so that the available services within primary care are what the primary care professionals, patients and public feel is truly needed. Derby & Derbyshire has a desire for transparency and this plan has been shared with key clinical leaders throughout its development.

Derby and Derbyshire ICB are adopting the following approach towards communications and engagement around the primary care recovery plan:

Informing and engaging local communities and stakeholders

- Primary care team leaders attended a session of our "Derbyshire Dialogue" engagement forum on 29 June 2023 to speak about the primary care recovery plan.
- A team of GP and ICB system leaders attended Healthwatch Derbyshire's AGM on 12 September and led a discussion about primary care recovery. Workshop sessions explored how patients would wish to receive information and education on using their GP practice team more effectively. Feedback from the event can be found in **Appendix 1.**
- We have worked with Derby and Derbyshire's Patient and Practice Group chairs' forum in their discussions in September about the recovery plan and the information and communications tools they would wish to see. This provided valuable insight and a potential forum for future testing of campaign materials.
- We have drawn on the insight available around health inequalities in the city carried out through community consultation done by Derby Health Inequalities Partnership.
- We have reviewed insight gained from two years' of reports and intelligence into primary care that was gathered in creating the Integrated Care Strategy.
- We are planning to present to the next Derbyshire County Council Health Improvement and Scrutiny Committee in December on GP access.
- We provide quarterly updates on primary care access and performance as part of our quarterly briefing to all Derby and Derbyshire MPs.

Local communications to support this primary care recovery plan

We supported the national announcement of the primary care recovery plan through sharing details through our stakeholder, staff and Primary Care Networks. We also developed a local case study to illustrate an element of the plan (around increased use of community pharmacy) and have shared that through our networks and with trade media.

Additionally, we have shared national campaign messaging on the recovery plan while our local plan is in development, so we are aligned to the national campaign timeline.

Communications activity is planned to take place to support the content and adoption of the local plan itself, focused on the improvements that are planned. Approval of the plan by the board and the wider system will provide a news opportunity and a point of focus.

Supporting our system winter communications campaign

The ICB communications and engagement team has agreed a joint approach to winter communications together with colleagues from the acute, mental health and community trusts, along with the provider of NHS111 and out of hours GP services.

One element of this campaign will be to inform audiences about the range of primary care services available. This will mirror the national NHS England-led campaigns on “the wider practice team”, “digital access” and “wider care available”.

The national communications campaign is scheduled to run in three phases:

- Autumn – introducing your wider GP practice team
- Autumn / winter - digital access
- Autumn / winter – wider care available through NHS111 and pharmacy

The ICB is working closely with the Midlands and national teams to plan and share messaging that supports and amplifies their plan.

Key objectives of the national campaigns are to explain and increase public understanding of the changes in the way GP teams operate, to build knowledge and confidence in use of digital access channels, and to explain the wider care available through pharmacy and NHS111.

These objectives are the same as those in the local winter communications campaign. Therefore, the communications approach for the primary care access recovery plan is the same approach as for the primary care elements of the winter campaign.

The local campaign will include:

- Toolkit of national resources, e.g. graphics, key messages, guides for staff and patients
- Toolkit of local resources, e.g. local examples of multi-disciplinary team members, local written and filmed case studies, local messages and resources that can be adapted by each practice, social media assets
- Sharing of resources through primary care channels and the ICB intranet
- Media launch and case studies

It should be noted that this campaign is being planned on the basis of zero budget. This inevitably limits the ICB's ability to advertise, take paid media opportunities, to produce printed materials and to target specific population groups.

10. How we will manage risks to the delivery of our plan

Risk	Mitigation
Clinical leaders are concerned regarding "Modernising General Practice" and the lack of agreement on some of the principles has led to an unprecedented imposition of the GP Contract for a second time.	Close working with the LMC to understand the issues being raised by General Practice around the contract and the implications that might have on delivery
A move towards web-based, digital, access shows that although the technology can be modernised it can also be deployed to take us away from person centred, holistic, care.	Ensure that there is still mixed model of delivery to suit the needs of the population
Moving to cloud-based telephony, with an infinite number of lines, but no additional people to answer the phone may make the patient experience worse as they wait in a potentially infinite queue or choose "ring back later" when they are then no longer available. This could increase patient frustration while also widening the digital exclusion gap.	Work with practices to ensure all elements of MGPAM are implemented to support the front end.
Receptionists (Care Navigators) cannot navigate to a sufficient workforce, either of GPs or other Primary Care specialists. This is clinical triage and deployment, by a non-clinical workforce. Evidence supports putting our most experience clinicians on the front line - but implementing PCARP will mean they are moved into an oversight role.	As part of the implement process ensure that practices are not only monitoring activity but also outcomes.
The implementation of PCARP could worsen clinical and patient experience outcomes.	As part of the implement process ensure that practices are not only monitoring activity but also outcomes.
The PCARP suggests that the plan will support winter 2023 but the initiatives will not be fully implemented or embedded in time to have an impact	Develop a winter plan for general practice that does not rely on the initiatives being embedded.
Despite providing more appointments demand continues to exceed capacity.	
There is a risk that too greater focus on 'on the day' will have a detrimental impact on the capacity of general practice to focus on the management of Long-Term Conditions and patients with high and rising complexity.	The clinical model being developed will take this into consideration
PCARP is mainly funded by repurposing existing funding contained with the PCN DES and not 'new' funding	Funding is outlined in this paper.
Workforce – driving a wage inflation spiral by chasing a very limited workforce pool for practice/PCN/other provider needs. Services are not resilient due to poor staffing and the work falls back to practices	Workforce issues are recognised and fed in as part of the system discussions. Implementation of 'cutting bureaucracy' actions will support practices
Community Pharmacy Clinical Lead national funding finishes at the end of March 2024 and there are currently no plans to continue this sue to national negotiations.	All ICBs have raised this as a concern and a joint letter is being prepared to share with ICB CEOs for support.

Appendix 1 Healthwatch AGM feedback

Breakout Group Feedback.pdf

Appendix 2

NHS
Derby and Derbyshire
Integrated Care Board

Derby & Derbyshire ICB System-level Primary Care Access Improvement Plan

October/November 2023

Timeline

Group	Date	Purpose
Primary Care Leadership/Operational Group	26.09.2023 10.10.2023	Review of headlines/first draft
Primary Care Sub-Group	10.10.2023	Review of draft before final version goes to PHSCC
Primary Care Sub-Group	19.10.2023	Review of final draft
ICB Executive Team	25.10.2023	Review of final draft
Primary and Community Care Delivery Board	27.10.2023	Review of final draft
PHSCC	09.11.2023	Sign off of final draft
ICB Board	16.11.2023	Sign off final plan

Contents

Our plan sets out:

Introduction

The plan is a ‘work in progress’. It is not intended as a definitive final statement but is the summary of discussion to date and the starting point for further discussion with General Practice and other providers. The focus is on the immediate actions up to 31st March 2024, though work will continue beyond that.

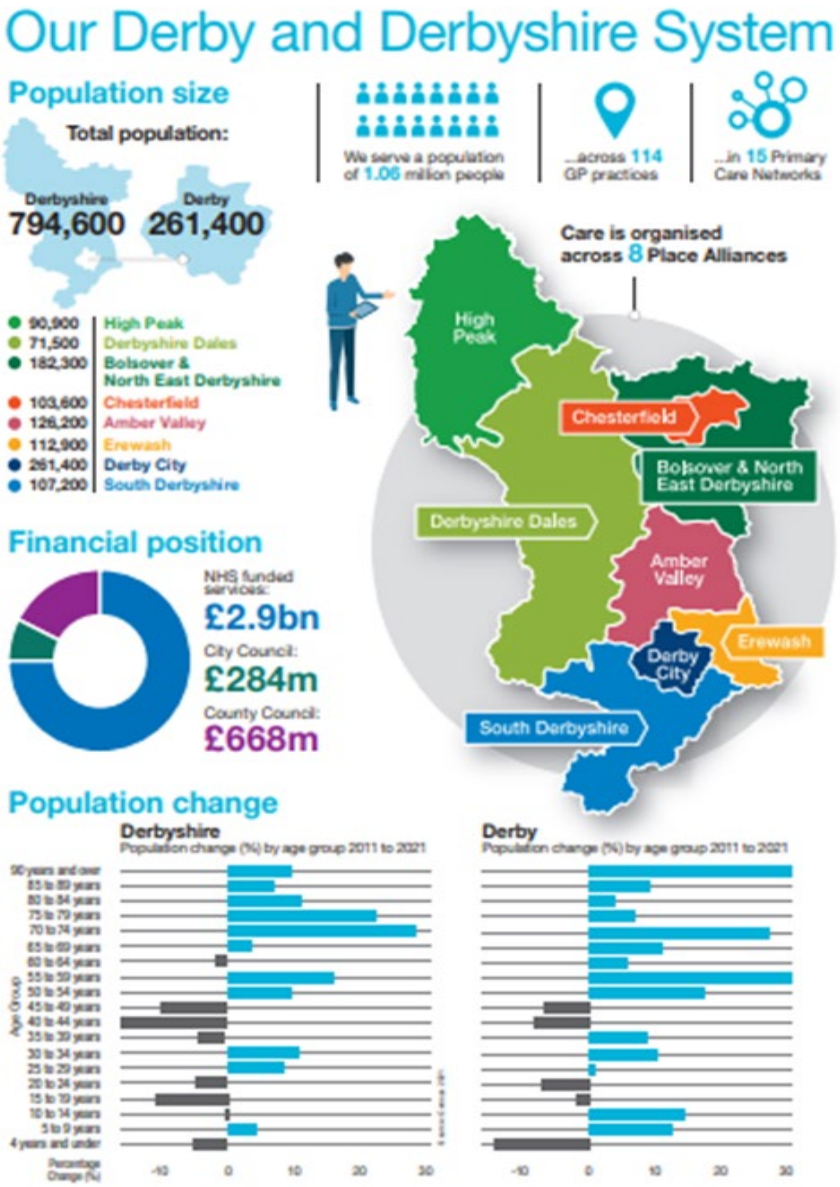
Our planning assumptions and outcomes have been aligned to and are interdependent with:

- Fuller Report
- Derby & Derbyshire ICB Joint Forward Plan
- Derby & Derbyshire ICB Integrated Care Strategy
- Derby & Derbyshire ICB Operational Plan 23/24
- Recovery Plan for Urgent & Emergency Care
- Recovery Plan for Planned Care

The primary interdependency is with the Primary Care Clinical Model for Derby & Derbyshire which is being developed by the GP Provider Board (GPPB).

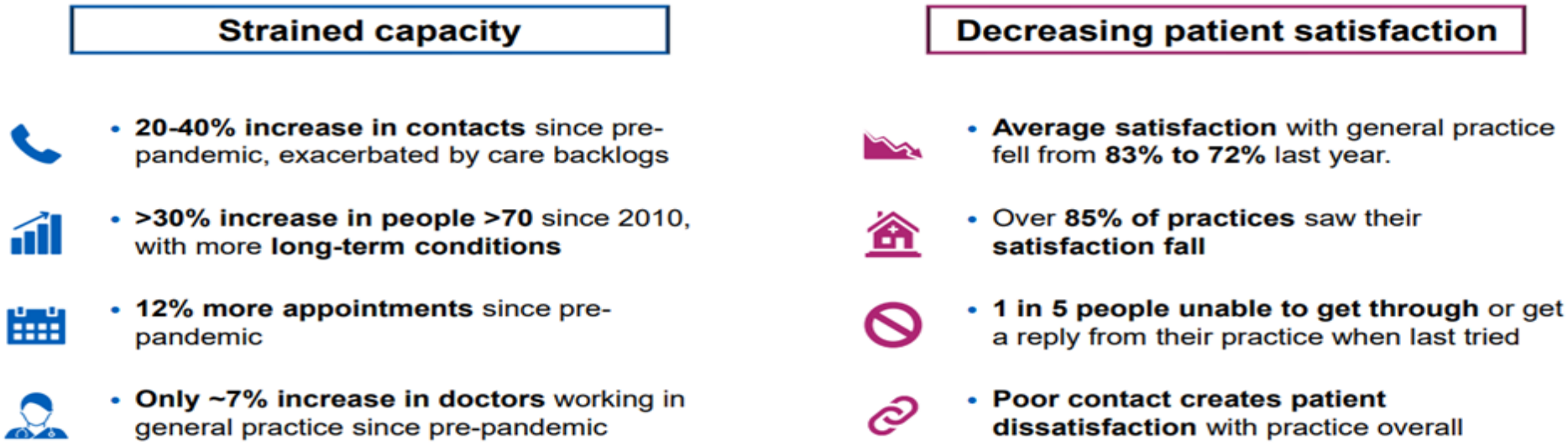
Derby & Derbyshire and our GP practices

- Derbyshire is a diverse county, with a population of over 1m people, 261,400 of which live in Derby. Our most deprived wards are largely in the city and the east of the county.
- We spend nearly £4b a year in health and social care and employ 53,000 people.
- There are 18 PCNs (113 practices) in Derby and Derbyshire, ranging in size from 32,000 – 100,000 population.
- The last three years have seen unprecedented demand on health and social care services. General Practices have had to make significant changes to the way they deliver services to adapt and respond to the COVID-19 pandemic.
- In 2022 we provided over 6.5 million appointments to our population.
- In January 2021 general practices provided 468,632 appointments increasing to 583,123 in January 2023, an increase of 24.4%.



National Context

Like many parts of the NHS, general practice is under intense pressure. Where demand is greater than capacity it means general practice cannot always be effective, and patient experience and access are negatively impacted. The diagram below describes the current situation for general practice:



National Context

The plan has two central ambitions:

- **1. To tackle the 8am rush and reduce the number of people struggling to contact their practice.** Patients should no longer be asked to call back another day to book an appointment, and we will invest in general practice to enable this.

- **2. For patients to know on the day they contact their practice how their request will be managed.**

a) If their need is clinically urgent it should be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their practice in the afternoon they may be assessed on the next day, where clinically appropriate.

b) If their need is not urgent, but it requires a telephone or face-to-face appointment, this should be scheduled within two weeks.

c) Where appropriate, patients will be signposted to self-care or other local services (e.g., community pharmacy or self-referral services).

National Context

The plan seeks to support recovery by focusing this year on four areas:

- **Empowering patients –** Empower patients to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy. This will relieve pressure on general practice.
- **Implementing Modern General Practice Access –** This aims to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another time. Patients will know on the day how their request will be handled.
- **Building capacity –** The national plan aims to build capacity to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.
- **Cutting bureaucracy –** Cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practice have more time to meet the clinical needs of their patients. The aim is to give practice teams more time to focus on their patients' clinical needs.

Empowering patients

Improving information and NHS App functionality – All Practices to have enabled all four NHS App functions for patients.

- Ensure directly bookable appointments are available online by 31 July 2023
- Apply system changes or manually update patient settings to provide prospective record access to all patients by 31 October 2023
- Offer secure NHS App messaging to patients where practices have the technology to do so
- Encourage patients to order repeat medications via the App supported by comms toolkit

Increasing self-directed care where clinically appropriate – Expand self-referral routes for the following services by 30 September 2023: Falls services, Musculoskeletal services, Audiology for older people including loss of hearing aid provision, Weight management services, Community podiatry and Wheelchair and community equipment services.

Expanding Community pharmacy services – Build on the success of the increasing role of our pharmacies.

- Introduce a Pharmacy First service by the end of 2023 that enables pharmacists to supply prescription only medicines
- Expand blood pressure check and oral contraceptive services
- Invest to improve the IT system connectivity between community pharmacy and general practice

Implementing Modern General Practice

Better digital telephony – Enable all practices to move from analogue to digital telephony by 31 December 2023 and the remainder by 31 March 2024. We will achieve this by co-ordinating access to specialist procurement, agreeing a sensible approach to roll-out and use our peer networks and demonstrations with practices, Patient Participation Groups to help practices and PCNs adopt digital telephony.

Simpler online requests – Ensure that all practices are providing online access by working with practices and PCNs to decide which tools will best enable them to shift to the Modern General Practice Access model.

Faster navigation, assessment and response – Make it easier for people to contact their practice and normalise getting a same day response, so patients know how their request will be dealt with. We have asked all practices to nominate one staff member to attend the Care Navigation Training and share the learning with their practice, therefore generating a network of experts.

Building capacity

Larger Multi-Disciplinary Teams – Continue to grow the practice team, especially roles with responsibility for direct patient care which can be part of larger MDTs. We will support PCNs to use their full ARRS budget £26m by the end of March 2024.

More Doctors – We want to increase our number of new doctors in general practice by training more GPs and supporting other doctors to transition to general practice. We will work to address the pension challenges and make the GP Return to Practice and International Induction programmes easier to access and more attractive.

Retention and return of experienced GPs – Encourage GPs to return to general practice or to support services like NHS 111 in flexible roles where, for example, working from home is possible. We will encourage practices and PCNs to review and take up local offers for retention and maximise the funding we have available for these schemes.

Higher priority for primary care in housing developments – Ensure new developments are accompanied by primary care infrastructure, and that this is supported by the planning system. As part of normal planning processes, ICBs should work with local stakeholders and take account of areas where housing developments are putting pressure on existing services.

Cutting bureaucracy

Improving the primary to secondary care interface – ICB Chief Medical Officers will establish a local mechanism, to allow both general practice and consultant-led teams to raise local issues, jointly prioritise working with LMCs, and to tackle the high-priority issues. ICBs will also address the following four areas:

- Onward referrals – if a patient has been referred to secondary care and need another referral, for an immediate or related need, the secondary care provider should make this referral, rather than sending the patient back to General Practice
- Complete care (fit notes and discharge letters) – Trusts should ensure that on discharge or after an outpatient appointment, patients receive everything they need, rather than leaving the patients to return to their practice.
- Call & recall – NHS Trusts should establish their own call/recall systems for patients for follow-up test or appointments, eliminating the need for patients having to ask their practice to follow up on their behalf
- Clear point of contact – Ensure providers establish single routes for general practice and secondary care teams to communicate rapidly

Building on the Bureaucracy Busting Concordat – Reduce the demands on practice time from unnecessary or low value asks and improve processes for only the most important requests for medical evidence.

Our local long-term vision for access

GP Provider Board are working on developing a 'Sustainable Clinical Model for Primary Care in Derby & Derbyshire'. The core purpose of this document is to seek agreement to a new, sustainable clinical model for General Practice in Derby and Derbyshire. The aim is to give people hope, by demonstrating how we can mitigate the crisis facing primary care, through a shared vision for improving quality of care and staff working lives.

The vision would stratify our population into three broad categories: people with low complexity; people with rising or high complexity, and; people with extreme complexity. We will structure services differently for each of these groups.

- For people with low complexity, there will be a focus on digital and self-care, a lower skill mix and more emphasis on rapid access and less on continuity of care.
- For people with rising / high complexity this will look more like traditional General Practice, with smaller GP led teams working with a registered list with a focus on continuity of care.
- People with extremely complex needs will be served by multi-disciplinary, multi-agency teams working on a neighbourhood footprint.

Our local long-term vision for access

Stratification	Population group	Clinical Model	Continuity	Staff Mix	Escalation/de-escalation	Activity examples
Low Complexity	~60% of population People that are stable and healthy that have health conditions that can be easily managed.	Delivery at population level (large population registered list) Multiple locations.	Delivered around episodes of care and around information. Access to medical record.	ACPs, FCPs Clinical Pharmacists, HCAs, Nursing associates, GP oversight. Comm pharmacists. Optom	Escalation up where clinical need dictates. Eg persistent unexplained symptoms. Escalation for invx should stay in service.	Reactive illness service. FCP. Mental health. NHS health checks. CVD primary prevention. Smears. CPCS. etc
Rising/High Complexity	~35% of population. Chronic conditions that move in and out of stability. Increasing frailty. Persistent and/or uncontrolled symptoms.	Delivered at small registered sub lists based within a small number of distributed locations.	Focus on relational continuity with a small team.	GPs, Practice nurses, Clinical Pharmacists, ACPs	Seeks to de-escalate where possible back to low complexity. Eg Cancer patient that achieves cure.	Reactive illness service. Medication optimisation. Structured medication reviews. Long term condition management. Care planning.
Extreme Complexity	<5% of population. Heterogenous group. Multiple complex illness combined with significant psychosocial complexity. Would include EOL and severe frailty	Delivery at population utilising an integrated, multi-agency, multi disciplinary neighbourhood teams. Delivered in the location most appropriate to the needs of the patient.	Team based continuity.	GPs, ACPs, DNs, HCAs, Physio, OT, Social worker, MH, Clinical pharmacist. Specialist input where required.	Receives escalation where multi agency approach is required. De-escalated where possible eg super users.	Personalised anticipatory care planning. Reactive service to need. SMRs focused around frailty and polypharmacy.

Our local long-term vision for access

The new service model will incorporate the following key principles:

- Access will be multi-modal. We should not force people to online, telephone or face to face appointments, there will be a choice. We accept that people need and desire different access methods.
- Information gathered will include pre-existing data from medical records as well as information from the patient about the reason for their contact. The information will be gathered in a consistent way to support achieving a consistent outcome.
- Based on the information gathered a decision will be made as to who, when and where there is an appropriate appointment available. The decision will consider pressures within the system and manage the complex risk associated with triage and primary care.
- This decision will then be communicated to the professional along with the booking mechanism (including a waiting function) e.g., booking link, appointment time, warm transfer.

The key enablers to support the delivery of this model are Culture & Organisational Development, Leadership and Quality Management.

How we will deliver the national plan

We worked with our 18 PCNs to develop their Capacity & Access Improvement Plans earlier in the year. The plans incorporated all requirements of the PCARP with the ambition to achieve or work towards the target where appropriate.

National Capacity & Access Support Payment (CASP) 70% Payment	Local Capacity & Access Improvement Payment (CAIP) part or all of 30%
• The Capacity and Access Support Payment for the period 1 April 2023 to 31 March 2024 is calculated as £2.765 multiplied by the PCN's Adjusted Population. • This funding will be unconditionally paid to PCNs, proportionally to their Adjusted Population • Paid via PCSE **1 in 12 equal payments over the 2023/24 financial year**	• The maximum a PCN could earn is £1.185 multiplied by the PCN's Adjusted Population as of 1 January 2023. • The commissioner will instruct PCSE Online to make the appropriate payment to the Nominated Payee of the PCN by no later than **31 August 2024.**
DD total funding £3,061,941	**DD total funding £1,312,260**

The plans were signed off by the Access Working Group following feedback on the draft plans submitted.

We are holding mid-year reviews with PCNs to assess their progress and provide support where necessary.

How we will deliver the national plan

The key themes from the PCN plans are:

- Collaboration with Patient Participation Groups and work towards and improving against the five patient survey questions relating to access
- Develop bespoke in-house surveys to engage with patients to support the results of the patient survey
- Facilitate learning time for practices on care navigation and awareness of services to enable the ability to support getting people to the right place, first time
- Increase in onboarding and usage of Community Pharmacy Consultation Services
- Review of websites to ensure they are fit for purpose
- Development of hubs within PCN to deliver services from
- Segmentation of the population
- Triangulation of Cloud-based Telephony & online consultation data – addressing demand/capacity and staff management
- Integrated working with system partners and the voluntary sector

How we will deliver the national plan

Key deliverables from PCARP

Area	Progress & action
Cloud-based Telephony	Identified 34 practices as critical. We are working to agree a process to allocate funding across these critical practices, to enable migration.
NHS App	96.5% of practices were offering the book and cancel appointment's function and all practices are offering the repeat prescriptions within the app. Work is ongoing to ensure full functionality within the app, including secure app messaging.
Online Consultations	48 practices are achieving the Online Consultation Usage target of 260 per 1000 registered patients per annum. Engagement to encourage increased uptake is ongoing and will be discussed with PCNs during their PCARP mid-year review meetings.
General Practice Appointment Data (GPAD)	60 practices are seeing at least 85% patients within 14 days of booking an appointment, with more than half of these are seeing 90%+ patients within 14 days. Data is shared regularly with PCNs to support them to achieve the target and DDICB will continue to work with the practices who are outliers.

Area	Progress & action
Care Navigation Training	54 practices have signed up to participate in the national Care Navigation Training. We will continue to communicate to PCN Operation Managers to encourage uptake and will also be discussed at the PCARP mid-year review meetings.
General Practice Improvement Programme (NGPiP)	DDICB have 33 practices signed up to NGPiP and one PCN and will be ringfenced for Transition Funding. DDICB are agreeing an allocation of funding process for those practices who are implementing the Modern General Practice Model but not taking part in the NGPiP.
GP Community Pharmacy Consultation Service (GP-CPCS)	All practices are engaged with the GP-CPCS scheme. Locally, we have made the decision to include the scheme within the PCARP with the aim of increasing the number of referrals.
Support Level Framework (SLF)	We are recommending that practices take advantage of the SLF. A working group has been established focusing on uptake and our approach.
GP Registration Service	DDICB have the lowest sign-up rate, 9.7%. We are promoting all webinars and considering arranging a local webinar to encourage practice sign up.
Self-referral Pathway	DDICB have undertaken the initial national self-assessment, with a second self-assessment completed in late September. Our baseline figure for self-referrals is 1,100 and our target is 1,650. We are awaiting data so we can understand our position against the target. Once available, the data will be built into our community performance.

How we will organise ourselves

The Primary Care access recovery work is overseen by the Director of Primary Care (SRO). The ICB work collaboratively with other partners on this programme of work including, but not limited to the following:

- Primary Care Networks – this is with both Clinical Directors and PCN managers.
- GP Provider Board who provide a collaborative voice for developing the future of general practice provision within the Derby & Derbyshire health and care system.
- Derby & Derbyshire Local Medical Committee
- General Practice Task Force (GPTF) who now deliver the Training Hub for Derby & Derbyshire amongst many other things including System Development Fund schemes.

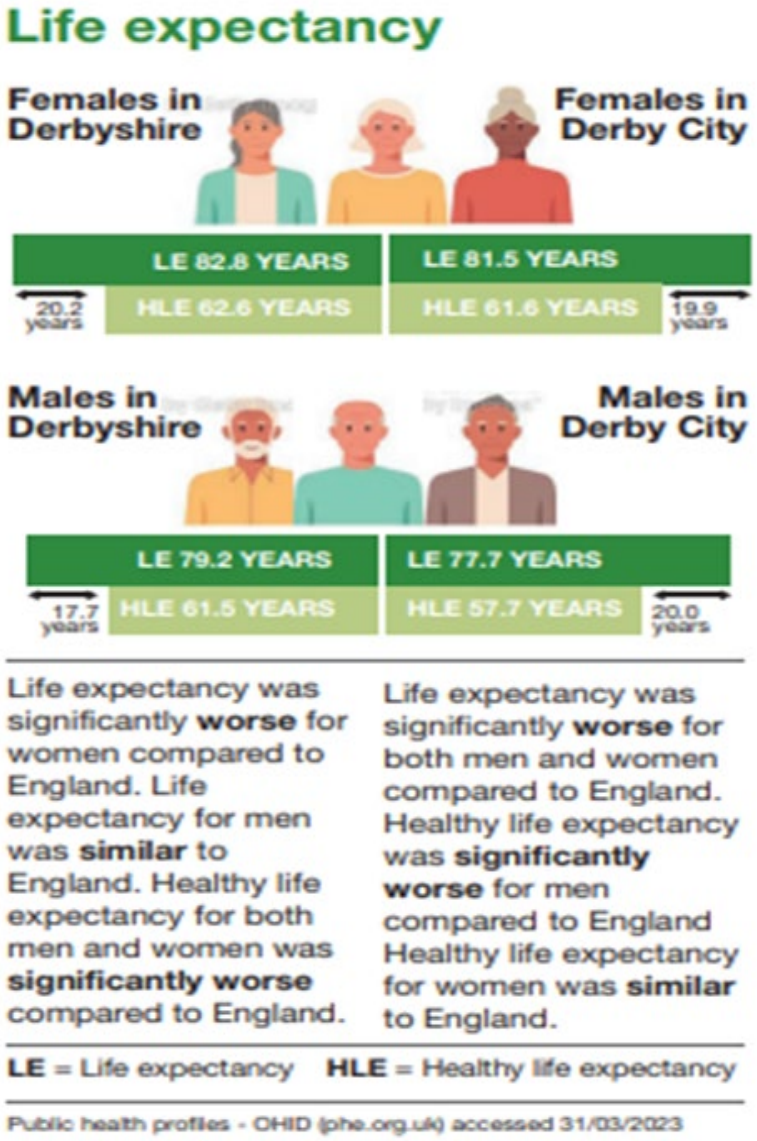
The programme of work is managed via the Access Working Group which is a subgroup of the Primary Care Network Delivery & Assurance Group, that oversees delivery of the PCN DES. The group has representation from the ICB, GP Provider Board, LMC & GPTF. The group meet monthly to discuss progress against the plan and advise on any issues/barriers that are being met.

Managing inequalities

Many people in Derby and Derbyshire live for a long time with long-term and often multiple conditions and there are stark differences in rates of healthy life expectancy between populations.

Similarly, there are also striking differences in life expectancy rates, when comparing the least and most deprived populations.

Work has been undertaken by JUCD System colleagues to develop a set of priority population outcomes and key indicators (known as Turning the Curve indicators) based upon the Derby and Derbyshire Joint Strategic Needs Assessments (JSNAs). These focus on increasing life expectancy, increasing healthy life expectancy, and reducing inequalities.



Managing inequalities

- **Start Well** - To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness

- **Stay Well** - To improve prevention and early intervention of the 3 main clinical causes of ill health and early death in the JUCD population - circulatory disease, respiratory disease and cancer

- **Age/ Die Well** - 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

How we will invest funding

The additional funding for primary care equates to £15.107m. We will ensure that funding is spent in year with practices and PCNs across Derbyshire, with deliverables being closely monitored against the funding allocations. Funding will be paid in a timely way, as per the ICBs agreement with providers, utilising payment mechanisms that are already in place and working well.

The funding has been split into the categories below providing assurance that the funding to support primary care is being used in addition to existing funding and for its intended purpose.

- Transition cover and transformation support funding
- Cloud based telephony transfer funding
- Digital 0.93p per weighted patient
- Capacity and access support payment (guaranteed element)
- Capacity and access improvement/ incentive payment (based on achievement of indicators)
- ARRS (additional value for 23/24 per allocation given)
- ARRS (funding required from ICB in line with contracts without national funding to support, high risk)

How we will involve patients

Engagement with patients, public & primary care workforce to deliver the PCARP is essential so that they can be part of the journey of transforming General Practice. Derby and Derbyshire ICB are adopting the following approach towards communications and engagement around the primary care recovery plan:

- **Amplifying national messaging –** We supported the national announcement of the primary care recovery plan by sharing key details through our stakeholder, staff and PCNs which included the development a local case study.
- **Informing and engaging local communities and stakeholders –** Primary care team leaders attended our “Derbyshire Dialogue” engagement forum in June to discuss the recovery plan and we presented at Healthwatch Derbyshire’s AGM in September, where we gained valuable insight from attendees.
- **Developing a locally specific communications campaign –** We are developing a local primary care access plan, with a view to board approval in October / November.
- **Supporting our winter campaign –** We have agreed a joint approach with our comms team and colleagues from the acute, mental health and community trusts, along with the provider of NHS111 and out of hours GP services. One element of this campaign will be to inform audiences about the range of primary care services available. This will mirror the national NHSE-led campaigns.

How we will manage risks to the plan

Key risks to the plan have been identified and mitigations will be agreed via the Access Working Group and other relevant forums. The main areas of concern are:

- Lack of agreement on some of the principles of “Modernising General Practice”
- Digital enhancements moving General Practice away from person centred holistic care and creating ‘infinite queues’, decreasing patient satisfaction even further
- Lack of workforce to support effective care navigation
- Senior and experienced clinicians moving into oversight roles when evidence suggests that they are needed on the ‘front-line’
- Plan will not be embedded or implemented in way that can support with winter pressures this year
- Demand still outweighs capacity
- Increased focus on ‘on-the-day’ care will have a detrimental impact on the management of long-term conditions and patients with high complexity
- The funding is not new and is being repurposed from the PCN DES

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NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 102

Report Title	Integrated Assurance and Performance Report
Author	Jo Hunter, Director of Quality Sukhi Mahil, Assistant Director Workforce Strategy, Planning and Transformation Sam Kabiswa, Assistant Director, Planning and Performance Georgina Mills, Head of Financial Reporting
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer
Presenter	• Quality – Professor Dean Howells, Chief Nurse Officer • Performance – Michelle Arrowsmith, Chief Strategy and Delivery Officer/Deputy CEO • Workforce - Linda Garnett, Interim ICB Chief People Officer • Finance – Keith Griffiths, Executive Director of Finance

Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐

Appendices	Appendix 1 – Integrated Assurance and Performance Report Appendix 2 – JUCD System Finance Report to 30th September 2023 (Month 6)
Assurance Report Signed off by Chair	Not Applicable
Which committee has the subject matter been through?	Finance and Estates Committee Quality and Performance Committee: People and Culture Committee Population Health & Strategic Commissioning Committee

Recommendations
The ICB Board are recommended to **NOTE** the Month 6 (M06) Integrated Assurance and Performance Report update against the plan commitments and targets.
Purpose
To update the board on M06 performance against the 2023/24 operational plan objectives/ commitments, quality standards workforce and finance.
Background
The 2023/24 Operational Plan set clear measurable objectives which are fundamental to the NHS' contribution to improving health outcomes. The Plan was submitted to NHSE on 4th May. It is now six months since we published the plan and the first real opportunity to fully review, as a system, how we are performing against our forecasts particularly as we move into the winter months. Work to review how we are performing against the forecasts we set out within the plan has now completed. The report attached represents the current assessment (M06 position) based on published data.

The review was undertaken as part of the NHSE commissioned winter preparedness process. As part of the process, we have reviewed our operational plan and the core assumptions underpinning our plan, particularly considering actual year to date delivery and any new risks emerging by:

- reviewing how performance was going in relation to the operational targets for planned care, cancer, and urgent & emergency care;
- recasting the forecast delivery position for the targets, for the period October 23-March 24, which involved a review and revision to the underpinning demand and capacity assumptions, as necessary; and
- setting out the 'how', by summarising the key actions that necessary to secure these forecasts.

The aim was not to conduct another operational planning round. Rather, the focus has been on reviewing the assumptions that we set for the second half of the year ('H2') against the key operational targets to establish an updated forecast position – taking into account specific winter pressures.

Report Summary

The summary below highlights the key areas to note, and additional information can be found in the supporting appendices.

QUALITY

Elmwood Medical Centre – Following an unannounced inspection in January 2023, CQC gave a rating of Inadequate with 2 warning notices and placed in Special Measures. A focussed reinspection was conducted in June 2023 to look at the actions carried out by GTD/Elmwood Practice. The practice was able to evidence the good progress made and whilst there was still work to complete, CQC took the decision that the warning notices would be closed, and requirement notices put in place for the remaining breaches.

Buxton Medical Practice - CQC carried out an unannounced inspection in September 2023. The report was published October 2023 with an overall rating of Good.

CQC - Over the coming months CQC intend to carry out targeted inspections of the responsive key question in response to concerns from the public in relation to access to GP appointments. The inspections will be carried out remotely and the rating of responsive will be updated as required. Providers will be given 5 working days' notice of assessment. It is anticipated these inspections will continue until the end of January 2024. Communications about this have been uploaded to the CQC website.

DCHS Hillside Unit/Ash Green – Traces of legionella were discovered in one of the patient bays on the Hillside unit isolated pending remedial work. Re-testing highlighted small doses of legionella in the remaining three bays led to the temporary transfer of residents to the vacant ward at Walton Hospital to allow for further work to be carried out. Safe & Well checks were completed for both individuals displaced with no issues identified. Service users continue to be cared for in a safe and secure environment and are expected to be transferred back on completion of the work.

UHDB Maternity - Tier 3 oversight is maintained by DDICB and NHSE with stillbirth rates above the MBRRACE rate and reported neonatal death rates above the national rate. The extended perinatal mortality thematic review has been completed and the final report is awaited. Major Obstetric Haemorrhage, foetal monitoring and triage are key areas of quality improvement at UHDB.

The LMNS has assessed the trust against the 6 elements of SBLCBv3 which identified that UHDB are 33% compliant compared to 37% for SBLCBv2 (Q4 22/23). This has provided a baseline with work identified to meet the increased interventions and extra element (Diabetes). The next

assessments will be in November and December prior to submission for CNST Maternity Incentive Scheme Year 5 which requires an overall 70% compliance.

Support for Asylum Seekers – The Home Office and Serco have made the decision to increase the hotel capacity for asylum seekers at two of the Hotels in Derbyshire.

OPERATIONAL PERFORMANCE

Planned Care and Cancer – August Performance

- The number of people waiting 65 weeks or longer on an incomplete RTT pathway: The position has declined further in August 2023, with 1,263 more patients waiting 65 weeks or longer than planned at an ICB level (UHDB: 2,572 actuals vs. 1,304 plan; CRH: 342 actual vs. 347 plan)
- The number of people on a community service waiting list: The community service waiting list at the end August 2023 is 25,971 an increase of 1,945 compared to when we started this financial year (24,026 as at end of March 2023).
- Cancer waits longer than 63 days: At the end of August 2023 CRH is slightly above plan at 59 with a plan of 54, UHDB have 481 against a plan of 466.
- 75% of cancers diagnosed within 28 days of referral: The CRH continue to deliver the 75% standard. UHDB are at 70% in August.
- Diagnostics: Based on the 7 tests measure CRH is at 83.3% and UHDB are at 70.9%.

(7 tests include: MRI / CT / Non-Obstetric Ultrasound / Echocardiography / Colonoscopy / Flexi Sigmoidoscopy / Gastroscopy)

Urgent and Emergency Care – September Performance

- 4 hr A&E: Both Trusts continue to achieve against their 4-hr target, with September performance standing at 69.1% and 69.4% at the CRH and UHDB respectively.
- Urgent Community Response: The Urgent Community Response Service continues to exceed the response time standard.
- General and Acute Bed Occupancy: Bed Occupancy for September is slightly above the national 92% target for both providers. CRH is at 93.3% and UHDB at 92.5%.
- Category 2 999 response times: Performance continues to operate above target both for Derbyshire (00:42:31) and the East Midlands as a whole (00:42:33).

Mental Health, Learning Disabilities and Autism

- IAPT, perinatal, adult SMI contacts: Good performance against plan with all 3 metrics, have over-achieved at the end of Q1.
- Dementia diagnosis rate: ahead of plan at the end of August.
- SMI Health checks – just fell short at the end of Q1 but on track for quarter 2.
- Out of area placements – off plan.

WORKFORCE

Whilst the system needs to monitor the position against the workforce plan submitted to NHSE earlier this year, a more rounded understanding of the position, through alignment of the Whole Time Equivalent (WTE) numbers and the finance pay bill is necessary. Appendix 3, therefore is summarized in two parts; M6 position against plan (tables 1a-c) and the actual workforce position compared to the pay-bill (tables 2a-b). Tables 2a and b, aim to provide the most reasonable overview based on the current mechanisms that are in place, recognising that there is further development required.

In addition, given the increasing level of scrutiny on agency spend and usage, Appendix 3 will now routinely include a breakdown against the four main KPIs.

It is recognised that there have been differences and variability in the accuracy of the workforce data (eg different data sources provide different data which then is difficult to reconcile). However,

concerted effort is being made to improve the workforce data as part of the alignment with finance with the ambition to create one version of the truth.

Workforce Plan Position: (NHS Foundations Trusts, including EMAS)

At M6, the total workforce across all areas (substantive, bank and agency) was 885.23 WTE above plan. Compared to M5, there was a decrease in all areas (substantive, bank and agency). All organisations, except for DCHS are reporting as above plan against the total workforce position.

The current high level primary care workforce plan position is included in table 1c in appendix 3. This identifies the current position against plan as 125WTE below plan. The was observed mainly from GPs (33WTE) & Direct Patient Care roles (ARRS funded) (34WTE). There is further work taking place with primary care colleagues to improve the primary care (General Practice) level data and reporting.

Workforce and Pay-bill Alignment

As a system work continues to better align workforce and finance and in the absence of the national requirement for workforce establishment plans, local arrangements have been established to monitor the actual workforce against the pay bill budget (i.e. costed WTE establishment).

Table 2a identifies that all organisations, except for UHDB are over their respective establishment; DCHS is almost exactly to establishment, with a difference of -1wte. At M6 the system has overspent against the pay budget by £14.3m with 531wte over-establishment in terms of total staff (substantive, bank and agency).

There will be a degree of reliance on temporary staffing (e.g. where there are recognised recruitment challenges for staffing groups/grades in specialist areas) and therefore plans factor in bank and agency usage. However, we know that temporary staffing (particularly agency) is generally more costly in comparison to substantive staff. Table 2b demonstrates the Bank and Agency position, which identifies that the system is overspent against plan in both these areas. Further analysis is required to align the WTEs to the associated costs, as at present this does not fully correlate, plus it appears that adjustments are made to the gross pay costs for bank and agency which need to be understood.

Through the joint workforce and finance improvement (JWFI) work there is an ask to breakdown all pay elements including sickness, maternity, non-contractual pay enhancements, overtime and trainees etc in order to ascertain where there may be other pay costs impacting on the pay-bill overspend. There is also inconsistency in the number of WTEs being recorded (contracted V worked) e.g. CRH record medics doing 1.4 sessions as 1.4WTEs whereas UHDB record this as 1WTE (comparatively this suggests less capacity at UHDB and on the other hand this is inflating the associated costs). This appears to be due to different interpretations of the PWR guidance (both could be argued as correct) and therefore this is also an area which the JWFI will be investigating further.

Tables 2a and 2b in appendix 3, are a significant step forward to begin looking at staffing levels and the pay bill as one. However, it is recognised that there are several caveats and further considerations needed before it is possible to draw firm conclusions. This approach is therefore intended to provide a best view of the position whilst the alignment work continues to evolve.

Agency Usage

Agency usage against the 4 KPIs is:

- **Total Agency Spend:** £22.4m against a plan of £13.4m
- **Agency spend as a % of total staff spend:** 2.8% against a national target of 3.7%
- **% of Off Framework shifts:** 5.4% of total agency YTD
- **% non price cap compliant shifts:** 49.4% of total agency YTD

Whilst overall agency usage has declined compared to the previous month, the position remains above plan. A significant proportion of this will be due to the changes in EMAS and the increase in the agency position against plan (200wte actual against a plan of 20wte). EMAS do not use agency staff to cover vacancies but the changes to the PWR have meant that the only place to record the over-time / additional PAS equivalents is in the agency category. This has the potential to skew the overall system agency position (including when looking at the agency spending cap) and therefore this proportion will need to be recognised as a separate component when looking at the overall agency position.

All Trusts are making a concerted effort to reduce agency usage and spend. A system agency reduction plan has been developed to progress system levels actions/areas for improvement. This plan is not intended to negate any actions the respective Trusts will be undertaking and is intended to complement and support those.

FINANCE

As of 30th September 2023, the JUCD year to date position is £36.2m deficit against a £15.6m planned deficit, a £20.6m overspend against the plan. The main factors driving this are industrial action, excess inflation and impact of pay award. The unmitigated likely case year end forecast for 2023/24 is a deficit of £68.0m which reflects these pressures that were not known at the time of planning and also pressures on delivering the agreed plan, including planned efficiencies.

The worst-case scenario of a £122.5m deficit includes additional risks related to not delivering the agreed JUCD Operational Plan, such as, pressures on capacity and activity, drugs costs, and income reduction.

The system efficiency delivery is £2.0m over plan year to date, this is split into £14.0m behind plan on recurrent efficiencies and £16.0m over plan on non-recurrent efficiencies. Unless planned levels of recurrent efficiencies can be delivered, it will impact in future years. The efficiencies have been phased based on an increasing rate of delivery as the year progresses, therefore, it is important that the development of schemes gathers pace to support the delivery of the current forecast position of breakeven. At month six, there is a total of £19.4m of schemes that are still in the opportunity phase or unidentified. As a result, the assurance on delivery of the planned £136.0m of efficiencies is increasing but we do not yet have full assurance.

The system is still committed to delivering a breakeven position at year end, a position approved by the Boards of all JUCD organisations. This is reflected in the best-case year-end forecast, but if this position is to be delivered it will require significant mitigations to be identified.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☒
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐

SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

No further risks identified.

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

Yes ☒	No☐	N/A☐

Details/Findings The papers are provided for information only and therefore have no financial impact.	**Has this been signed off by a finance team member?** Darran Green, Acting Operational Director of Finance

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

There are no risks that would affect the ICB's obligations.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
The ICB is committed to the achievement of Net Zero Targets and the delivery of the Derbyshire ICS Green Plan.

Derby and Derbyshire
Integrated Care Board

Integrated Assurance and Performance Report

October 2023

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

Quality

Prof Dean Howells, Chief Nurse Officer
Dr Deji Okubadejo, Non-Executive Member

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

NHS
Derby and Derbyshire
Integrated Care Board

Key Messages1

#	Concern or Issue	Programme/Specialty i.e. Maternity, cancer	Organisation/Place / System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
1	Safety	Maternity	UHDB/CRH	Increasing stillbirth rate	**UHDB** - The stillbirth rate in August 2023 was 4.69/1000 births with and remains above the MBRRACE rate of 3.6/1000 (2023). The reported neonatal death rate for August 2023 was 1.55/1000 live births. This is above the national rate of 1.6/1000 (2023) however a decrease in rates has been seen since April 2023. No stillbirths or neonatal deaths were reported in August. The extended perinatal mortality thematic review has been completed and the final report is awaited. - The CQC inspection has taken place and the report awaited. Tier 3 oversight is maintained by DDICB & NHSE. - Major Obstetric Haemorrhage, fetal monitoring and triage are key areas of quality improvement at UHDB. - The draft CQC reports for Royal Derby Hospital and Queens Hospital Burton are with the Trust for factual accuracy. **CRH** - The stillbirth rate has increased to 1.79/1000 total births following 2 stillbirths in August. The neonatal death rate remains at 0.0/1000 live births. Both are below the ONS & MBRRACE national averages. - Third- and fourth-degree tear rates are reducing but remain above the national average. **National reports** The LMNS has assessed both Trusts for compliance against the 6 elements of SBLCBv3. CRH are 63% compliant compared with 86% when last assessed against SBLCBv2 (Q1 23/24). UHDB are 33% compliant compared to 37% for SBLCBv2 (Q4 22/23). This has provided a baseline for both Trusts, with work identified to meet the increased interventions and extra element (Diabetes). The next assessments will be in November and December prior to submission for CNST Maternity Incentive Scheme Year 5 which requires an overall 70% compliance.
2	IPC	HCAI	System	Trajectories for 23/24 released by NHSE. The targets will be challenging to meet based on last year's performance and data for year so far.	- CRH and UHDB remain on enhanced monitoring and support on the NHSE Midlands IPC escalation matrix. - Work continues at both Acute Trusts to effectively implement recovery action plans. Assurance gained at Trust internal IPC committees. Verbal updates provided to IPC System Assurance Group. CDI case numbers in the acute trusts continue to track above trajectory for the year with a forecast to exceed threshold activity if rates do not improve. - Challenges around capacity have prevented full implementation of deep clean programmes and trusts have needed to apply a risk-based approach to maximise opportunities for environmental cleansing. - Following regional IPC face to face meetings in July and September a suite of improvement measures has been agreed including training videos on an open YouTube channel, discussions with universities around IPC content in student training, CDI specific education package and a task & finish group to focus on HCAI Data Capture System. - -PODs – East Midlands will be hosted by Nottingham ICB. Regional NHSE Assistant Director of IPC has met with ICB System colleagues. Data assessment including risk stratification is being undertaken. - -WINTER PREPAREDNESS – A letter has from regional CNO has been sent to all providers (6/10/23) suggesting reintroduction of universal masking particularly across UEC pathways and risk-based management of outbreaks to reduce the length of the outbreak while minimising disruption to flow. Providers are currently working with IPC & communications teams to implement.

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 Messages1					
#	Concern or Issue	Programme/Specialty i.e. Maternity, cancer	Organisation/Place / System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
3	Safety	LD&A	DCHS	- Identification of legionella in the water supply on the Hillside Unit at Ash Green	- Initially legionella was discovered in one of the patient bays on the Hillside unit during the summer and was isolated pending remedial work by the estates team. Re-testing highlighted small doses of legionella was also detected in the remaining three bays which has led to the temporary, precautionary transfer of residents to the vacant ward at Walton Hospital to allow for further work to be carried out. - Currently two services users are displaced at Walton Hospital. Safe & Well checks completed for both individuals. No issues identified. - Service users continue to be cared for in a safe and secure environment and are expected to be transferred back on completion of the work.
4	Safety	Primary Care	Osmaston Surgery	Member of the Deby City North PCN commissioned via a PMS contract to deliver General Practice services and is not a dispensing practice. CQC carried out an unannounced site inspection at on the 5th of June. Inspection Report was published on the 16th of August, with an overall Rating of Inadequate.	- The practice has developed a Remedial Action Plan, this must be submitted to CQC on the 28th of each month. To date submissions have been sent in July and August. This will be reviewed monthly along with evidence monthly at planned engagement meeting with the DDICB and CQC local inspector, this will commence in October following a Post Inspection meeting with CQC in September. - ICB Communications Team & Practice have developed a communications plan to assist in answering any media enquiries. Communication has also been developed for the DDICB in the event of media enquiries to the ICB. - The practice has also written to their local MP requesting a meeting to update about the practice and future. - The practice is also working with Healthwatch and the practice PPG to provide information to patients and gain patient feedback to support practice improvement.
5	Safety	Primary Care	Elmwood Medical Centre	Care Quality Commission conducted an unannounced inspection on 23rd January 2023. The outcome of the CQC inspection was Elmwood Medical Centre been given a rating of Inadequate, issued with 2 warning notices and placed in Special Measures.	- The practice was given until 31st March 2023 to provide assurance to the CQC in regard to the warning notices with the plan that a follow up focused CQC inspection would take place in the near future. - CQC carried out a focussed reinspection of the practice on the 26th June 2023 to look at the actions carried out by GTD/Elmwood Practice in response to the warning notices issued in January 2023. - The practice were able to evidence the good progress made and whilst there was still work to complete, CQC took the decision that the warning notices would be closed down and requirement notices put in place for the remaining breaches.
6	Safety	Primary Care	Buxton Medical Practice	CQC carried out an announced site inspection at Buxton Medical Practice on 6th September 2023.	- commissioned via a PMS contract to deliver General Practice services and is not a dispensing practice. - The CQC Inspection Report was published on the11th October 2023, overall Rating of Good

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

Derby and Derbyshire Integrated Care Board

INTELLIGENCE SHARING - horizon scanning, trends etc

Derby and Derbyshire Safeguarding Children Partnership (DDSCP) are preparing the media / communication strategy for the publication of a forthcoming child practice review that is highly likely to attract further national and local media attention.
CRH Deputy Chief Nurse attended the Ward Accreditation for Quality conference and presented their ACE (Assessment of Care Excellence) programme. The attendees were interested in the GENOME digital platform system, which the Trust are piloting, and the process involved in developing this further to support care accreditation, including how the Trust obtains immediate assurance to support improved action plans.
On 7 September, UHDB Paediatric service received a visit from the Operational Delivery Network (ODN) to review surgery in children services. These visits are being undertaken at each regional provider Trust against the relevant national standards and self-assessment process. These visits aim to gain an understanding of the services across the region which will inform a wider Midlands Paediatric Sustainability Programme that the network is collaborating on with NHSE Midlands.
CQC have announced that over the coming months they intend to carry out targeted inspections of the responsive key question in response to concerns from the public in relation to access to GP appointments. The inspections will be carried out remotely (without a site visit) and the rating of responsive will be updated as required. Providers will be given 5 working days' notice of assessment. It is anticipated these inspections will continue until the end of January 2024. Communications about this have been uploaded to the CQC website.

LEARNING AND SHARING - best practices, outcomes

Several high-profile children safeguarding cases have attracted considerable local and media attention – the Derby and Derbyshire Safeguarding Children Partnership have formulated media responses/ communication strategies.
Home Office and Serco have made the decision to increase the hotel capacity for asylum seekers at two of the Hotels in Derbyshire.

Performance

Michelle Arrowsmith, Chief Strategy & Delivery Officer
Dr Deji Okubadejo, Non-Executive Member

Operational Plan Summary

NHS
Derby and Derbyshire
Integrated Care Board

Planned Care and Cancer – August Performance

- **The number of people waiting 65 weeks or longer on an incomplete RTT pathway:** The position has declined further in August 2023, with 1,263 more patients waiting 65 weeks or longer than planned at an ICB level (UHDB: 2,572 actuals vs. 1,304 plan; CRH: 342 actual vs. 347 plan)
- **The number of people on a community service waiting list:** The community service waiting list at the end August 2023 is 25,971 an increase of 1,945 compared to when we started this financial year (24,026 as at end of March 2023).
- **Cancer waits longer than 63 days:** At the end of August 2023 CRH is slightly above plan at 59 with a plan of 54, UHDB have 481 against a plan of 466.
- **75% of cancers diagnosed within 28 days of referral:** The CRH continue to deliver the 75% standard. UHDB are at 70% in August.
- **Diagnostics:** Based on the 7 tests measure CRH is at 83.3% and UHDB are at 70.9%.
  (7 tests include: MRI / CT / Non-Obstetric Ultrasound / Echocardiography / Colonoscopy / Flexi Sigmoidoscopy / Gastroscopy)

Urgent and Emergency Care – September Performance

- **4 hr A&E:** Both Trusts continue to achieve against their 4-hr target, with September performance standing at 69.1% and 69.4% at the CRH and UHDB respectively.
- **Urgent Community Response:** The Urgent Community Response Service continues to exceed the response time standard.
- **General and Acute Bed Occupancy:** Bed Occupancy for September is slightly above the national 92% target for both providers. CRH is at 93.3% and UHDB at 92.5%.
- **Category 2 999 response times:** Performance continues to operate above target both for Derbyshire (00:42:31) and the East Midlands as a whole (00:42:33).

Mental Health, Learning Disabilities and Autism

- **IAPT, perinatal, adult SMI contacts**: Good performance against plan with all 3 metrics, have over-achieved at the end of Q1.
- **Dementia diagnosis rate:** ahead of plan at the end of August.
- **SMI Health checks** – just fell short at the end of Q1 but on track for quarter 2.
- **Out of area placements** – off plan.

Planning Compliance with Operational Plan

NHS
Derby and Derbyshire
Integrated Care Board

Area	Objective	Level	Operational Plan / Local Target	Full Year OP Target Profile	M05/Q2 OP Target Profile	M1 Position	M2 Position	M3 Position	M4 Position	M5 Position	M6 Position	Comment
Primary Care	Increase General Practice appointment activity		Operational Plan	6,707,340	529,190	471,753	538,841	568,802	536,175	549,860		
	Increase referrals into Community Pharmacy Consultation Services (Quarterly Target)		Operational Plan	39,197	9,373	*2,559*	*2,463*	*2,255*	*2,027*			
	Recover dental activity to pre-pandemic levels (Quarterly Target)		Operational Plan	1,531,764	382,941	*615,762*						This is YTD dental activity at 29/09/23. this represents 39.7% of the total planned activity. Activity can be submitted up to two months after treatment date.
Mental Health, Autism & Learning Disabilities	Increase the dementia diagnosis rate (Quarterly Target)	ICB	Operational Plan		64.5%	66.3%	66.4%	67.1%	67.7%	68.0%		
	Provide access for 28,294 people to receive IAPT in 23/24 (Quarterly Target)	ICB	Operational Plan	28,294	7008	2265	4700	7205	2370			Rolling total each quarter
	Increase the number of women accessing specialist perinatal services in 2023/24 (Quarterly Target).	ICB	Operational Plan	2,757	546	260	365	465	535			
	Increase the number of children and young people accessing a mental health service (Quarterly Target).	ICB	Operational Plan	52,481	12,600	10,630	10,720	11,205	11,545			Monthly activity number is a rolling 12 month total
	Increase the number of adults with a severe mental health illness receiving 2+ contacts with a community health service (Quarterly Target).	ICB	Operational Plan	44,815	10,972	11,730	11,685	11,690	11,635			Monthly activity number is a rolling 12 month total
	Ensure that 75% of individuals listed on GP registers as having a learning disability will receive annual health check (Quarterly Target).	ICB	Operational Plan	75%	24.5%	2.7%	6.7%	11.5%	15.7%	20.6%		Qtr 1 target missed by 0.46% - rolling total
	Reduce the number of adults who are autistic, have a learning disability or both who are in beds commissioned by the ICB and NHSE.	ICB	Operational Plan	36	46	45	49	48	42	47		Revised targets have been agreed with the Regional Team. The Q2 revised target is 42.
	Reduce the number of children who are autistic, have a learning disability or both who are in inpatient beds	ICB	Operational Plan	3	5	6	7	4	3	2		
	Reduce out of area placements - Bed Days	DHCFT	Operational Plan	736	1,196	555	1,200	2,065	785			Rolling total each quarter

Figures in italics are ***provisional*** *- Unavailable data is marked as n/a*
** Provisional data is unpublished by NHSE*

Key to RAG Ratings
On Plan
Close to Plan
Off Plan

Planning Compliance with Operational Plan

NHS
Derby and Derbyshire
Integrated Care Board

Area	Objective	Level	Operational Plan / Local Target	Full Year OP Target Profile	M05/Q2 OP Target Profile	M1 Position	M2 Position	M3 Position	M4 Position	M5 Position	M6 Position	Comment
Cancer	Ensure that at least 75% of people receive communication of a diagnosis for cancer or ruling out of cancer, or a decision to treat if made before a communication of diagnosis, within 28-days following an urgent referral for suspected cancer.	CRH	Operational Plan		80%	77.0%	77.8%	78.2%	79%	*78%*		
		UHDB	Operational Plan		69%	66.9%	70.0%	71.6%	72%	*70%*		
	Reduce the number of people waiting longer than 62 days for their first definitive treatment for cancer.	CRH	Operational Plan	43	54	47	48	44	47	49	59	
		UHDB	Operational Plan	268	466	473	473	369	366	477	481	
Planned Acute Care	No person waiting longer than 65 weeks on an RTT pathway at the end March 2024.	CRH	Operational Plan	0	347	314	313	314	312	342		
		UHDB	Operational Plan	0	1,304	1,704	1,924	1,985	2,073	2,572		
		DDICB	Operational Plan		1,253	1,813	1,988	2,059	2,143	2776		
	No person waiting longer than 78 weeks on an RTT pathway.	CRH	Not OP targets	0	0	16	14	6	12	14		
		UHDB	Not OP targets	0	0	144	130	99	112	200		
		DDICB	Not OP targets	0	0	195	193	129	148	201		
	No person waiting longer than 104 weeks on an RTT pathway.	CRH	Not OP targets	0	0	0	0	0	0	0		
		UHDB	Not OP targets	0	0	0	0	1	0	0		
		DDICB	Not OP targets	0	0	3	6	0	2	0		
	At least 85% of people receive a diagnostic test within 6 weeks by March 2024.	CRH	Operational Plan	85%	76%	82.9%	82.5%	85.1%	84.0%	83.3%		Percentage compliance is based on seven diagnostic tests (MRI / CT / Non Obs Ultrasound / Echocardiography / Colonoscopy / Flexi Sigmoidoscopy / Gastroscopy
		UHDB	Operational Plan	85%	72%	68.1%	70.0%	71.6%	71.1%	70.9%		
Urgent and Emergency Care	No less than 76% attending ED waiting longer than 4 hours either to be treated, admitted or discharged, by March 2024.	CRH	Operational Plan	76%	61%	67.9%	64.8%	68.8%	70.9%	65.7%	69.1%	Both Trusts are currently meeting and exceeding the 4 hour operational plan target.
		UHDB	Operational Plan	76%	57%	66.7%	68.4%	67.7%	71.8%	69.4%	69.4%	
	30 minutes or less for EMAS to respond to a category 2 incident, on average.	ICB	Operational Plan		0	00:31:00	00:35:00	00:40:00	00:38:48	00:39:33	00:42:31	
		EMAS	Operational Plan	30 Mins	30 mins	00:33:32	00:34:23	00:39:34	00:36:16	00:36:49	00:42:33	
	Both Acute Trusts to operate at an average general and acute occupancy rate of 92%.	CRH	Operational Plan	88.97%	86.6%	94.2%	94.5%	94.0%	92.4%	91.8%	93.3%	The operational plan targets for September are 97.4% CRH and 92.1% UHDB.
		UHDB	Operational Plan	92.89%	94.1%	89.8%	93.3%	94.0%	92.2%	91.7%	92.5%	In September the UHDB actual is close to plan, for CRH it is under plan. This is based on the Covid unadjusted number. For September Covid adjusted is CRH - 93.9%% / UHDB 92.6%
	At least 70% of referrals into the Urgent Community Response Service to be responded to within 2 hours.	ICB	Operational Plan		70%	67%	90%	89%	91%	*90%*		There is still a small discrepancy between local and nationally reported data. The locally reported position is 87% at August.
	Increase virtual ward capacity.	ICB	Operational Plan	255	182	102	102	102	114	125	130	Month end snapshot
	Increase virtual ward utilisation.	ICB	Local Target	80%	50%	39.0%	25.0%	61.0%	26.0%	46%	58%	
	Reduce emergency admissions resulting from a frailty induced fall.		Local Target			*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	

Planning Compliance with Operational Plan

Derby and Derbyshire Integrated Care Board

Area	Activity Metric	Level	Operational Plan / Local Target	Full Year OP Target Profile	M05/Q2 OP Target Profile	M1 Position	M2 Position	M3 Position	M4 Position	M5 Position	M6 Position	Comment
Community Data	D2A - The number of people discharged by location and discharge pathway per month	ICB	OP Activity Measure		7,095	7,585	8,360	8,378	8654	8525	8096	
	D2A - Pathway 0 - Non-complex discharge		OP Activity Measure		6,406	6,989	7,676	7,652	7943	7834	7422	
	D2A - Pathway 1 - Home with Support		OP Activity Measure		386	300	381	384	380	382	376	
	D2A - Pathway 2 - Intermediate Care		OP Activity Measure		253	236	256	276	259	250	243	
	D2A - Pathway 3 - 24-hour care placement		OP Activity Measure		50	60	47	66	72	59	55	
	Community Waiting List - Quarterly Target	ICB	OP Activity Measure	24,026		24,352	23,483	24,186	21,865	25,971		24,026 target is the Mar 23 waiting list position
	Community Waiting List by weeks - 0-1 weeks	ICB		4,257		4,260	3,343	3,217	3081	3,770		Full year target is the Mar 23 waiting list position Red / Green highlights indicate monthly position in comparison to previous month
	Community Waiting List by weeks - 1-2 weeks			2,372		2,360	2,124	2,304	2046	1,961		
	Community Waiting List by weeks - 2-4 weeks			3,126		2,688	3,184	3,231	3236	3,240		
	Community Waiting List by weeks - 4-12 weeks			6,813		6,956	6,590	6,368	6417	7,672		
	Community Waiting List by weeks - 12-18 weeks			1,581		2,198	2,458	2,594	2369	2,841		
	Community Waiting List by weeks - 18-52 weeks			4,500		4,413	4,493	4,994	3781	4,860		
	Community Waiting List by weeks - over 52 weeks			978		1,124	1,291	1,478	935	1,627		
	Community Waiting List by weeks - Unknown			399		353						

CRHFT Activity Measures Operational Plan

NHS
Derby and Derbyshire
Integrated Care Board

Data Extracted from NHS Futures - Operational Planning Tool - Activity and Performance

Provider	Subject	Measure Name		Apr-23	May-23	Jun-23	Jul-23	Aug-23
CRH	Elective	Elective day case spells - E.M.10a	2023/24 Actuals	2,154	2,492	2,429	2,303	
			2023/24 Plans	2,289	2,421	2,326	2,690	2,378
		Elective ordinary spells - E.M.10b	2023/24 Actuals	255	330	343	307	
			2023/24 Plans	321	385	373	393	389
	Outpatients	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance - E.M.32g	2023/24 Actuals	6,160	7,110	7,128	6,517	
			2023/24 Plans	6,841	6,922	6,440	7,401	6,467
		Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance - E.M.32h	2023/24 Actuals	17,896	19,565	19,759	18,443	
			2023/24 Plans	18,325	19,551	18,238	20,038	17,997
	A&E	A&E - Type 1 - E.M.13a	2023/24 Actuals	5,365	5,697	6,487	7,573	7,128
			2023/24 Plans	5,673	5,762	5,700	5,925	5,720
		A&E - Other - E.M.13b	2023/24 Actuals	2,552	3,067	2,192	1,185	1,364
			2023/24 Plans	2,668	2,841	2,765	2,685	2,479
		A&E - Total - E.M.13	2023/24 Actuals	7,917	8,764	8,679	8,758	8,492
			2023/24 Plans	8,341	8,603	8,465	8,610	8,199
	Non Elective and Emergency Care	Non-elective spells with a length of stay of 1 or more days - E.M.11b	2023/24 Actuals	2,157	2,168	2,286	2,340	
			2023/24 Plans	2,131	2,187	2,143	2,111	2,101
		Non-elective spells with a length of stay of zero days - E.M.11a	2023/24 Actuals	1,370	1,602	1,615	1,601	
			2023/24 Plans	540	555	567	590	467

Provider	Subject	Measure Name		Apr-23	May-23	Jun-23	Jul-23	Aug-23
CRH	RTT	New RTT pathways (clock starts) - E.M.20	2023/24 Actuals	4,766	5,735	5,521	5,353	
			2023/24 Plans	3,443	3,941	3,864	4,030	4,019
		Number of 52+ week RTT waits - E.B.18	2023/24 Actuals	1,211	1,242	1,183	1,184	
			2023/24 Plans	1,698	1,665	1,605	1,547	1,488
		Number of 65+ week RTT waits - E.B.20	2023/24 Actuals	314	313	314	312	
			2023/24 Plans	467	452	417	382	347
		RTT completed admitted pathways - E.M.18	2023/24 Actuals	326	411	508	360	
			2023/24 Plans	660	789	593	659	510
		RTT completed non-admitted pathways - E.M.19	2023/24 Actuals	3,964	4,426	4,685	4,173	
			2023/24 Plans	4,673	4,802	4,468	5,036	4,333
		RTT waiting list - E.B.3a	2023/24 Actuals	25,108	25,638	25,294	26,015	
			2023/24 Plans	24,595	24,672	25,081	25,989	26,554

UHDBFT Activity Measures Operational Plan

Derby and Derbyshire Integrated Care Board

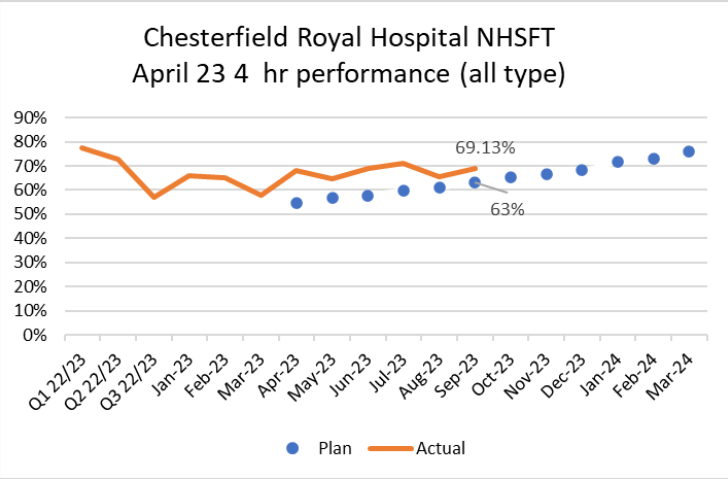
Data Extracted from NHS Futures - Operational Planning Tool - Activity and Performance

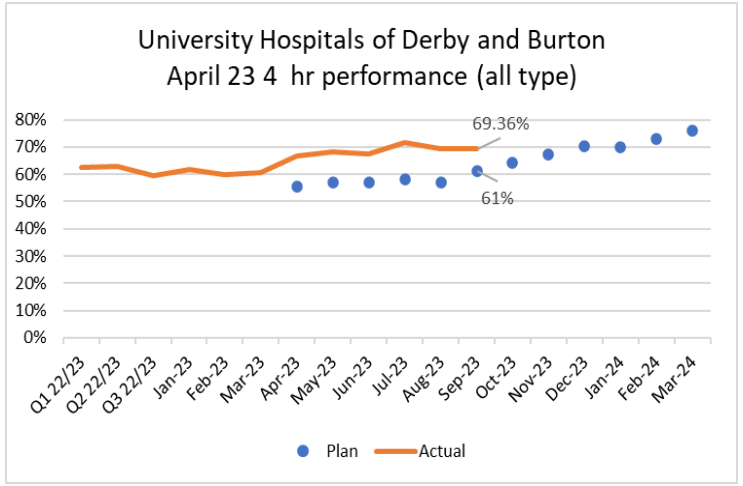
Provider	Subject	Measure Name	Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23
UHDB	Elective	Elective day case spells - E.M.10a	2023/24 Actuals	8,443	9,212	9,338	8,692	
			2023/24 Plans	9,414	10,404	9,909	10,404	10,900
		Elective ordinary spells - E.M.10b	2023/24 Actuals	954	1,149	1,221	1,156	
			2023/24 Plans	1,089	1,204	1,146	1,204	1,261
	Outpatient	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance - E.M.32g	2023/24 Actuals	25,817	30,819	32,043	29,244	
			2023/24 Plans	30,681	33,910	32,296	33,910	35,525
		Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance - E.M.32h	2023/24 Actuals	62,814	72,800	72,888	68,550	
			2023/24 Plans	64,583	71,382	67,983	71,382	74,781
	A&E	A&E - Type 1 - E.M.13a	2023/24 Actuals	14,480	15,992	15,999	15,491	16,534
			2023/24 Plans	15,398	16,029	15,799	15,443	14,567
		A&E - Other - E.M.13b	2023/24 Actuals	12,831	14,370	14,170	14,435	12,088
			2023/24 Plans	8,612	9,377	9,181	9,341	8,584
		A&E - Total - E.M.13	2023/24 Actuals	27,311	30,362	30,169	29,926	28,622
			2023/24 Plans	24,010	25,406	24,980	24,784	23,151
	Non Elective and Emergency Care	Non-elective spells with a length of stay of 1 or more days - E.M.11b	2023/24 Actuals	4,995	5,227	5,400	5,188	
			2023/24 Plans	4,733	4,891	4,733	4,891	4,891
		Non-elective spells with a length of stay of zero days - E.M.11a	2023/24 Actuals	2,520	2,678	2,723	2,800	
			2023/24 Plans	2,805	2,898	2,805	2,898	2,898

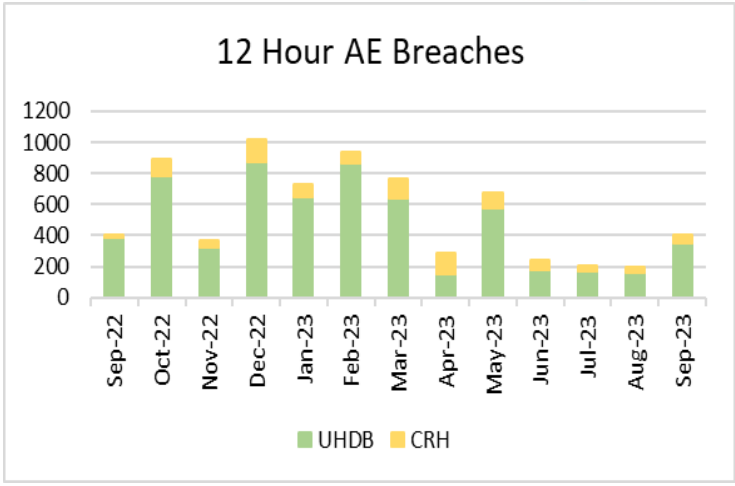
Provider	Subject	Measure Name	Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23
UHDB	RTT	New RTT pathways (clock starts) - E.M.20	2023/24 Actuals	19,474	22,704	23,166	22,769	
			2023/24 Plans	18,729	21,518	20,367	20,399	21,583
		Number of 52+ week RTT waits - E.B.18	2023/24 Actuals	6,218	6,654	7,049	7,226	
			2023/24 Plans	6,698	6,469	6,273	6,063	5,882
		Number of 65+ week RTT waits - E.B.20	2023/24 Actuals	1,704	1,924	1,985	2,073	
			2023/24 Plans	2,156	1,935	1,729	1,511	1,304
		RTT completed admitted pathways - E.M.18	2023/24 Actuals	3,200	3,610	3,829	3,155	
			2023/24 Plans	4,522	4,857	4,756	5,405	4,591
		RTT completed non-admitted pathways - E.M.19	2023/24 Actuals	11,835	14,038	14,086	12,987	
			2023/24 Plans	13,306	14,100	13,475	14,913	13,345
		RTT waiting list - E.B.3a	2023/24 Actuals	109,698	110,032	110,690	110,973	
			2023/24 Plans	110,285	107,883	105,275	100,337	99,113

Urgent & Emergency Care

Derby and Derbyshire Integrated Care Board







A&E 4hr target: Both Trusts are consistently meeting and exceeding the Operational Plan target for 4hr A&E wait.
CRH had a target of 63% but achieved 69.1% / UHDB had a target of 61% but achieved 69.4%.

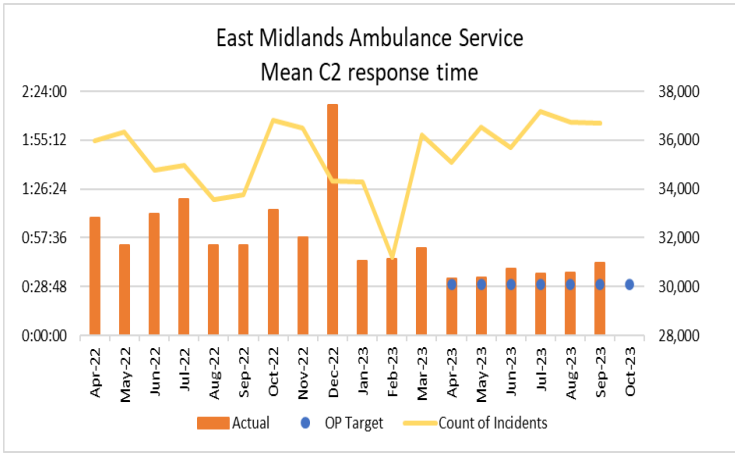
12-hour Trolley breaches in September 2023 - 54 at CRH / 354 at UHDB, an increase on last month at both Trusts.

A key focus is in achieving and exceeding the 76% national target by March 2024.
Both Acute sites have taken contractual ownership of Co-located type 3 services to integrate further into the ED front door flow management & performance improvement, with a similar arrangement at Burton proposed. RDH and CRH have been visited by NHSE and advised on designation and data reporting.
Both acute focused on ED to SDEC flow, specifically frailty response and referrals from GPs and Nurses.
Both acute sites and ICB reviewing Type 1 performance/data tracking methods to ensure appropriate benchmarking with other systems.

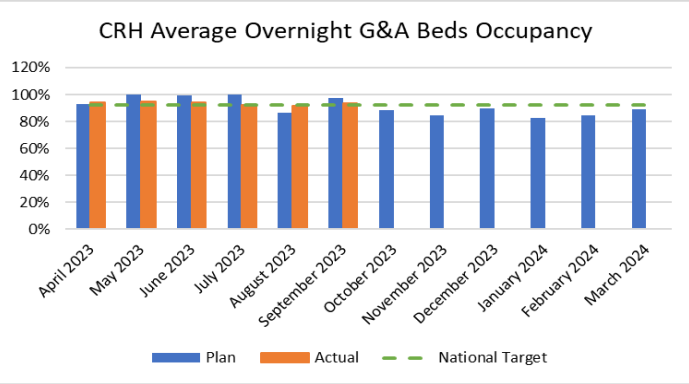
Ambulance C2 Response time: The East Midlands Ambulance Service achieved a performance of 42:33 minutes for C2 response times against a target of 30 mins.

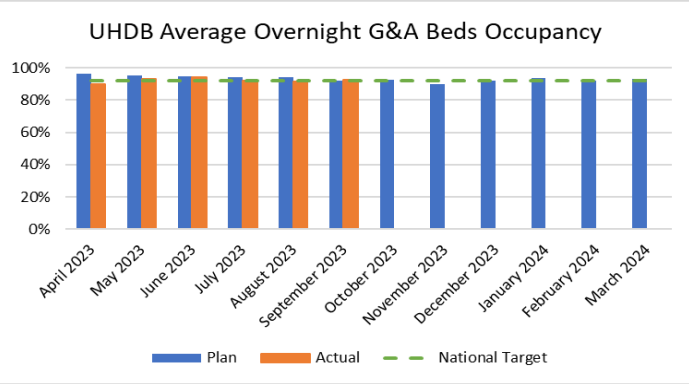
Ambulance Handover delays: At both CRH and RDH, there have been fewer hours lost to delay when comparing this financial year to last – despite there being more ambulance arrivals. However, for RDH more hours were lost in May and the first half of September indicating longer handovers compared to last year.

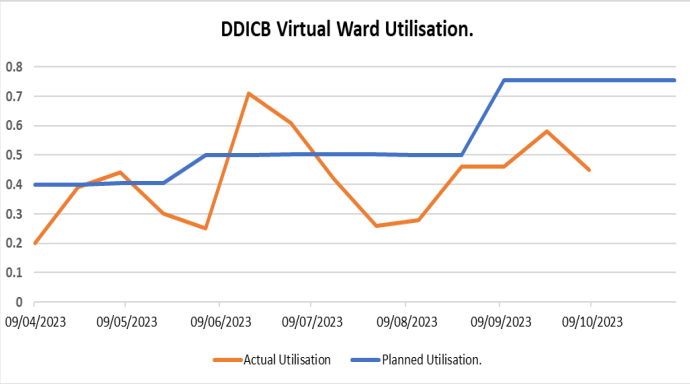
Work is ongoing to improve the ambulance response time to achieve the 30min target.
Ambulance UECC transformation team, through Specialist Paramedic Hubs, is assisting with the introduction of a clinical navigation hub (CNH) and CNH+ that serves to filter out patients who didn't need ED and could find an alternative pathway reducing pressure at the front door.
There is daily monitoring of handover delays, with a monthly improvement meeting with Acutes to discuss performance .



Urgent & Emergency Care







Bed Occupancy:
The current national target is 92%. In September CRH achieved 93.3% and UHDB achieved 92.5%.

Patients remaining in hospital who no longer meet the criteria to reside: The number of patients in an acute hospital bed who no longer meet the criteria to reside is not significantly different this year compared to same period last year.

Reasons for Delayed Discharges: relating to patients who no longer meet the CTR (Criteria to Reside) but remain in hospital for 7 days or longer: 21% of the delays are associated with hospital process issues, 45% are due to social care capacity and 22% due to community care capacity.

Virtual Wards: As at the 22nd September 2023 the capacity for virtual ward stood at 130, against a target of 195. Utilisation at the 22nd September was 58%.
Key Actions
Discharge Improvement;
County Council's P1 transformation will increase to 15 new P1 starts by Feb 24
Community Response Team (CRT) will increase by 7 new starts by Dec 23
County Council's Brokerage increase by 6 starts Dec
Additional staff investment to reduce delays in CRH and UHDB and focus on discharge 59
New VCSE service (Derby City only) to support P0 discharges started on 12th June; took 13 people on in the first week to support discharge back home.

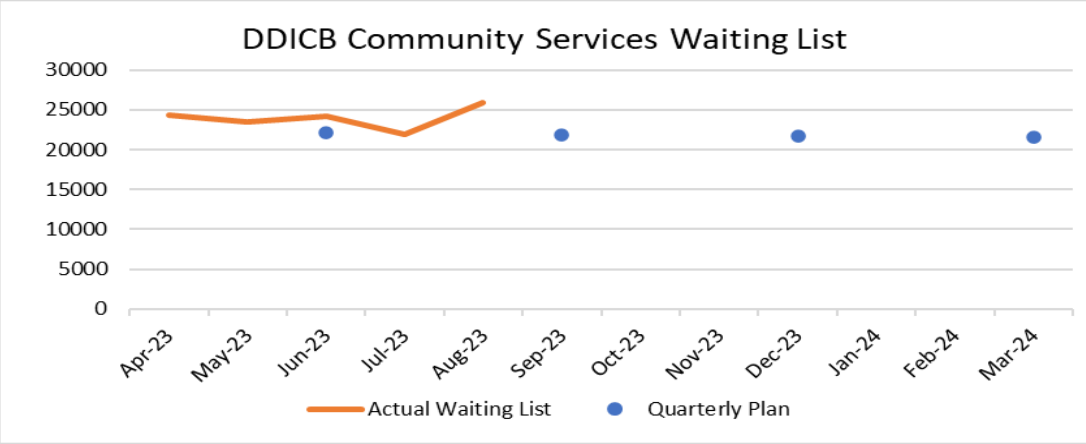
Virtual Wards;
There are now nine virtual wards live across the system and all wards are now digitally enabled and consistently onboarding patients. Actions being implemented to boost utilisation include;
Digital enabled all VWs to consistently onboard and monitor
VW Summit held and actions to improve utilisation and improve system position agreed.
Reviewing workforce requirements to ensure impact to service over winter in minimised

Mental Health Crisis Response;
Recognised as a key UEC driver our board is working with system MH teams to ensure collaborative approach to crisis response.
The Crisis Alternatives include Safe Havens, Crisis Cafes and Crisis Houses.
MHRV will now come online early 2024 in a collaboration with MH and EMAS teams.

Community Care

Derby and Derbyshire Integrated Care Board

Community Waiting Lists



Services with highest percentage waiters over 18 weeks - August 2023			
Service	Total Waiting List	Waiting list above 18 weeks	% Waiting list above 18 weeks
(CYP) Community paediatric service	2,208	1,759	80%
(A) Podiatry and podiatric surgery	7,328	3,593	49%
(A) Nursing and Therapy support for LTCs: Respiratory/COPD	456	125	27%
(CYP) Therapy interventions: Speech and language	864	216	25%
(A) Neurorehabilitation (multi-disciplinary)	580	138	24%

The DDICB Community waiting list in August (25,971) is above both the Operational Plan and the Mar 23 position (24,026).
In August 25% of those waiting exceed 18 weeks, the main areas are Community Paediatric and Adult Podiatry service.

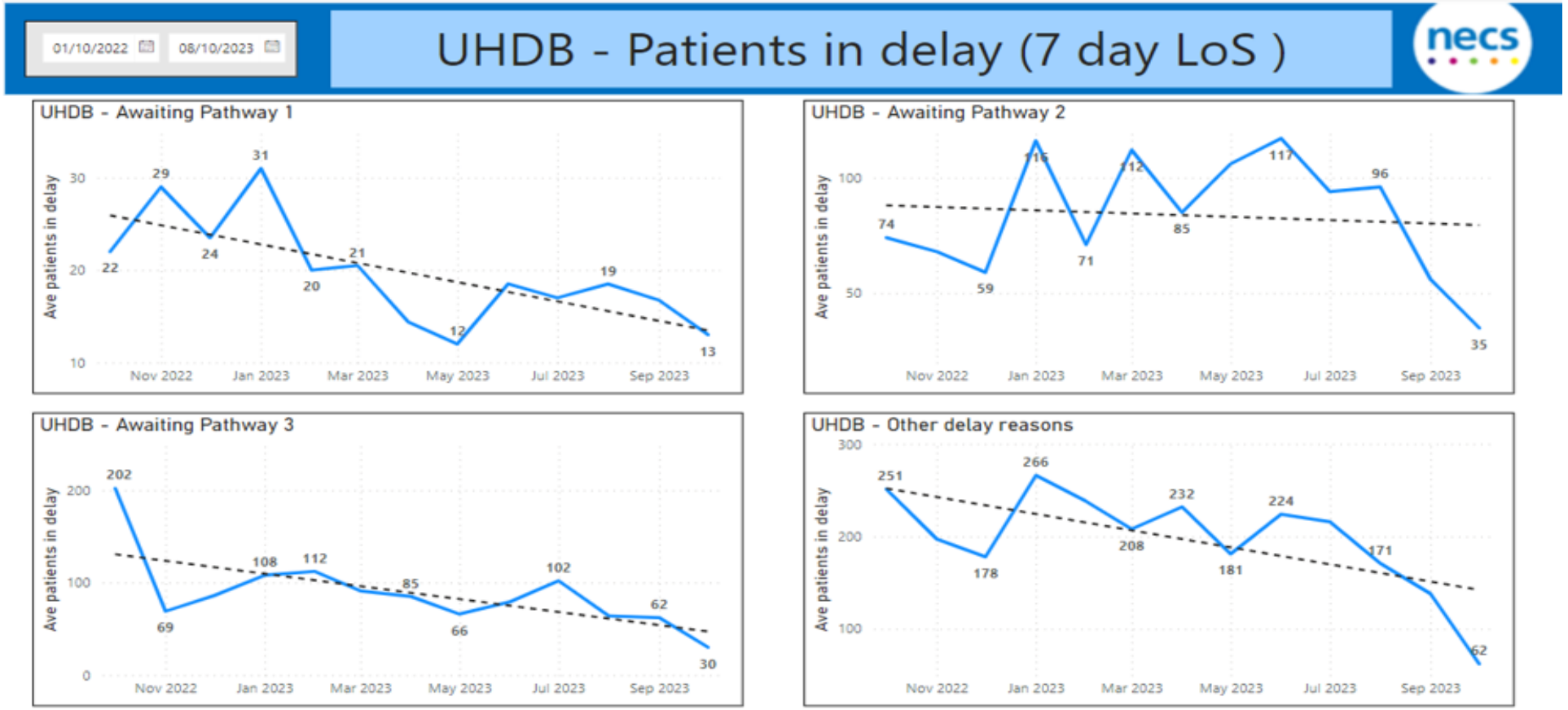
Discharge Activity

D2A Hospital Discharge Pathway Activity		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
The number of people discharged by location and discharge pathway per month	Target	6,770	7,040	7,926	8,491	7,095	7,258
	Actual	7,585	8,360	8,378	8,654	8,525	8,096
Pathway 0 - Non-complex discharge	Target	6,080	6,314	7,220	7,710	6,406	6,581
	Actual	6,989	7,676	7,652	7,943	7,834	7,422
Pathway 1 - Home with Support	Target	357	432	433	494	386	424
	Actual	300	381	384	380	382	376
Pathway 2 - Intermediate Care	Target	270	243	214	217	253	202
	Actual	236	256	276	259	250	243
Pathway 3 - 24-hour care placement	Target	63	51	59	70	50	51
	Actual	60	47	66	72	59	55

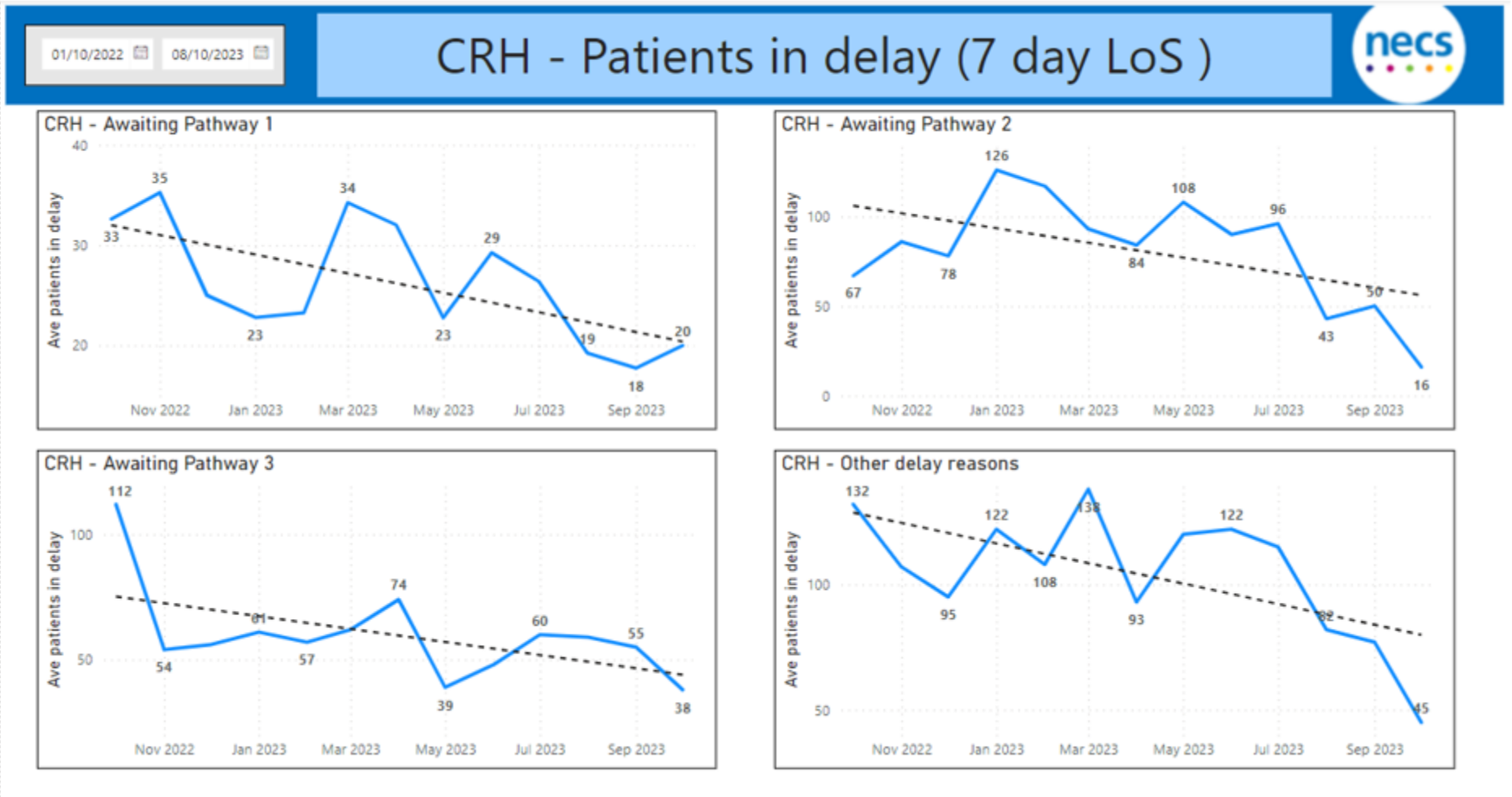
Non-complex discharge activity is consistently performing and is above plan, except for Pathway 1 & 2 discharges.

Length of Stay Weekly Snapshot – Weekly Delays (UHDBFT)

Derby and Derbyshire Integrated Care Board



Length of Stay Weekly Snapshot – Weekly Delays (CRHFT)



Planned Care & Cancer

Derby and Derbyshire Integrated Care Board

- Elective care waits of more than 78 weeks should be eliminated from April 2023, from August, this activity has started to increase.

Objective	Level	Apr-23	May-23	Jun-23	Jul-23	Aug-23
No person waiting longer than 78 weeks on an RTT pathway.	CRH	16	14	6	12	14
	UHDB	144	130	99	112	200
	DDICB	195	193	129	148	201

- The 65-Week performance is declining.
- CRH have been performing well against the operational plan.
- UHDB will find it challenging to achieve the target.
- The total incomplete pathway position for CRH is tracking close to the operational plan.
- UHDB have submitted a revised winter plan showing a position of 94,667 by Mar 24 (a variance of 9,075 on the operational plan).
- The current performance for UHDB is 114,562 against a revised plan of 109,621.

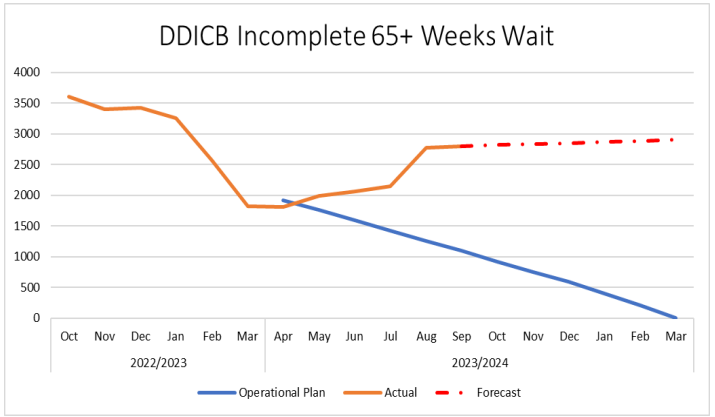
Current actions include:

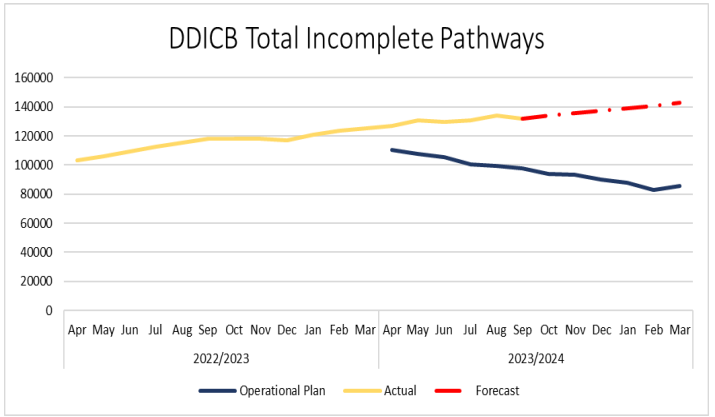
UHDB

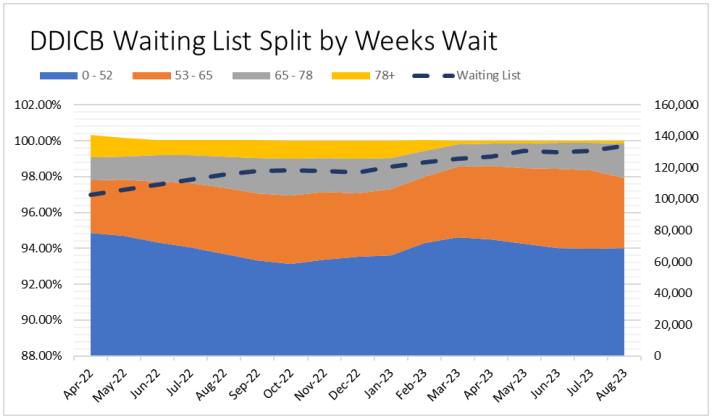
- The return of the orthopaedic ward at RDH but emergency pressures over the winter could put this transition at risk
- Outsourcing and Insourcing contracts that are in place continue with some expanded such as Echo, and new ones have been agreed and are being sought. Medacs have been brought in to support orthopaedics, an insourcing arrangement to boost endoscopy capacity commenced in September and Cardiology are in talks to secure capacity for October.
- Capacity is further being boosted through additional internal sessions where they can be agreed with UHDBs workforce
- The transfer of ASIs to IS providers continues
- Mutual Aid is being used particularly to support orthopaedics

CRH

- Further work is ongoing with theatre capacity and further opportunities for additional theatre lists for specific specialities continues to be reviewed daily.
- Beds for Elective Care will continue to be ring-fenced, however an increase in demand beyond modelled/assumed level for emergency pathways (including COVID) could potentially impact on this during the year – Currently 31 elective beds vs 46 planned.







Weeks	Total	%
0 - 52	125,833	94%
53 - 65	5,231	4%
65 - 78	2,575	2%
78+	201	0%
Total	133,840	100%

Planned Care & Cancer

Cancer 2 Week Wait: Referrals remain high and current capacity constraints are impacting upon the ability to meet the demand.

Cancer 28 Day Faster Diagnosis (target 75%): CRH in August achieved 78.1%, above the national 75% target but slightly lower than the 80% plan trajectory. UHDB achieved 69.5% above the local plan value of 69% (UHDB is projecting to achieve 75% by March 24).

Cancer 31 Day Wait from Diagnosis to 1st Treatment: CRH performance for August was 94.6%, UHDB was 89.3%

Cancer 62 Day Backlog: CRH has 59 patients against a target of 56 / UHDB has 481 patients against a target of 469.

Cancer 62 Day Referral to First Treatment: In August CRH achieved 81.6% and UHDB achieved 55.1%.

Key Recovery Actions:

Best Practice Timed pathways (BPTP) Tumour site specific actions:

- Tumour site recovery plans being refreshed following IST support – updates expected end Oct-23

LGI:

- LGI Clinical triage operational at both sites. Work ongoing to confirm FIT negative pathway fully in place and outcome of triage to reviewed at PCDB Oct-23
- UHDB FIT data for September (FIT included with LGI referral): QHB: 38% RDH: 77%

Urology:

- CAS commenced RDH Sep-23 with QHB to commence Oct-23
- STT Diagnostics work in place to improve transition through BPTP milestones

Gynae

- CAS in place at both sites
- Developing key pathways to implement DA US. Ongoing engagement with Primary Care – pilot sites to be developed through Oct-23

Skin

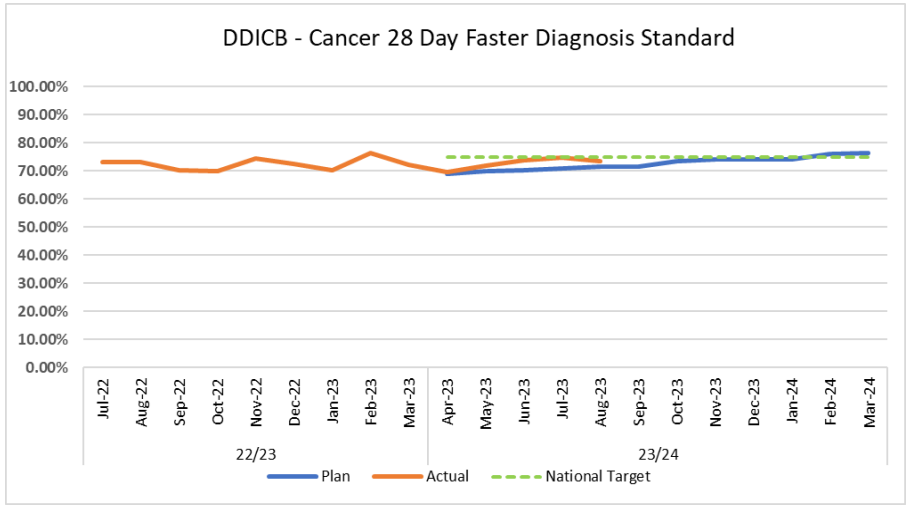
- Pilot to test photographic hub model at FNCH in development. Work ongoing to develop estates to implement this work. Require further attention to develop plans in Oct-23

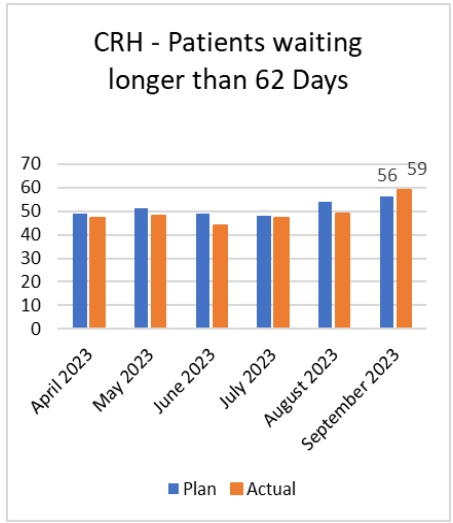
Non-Site Specific (NSS)

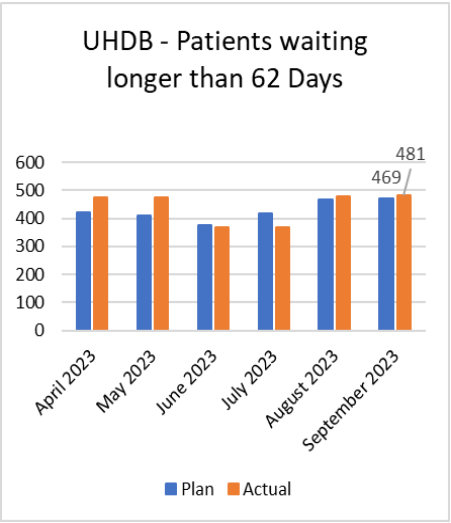
- Pathway available to 100% of Derbyshire practices but uptake minimal. Work ongoing to align blood panels across JUCD and ensure pathway in place. Data analysis complete and about to confirm how we will work with Primary care to promote this

28 day take off letters

- Ongoing MDT improvements to support 28 day take off letter processes



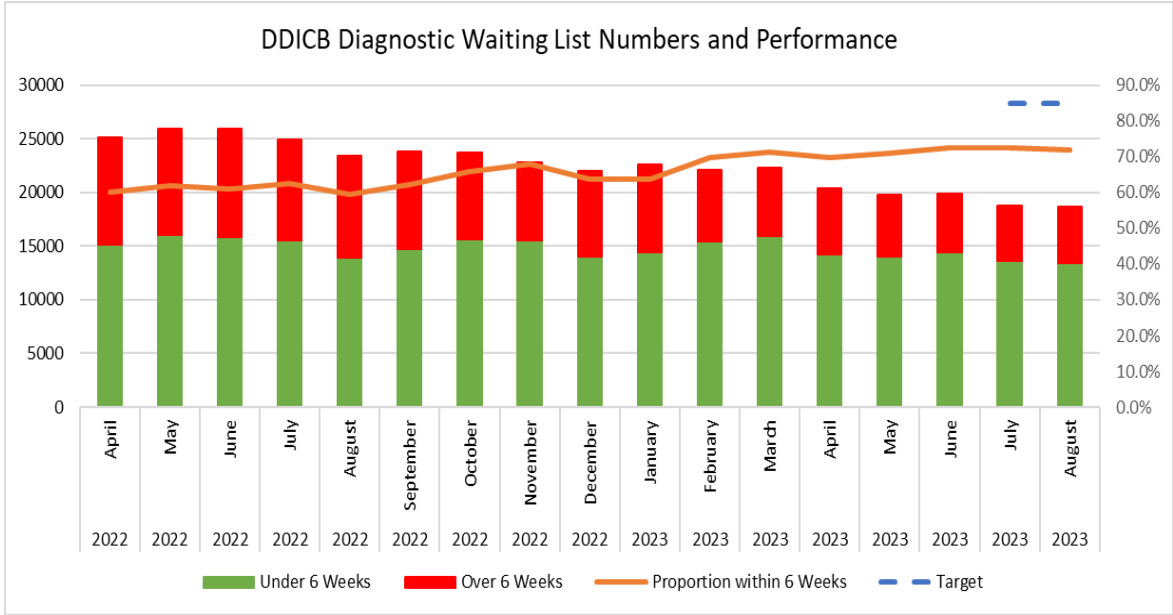


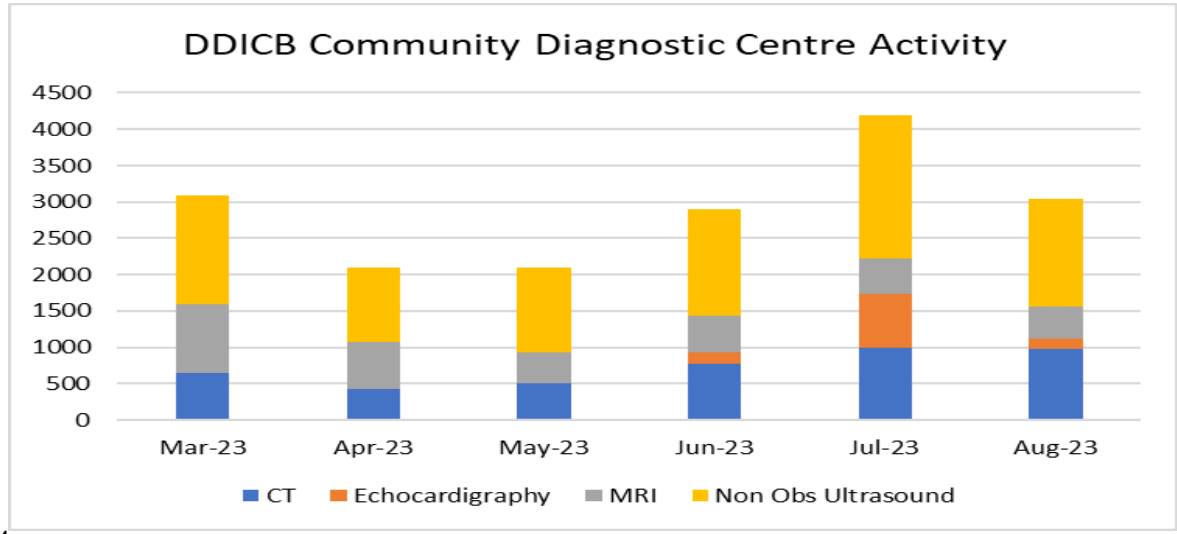


Indicator		Currency	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Increase % of Lower GI suspected cancer referrals with an accompanying FIT result	ICB	Actual	73%				
		Plan	63%	63%	63%	63%	65%

Diagnostics

- The Operational Plan target is to increase the percentage of patients that receive a diagnostic test within six weeks to 95% by March 2025. The expectation is for the ICB to be at 85% by March 2024.
- Current ICB performance is at 71.9%.
- Echocardiography and Colonoscopy have the highest volume of activities waiting over 6 weeks.
- Community Diagnostic Centre activity is approx. 3,000 tests per month.
- UHDB have agreed an extension of the insourcing contract for Echo activity as well as enhanced rates for internal staff to boost capacity.
- Endoscopy insourcing commenced in the middle of September which will provide 6-7 all day sessions (12-14 lists) which will boost capacity considerably.





Mental Health, Learning Disabilities & Autism Services

Derby and Derbyshire Integrated Care Board

Inpatient Services has a recovery action plan in place targeting flow through the system.

Key areas and actions are:

Reducing Inflow

- Non-Clinical in-reach now fully mobilised
- Revised action plans on LAEP, DSR and CTRs processes
- RCA evidencing that when clinically challenged around function of behaviours V treatable mental illness alternatives to hospital are being explored and admissions avoided
- ND elements being fed into new design framework for flow for adult acute mental health – including practical packages element to eliminate MFFDs
- Pilot of ASD case management for 6 months support for high intensity and High ED/acute frequency patients

Improving Flow

- Implementing new cohorting approach for RAG-rating of discharge planning, attached to LoS expectations, DSR usage and systematic escalation processes
- Recruited a lead to coordinate all the AMH, out of area locked rehabs/ATU and spec com beds and plan repatriation back to Derbyshire. Including setting up community services for these individuals including contracting linking in with ICB (started on 4th July 2023)
- Non-clinical in reach extending scope to include mobilisation of a high intensity/high frequency service user expediting discharge from AMH
- Key working tendered to Affinity and strategic manager recruited – targeted resource for 0-25 yrs ‘Go live’ August 2023 referrals starting to be received

Expediting complex discharges / Improving outflow

- Introduction of new cohorting approach with attached escalation and management. This will include ensuring 12 step discharge planning is commenced immediately, that barriers to discharges are identified at earliest stage and where possible processes run in parallel
- New bi-weekly LDA/AMH discharge meetings underway, jointly chaired by Managing Directors covering acute mental health and neurodevelopmental with attendance from consultants, matrons, TCP leads and other operational colleagues

Constitutional Standards – Urgent Care

Derby and Derbyshire Integrated Care Board

ICB Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire ICB				Chesterfield Royal Hospital FT				University Hospitals of Derby & Burton FT				NHS England			
					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance		Current Month	YTD	consecutive months non-compliance		Current Month	YTD	consecutive months non-compliance	
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Sep-23	↑	75.1%	75.0%	53	79.4%	79.0%	96		73.6%	73.5%	25		71.1%	73.8%	96	
		A&E 12 Hour Trolley Waits	0	Sep-23					54	452	38		354	1,562	18		33,107	170,824	38	

EMAS Dashboard for Ambulance Performance Indicators

	Area	Indicator Name	Standard	Latest Period	East Midlands Ambulance Service Performance (NHSD&DICB only - National Performance Measure)				EMAS Performance (Whole Organisation)				EMAS Completed Quarterly Performance 2023/24				NHS England			
					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	Current Month	YTD	consecutive months non-compliance	
Urgent Care	Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Sep-23	↓	00:08:48	00:08:35	39	00:08:36	00:08:35	38	00:08:36	00:08:36			00:08:31	00:08:22	29	
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Sep-23	↓	00:14:54	00:14:59	0	00:15:25	00:15:33	27	00:15:30	00:15:38			00:15:07	00:14:55	1	
		Ambulance - Category 2 - Average Response Time	00:18:00	Sep-23	↓	00:42:31	00:38:06	38	00:42:38	00:37:16	39	00:35:56	00:38:37			00:37:38	00:33:08	38	
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Sep-23	↓	01:34:05	01:22:17	38	01:32:48	01:20:27	38	01:17:42	01:23:32			01:21:04	01:10:55	30	
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Sep-23	↓	06:50:16	05:52:44	38	07:00:30	05:35:21	38	05:15:07	05:55:04			05:26:59	04:27:53	30	
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Sep-23	↓	05:10:51	04:25:09	30	05:00:26	04:30:35	30	04:28:26	04:41:20			06:25:35	05:36:22	30	

111 Indicators

Area	Indicator Name	Standard	Latest Period	DHU Performance	
				Direction of Travel	Current Month
111 Key Indicators	Abandonment Rate	5%	Aug-23	↑	1.1%
	Average Speed of Answer	00:00:27	Aug-23	↑	00:00:19

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

Constitutional Standards – Planned Care & Cancer

Derby and Derbyshire Integrated Care Board

ICB Dashboard for NHS Constitution Indicators				Direction of Travel	NHS Derby & Derbyshire ICB			Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England		
Area	Indicator Name	Standard	Latest Period		Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Aug-23	↓	55.3%	56.5%	67	57.8%	60.1%	52	53.1%	53.6%	68	58.0%	58.7%	90
	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Aug-23	↓	8,007	38,162	43	1,190	6,010	41	7,392	34,539	42	396,643	1,925,811	196
	Number of 78 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Aug-23	↑	201	866	29	14	62	29	200	685	29	8,998	46,387	29
	Number of 104 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Aug-23	↓	0	11	0	0	0	0	0	0	0	265	1,861	29
Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Aug-23	↑	29.53%	29.24%	63	23.85%	22.87%	41	30.86%	31.29%	42	27.47%	26.30%	120
2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Aug-23	↓	78.0%	80.5%	36	78.3%	83.7%	9	65.1%	71.4%	36	74.8%	78.2%	39
	Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Aug-23	↓	73.1%	79.8%	15	41.9%	66.0%	12	84.2%	88.8%	5	70.3%	72.9%	39
28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Aug-23	↓	73.6%	72.8%	6	78.1%	78.2%	0	69.5%	70.0%	25	71.6%	72.4%	6
31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Aug-23	↓	88.2%	88.1%	32	94.6%	92.9%	24	89.3%	88.1%	37	91.0%	91.0%	32
	Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Aug-23	↑	75.9%	64.5%	45	100.0%	93.7%	0	82.8%	67.2%	27	77.8%	77.9%	61
	Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Aug-23	↑	98.7%	96.3%	0	100.0%	100.0%	0	98.5%	96.4%	0	97.7%	97.7%	1
	Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Aug-23	↓	79.1%	76.3%	17				72.2%	68.5%	17	88.4%	89.0%	2
62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Aug-23	↑	62.6%	56.7%	54	81.6%	72.3%	49	55.1%	51.9%	64	62.8%	60.9%	92
	First Treatment Administered - 104+ Day Waits	0	Aug-23	↓	43	229	89	3	31	64	45	219	89	1,868	9,420	92
	First Treatment Administered Within 62 Days Of Screening Referral	90%	Aug-23	↓	52.8%	62.3%	52	44.4%	75.2%	52	68.0%	53.2%	33	65.1%	63.9%	65
	First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Aug-23	↑	76.0%	73.4%		70.6%	78.8%		73.1%	78.8%		74.5%	73.6%	

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	↓

Data Source

NHS
Derby and Derbyshire
Integrated Care Board

Area	Data source	Link
Increase General Practice appointment activity	NHS Digital - Appointments in General Practice	Appointments in General Practice - NHS Digital
Increase referrals into Community Pharmacy Consultation Services (Quarterly Target)	NHS Futures - NHS England Pharmacy Integration Programme Workspace - Primary Care Pharmacy - Monthly Report by phODS - Pharmacy Regional Reports - Midlands Regional Report - Latest month -	https://future.nhs.uk/connect.ti/PharmacyIntegration/view?objectId=38360112
Recover dental activity to pre-pandemic levels (Quarterly Target)	eDEN Dental data via BSA	
Increase the dementia diagnosis rate (Quarterly Target)	NHS Futures - Mental Health Core Data Pack	2324_DASHBOARD_CDP_VW - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform
Provide access for 28,294 people to receive IAPT in 23/24 (Quarterly Target)		
Increase the number of women accessing specialist perinatal services in 2023/24 (Quarterly Target).		
Increase the number of children and young people accessing a mental health service (Quarterly Target).		
Increase the number of adults with a severe mental health illness receiving 2+ contacts with a community health service (Quarterly Target).		
Ensure that 75% of individuals listed on GP registers as having a learning disability will receive annual health check (Quarterly Target).	Foundry - NHS Performance Overview - Learning Disabilites & Autism - Annual Health Check	
Ensure that at least 75% of people receive communication of a diagnosis for cancer or ruling out of cancer, or a decision to treat if	Statistics » Cancer Waiting Times (england.nhs.uk)	https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
Reduce the number of people waiting longer than 62 days for their first definitive treatment for cancer.	Statistics » Cancer Waiting Times (england.nhs.uk)	https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
No person waiting longer than 65 weeks on an RTT pathway at the end March 2024.	Statistics » RTT (england.nhs.uk)	Statistics » Referral to Treatment (RTT) Waiting Times (england.nhs.uk)
At least 85% of people receive a diagnostic test within 6 weeks by March 2024.	Statistics » Monthly Diagnostic Waiting Times and Activity (england.nhs.uk)	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
No less than 76% attending ED waiting longer than 4 hours either to be treated, admitted or discharged, by March 2024.	Data taken from: A&E 4 hour performance - NHS England,	https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
30 minutes or less for EMAS to respond to a category 2 incident, on average.	https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators).	
Both Acute Trusts to operate at an average general and acute occupancy rate of 92%.	Statistics - NHS England - Critical care and General & Acute Beds – Urgent and Emergency Care Daily Situation Reports 2023-24	https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/critical-care-and-general-acute-beds-urgent-and-emergency-care-daily-situation-reports/critical-care-and-general-acute-beds-urgent-and-emergency-care-daily-situation-reports-2023-24/
At least 70% of referrals into the Urgent Community Response Service to be responded to within 2 hours.	https://www.england.nhs.uk/statistics/statistical-work-areas/2-hour-urgent-community-response/	
Increase virtual ward capacity.	Foundry (Virtual Ward Dashboard)	
Increase virtual ward utilisation.		
D2A - The number of people discharged by location and discharge pathway per month	NECS	\\ntpcts60.nntha.loc\shared_info\Collaborative Working\NECS Derbyshire Contract Reporting\Sitrep_metrics\Intial_Sample_data.xlsx
D2A - Pathway 0 - Non-complex discharge		
D2A - Pathway 1 - Home with Support		
D2A - Pathway 2 - Intermediate Care		
D2A - Pathway 3 - 24-hour care placement		
Community Waiting List - Quarterly Target	Statistics - NHS England - Community Waiting list	Statistics » Community Health Services Waiting Lists (england.nhs.uk)
Activity	NHS Futures	NHS Futures – NHS Planning Workspace – Tools – Activity and Performance Plan VS Actual Tool

Workforce

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

2023/24 Workforce Summary: Month 6 (including EMAS)

NHS
Derby and Derbyshire
Integrated Care Board

Workforce Plan Position

- The total workforce across all areas (substantive, bank and agency) was 885.23 WTE above plan at M6.
- Compared to M5, there was a decrease in substantive positions (-31.22WTE) but there was also a decrease in both bank (-185.26 WTE) & agency usage (-8.24WTE).
- The majority of the fluctuation in substantive positions was due to the Foundation Trainees (F1) Rotation in July and August which should stabilise during September and October.

Workforce and Pay-bill Alignment

- As a system work continues to better align workforce and finance.
- In the absence of the national requirement for workforce establishment plans, we have put local arrangements in place, to monitor the actual workforce against the pay bill budget (i.e. costed WTE establishment)
- Table 2a aims to demonstrate the pay costs associated with the total workforce plan staff in post actuals (note this is with the recognition that there is some misalignment between ESR and finance ledger systems and actions are being taken to resolve this and/or agree acceptable tolerance levels).
- At M6 the system has overspent against the pay budget by £14.3m with 531wte over-establishment in terms of total staff (substantive, bank and agency).
- There will be a degree of reliance on temporary staffing (e.g. where there are recognised recruitment challenges for staffing groups/grades in specialist areas) and therefore plans factor in bank and agency usage. However, we know that temporary staffing (particularly agency) is generally more costly in comparison to substantive staff.
- Table 2b demonstrates the Bank and Agency position, which identifies that the system is overspent against plan in both these areas. Further analysis is required to align the WTEs to the associated costs, as at present this does not fully correlate, plus it appears that adjustments are made to the gross pay costs for bank and agency which need to be understood.
- Through the joint workforce and finance improvement (JWFI) work there is an ask to breakdown all pay elements including sickness, maternity, non-contractual pay enhancements, overtime and trainees etc in order to ascertain where there may be other pay costs impacting on the pay-bill overspend.
- There is also inconsistency in the number of WTEs being recorded (contracted V worked) e.g. CRH record medics doing 1.4 sessions as 1.4WTEs whereas UHDB record this as 1WTE (comparatively this suggests less capacity at UHDB and on the other hand this is inflating the associated costs). This appears to be due to different interpretations of the PWR guidance (both could be argued as correct) and therefore this is also an area which the JWFI will need to investigate further.

Agency Usage

Given the increasing level of scrutiny on agency spend and usage the report now provides the agency overview which includes a breakdown against the four main KPIs:

- Total Agency Spend - £22.4m against a plan of £13.4m
- Agency spend as a % of total staff spend – 2.8% against a national target of 3.7%
- % of Off Framework shifts – 5.4% of total agency YTD
- % non price cap compliant shifts – 49.4% of total agency YTD

Table 1a: 2023/24 Workforce Plan Position Month 6 (including EMAS)

Derby and Derbyshire Integrated Care Board

ICB Total	Reporting Period: Sep 2023					
	Month 6			Trend		
	Plan	Actual	Variance from plan	Previous month	Changes in actual vs previous month	Trend (Actual) previous 12 months
Workforce						
Total Workforce (WTE)	28,948.00	29,833.23	-885.23	30,057.96	↓	
Substantive (WTE)	27,490.18	27,756.96	-266.78	27,788.18	↓	
Bank (WTE)	1,189.36	1,571.70	-382.34	1,756.97	↓	
Agency (WTE)	268.47	504.57	-236.10	512.81	↓	
Cost						
Pay Cost (£'000) *	123,786	122,775	1,010	128,431	↓	

* Planned pay costs now include the agreed AfC pay uplift from M5 but do not fully reflect the workforce impact as a result of efficiency plans consistently for all Trusts.

Table 1b: 2023/24 Workforce Plan Position Month 6 – Provider Summary

NHS Derby and Derbyshire

		Plan	Actual	Variance from plan	Supporting Narrative
CRH	Workforce (WTE)				
	Total Workforce	4,702.17	5,030.47	-328.30	• Foundation Trainees (F1) Rotation in July & Aug which caused the increase of WTE in Medical Dental Staff Group temporarily. Trainee numbers should stabilise in September and October.
	Substantive	4,299.71	4,541.72	-242.00	
	Bank	295.20	377.75	-82.55	
	Agency	107.26	111.00	-3.74	
	Cost (£)				
	Pay Cost (£'000)	£20,333	£22,448	-£2,115	
DCHS	Workforce (WTE)				
	Total Workforce	3,850.94	3,801.39	49.55	• Overall WTE usage is below plan. • The actual pay costs reflect gross staff costs, which do not take the capitalised workforce adjustments into account.
	Substantive	3,757.25	3,681.09	76.16	
	Bank	69.08	88.58	-19.50	
	Agency	24.61	31.72	-7.11	
	Cost (£)				
	Pay Cost (£'000)	£13,550	£13,853	-£303	
DHcFT	Workforce (WTE)				
	Total Workforce	3,114.43	3,128.74	-14.31	• Overall WTE usage is slightly over plan. • Challenge remains with recruiting into substantive posts to reduce bank and agency usage.
	Substantive	2,902.57	2,864.77	37.80	
	Bank	162.05	204.14	-42.09	
	Agency	49.81	59.83	-10.02	
	Cost (£)				
	Pay Cost (£'000)	£12,866	£13,607	-£741	
EMAS	Workforce (WTE)				
	Total Workforce	4,216.55	4,330.70	-114.15	• Substantive staff costs have reduced in M6 for the following reasons i) The expenditure for substantive has been deflated by £2.6m from the release of the Flowers Provision. This forms part of the £5m EMAS surplus agreed with JUCD ii) In month, the expenditure associated with the Cat 2 Investment initiative, including the implementation of the Pathways system
	Substantive	4,143.89	4,077.57	66.32	
	Bank	52.66	52.98	-0.32	
	Agency	20.00	200.15	-180.15	
	Cost (£)				
	Pay Cost (£'000)	£17,454	£10,251	£7,203	
UHDB	Workforce (WTE)				
	Total Workforce	13,063.91	13,541.93	-478.02	• Foundation Trainees (F1) Rotation in Jul & Aug which caused the increase of WTE in Medical Dental Staff Group temporarily. Trainee numbers resumed normal level in September • Workforce data for UHDB has now been revised following the identification the 'scripting issues' in calculating workforce data for PWR; all data for previous months have now been corrected
	Substantive	12,386.75	12,591.81	-205.06	
	Bank	610.37	848.25	-237.88	
	Agency	66.79	101.87	-35.08	
	Cost (£)				
	Pay Cost (£'000)	£59,583	£62,616	-£3,033	

Table 1c: 2023/24 Primary Care Workforce

Derby and Derbyshire Integrated Care Board

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

	Baseline	Plan	Actual	Plan	Plan	Plan
Primary Care	**Staff in post outturn**	**Q1**		**Q2**	**Q3**	**Q4**
Joined Up Care Derbyshire STP	**Year End**	**As at the end of**	**As at the end of**	**As at the end of**	**As at the end of**	**As at the end of**
	(31-Mar-23)	**Jun-23**	**Aug 23**	**Sep-23**	**Dec-23**	**Mar-24**
Workforce (WTE)	**Total WTE**	**Total WTE**	**Total WTE**	**Total WTE**	**Total WTE**	**Total WTE**
Total Workforce	**3,378**	**3,439**	**3,423**	**3,548**	**3,614**	**3,647**
GPs excluding registrars	766	767	**762**	795	789	778
Nurses	364	365	**343**	363	363	361
Direct Patient Care roles (ARRS funded) *	465	510	**546**	580	636	669
Direct Patient Care roles (not ARRS funded)	282	286	**268**	290	293	298
Other – admin and non-clinical	1,502	1,512	**1,503**	1,519	1,532	1,542

Summary

- Primary care are only required to submit quarterly plans and therefore the M6 workforce position has been compared to the September plan to demonstrate the forward position in the absence of the monthly plan.
- The total workforce was 125WTE below plan at M6 (comparing the plan by end of Q2). The gap was observed mainly from GPs (33WTE) & Direct Patient Care roles (ARRS funded) (34WTE).

Caveats to the 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 information for ARRS is a month in arrears**

Table 2a: M6 Actual Workforce and Pay-bill Comparison – Total

NHS Derby and Derbyshire Integrated Care Board

	M6 Pay Budget	M6 Pay Actual	M6 Pay Variance	YTD Pay Budget	YTD Pay Actual	YTD Pay Variance	M6 Establishment (as per Finance) *	Staff in Post (Substantive) M6 Actual	Vacancy **	Vacancy Rate	Bank M6 Actual	Agency M6 Actual	Net Staffing (Substantive, Bank & Agency Total) M6 Actual	Establishment V Actual Variance
	£'000	£'000	£'000	£'000	£'000	£'000	WTE	WTE	WTE	%	WTE	WTE	WTE	WTE
ICB Total	123,786	122,775	1,010	750,789	765,098	-14,309	29,302	27,757	1,545	5.27%	1572	505	29,833	-531
CRH	20,333	22,448	-2,115	122,510	128,765	-6,255	4,652	4,542	110	2.36%	378	111	5,030	-379
DCHS	13,550	13,853	-303	81,594	83,413	-1,819	3,800	3,681	119	3.13%	89	32	3,801	-1
DHcFT	12,866	13,607	-741	76,281	79,608	-3,327	3,019	2,865	154	5.10%	204	60	3,129	-110
EMAS ^	17,454	10,251	7,203	103,033	94,020	9,013	4,284	4,078	206	4.82%	53	200	4,331	-47
UHDB	59,583	62,616	-3,033	367,372	379,292	-11,920	13,548	12,592	956	7.06%	848	102	13,542	6

Notes:

* The establishment figures do not include the full impact of all the required efficiencies and subsequent impact on workforce consistently across all Trusts

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

^ Due to PWR changes EMAS paramedics (overtime and 3rd party) are needing to be recorded in the agency WTE but it is noted that these have specific funding associated with the roles (170.54 WTE)

Data Sources:

Provider Finance Returns (PFR) Net Staffing Costs

Finance - Deputy DoFs (extracted from Finance Ledgers)

Provider Workforce Returns (PWR)

Table 2b: M6 Actual Workforce and Pay-bill Comparison – Bank and Agency

The 531wtes are total staff (substantive, bank and agency), therefore the table below aims to identify the pay-bill position in relation to Bank and Agency, both of which are overspent against plan. We know that temporary staffing (particularly agency) is generally more costly in comparison to substantive staff so further analysis will be required to align the WTEs to the associated costs, as at present this does not fully correlate, plus it appears that adjustments are made to the gross pay costs for bank and agency which need to be understood.

	Bank M6 (Plan)	Bank M6 (Actual)	Bank M6 Plan V Actual	YTD Bank Spend (Plan)	YTD Bank Spend (Actual)	YTD Variance (Overspend against Bank Plan)	Agency M6 (Plan)	Agency M6 (Actual)	Agency M6 Plan V Actual	YTD Agency Spend (Plan)	YTD Agency Spend (Actual)	YTD Variance (Overspend against Agency Plan)
	WTE	WTE	WTE	£'000	£'000	£'000	WTE	WTE	WTE	£'000	£'000	£'000
ICB Total	1189	1572	-382	26,812	37,389	-10,577	268	505	-236	13,395	22,399	-9,004
CRH	295	378	-83	6,621	8,423	-1,802	107	111	-4	4,793	7,142	-2,349
DCHS	69	89	-20	1,718	1,934	-216	25	32	-7	650	595	55
DHcFT	162	204	-42	3,936	4,130	-194	50	60	-10	2,649	5,249	-2,600
EMAS	53	53	0	1,214	1,540	-326	20	200	-180	415	562	-147
UHDB	610	848	-238	13,323	21,362	-8,039	67	102	-35	4,888	8,851	-3,963

2023/24 Month 6 JUCD Agency KPIs

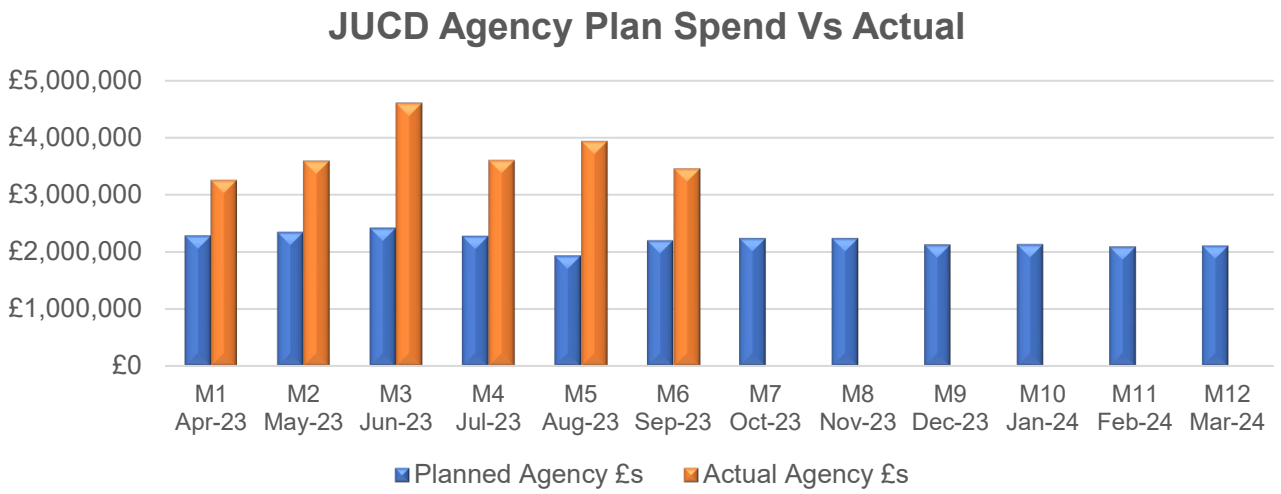
Derby and Derbyshire Integrated Care Board

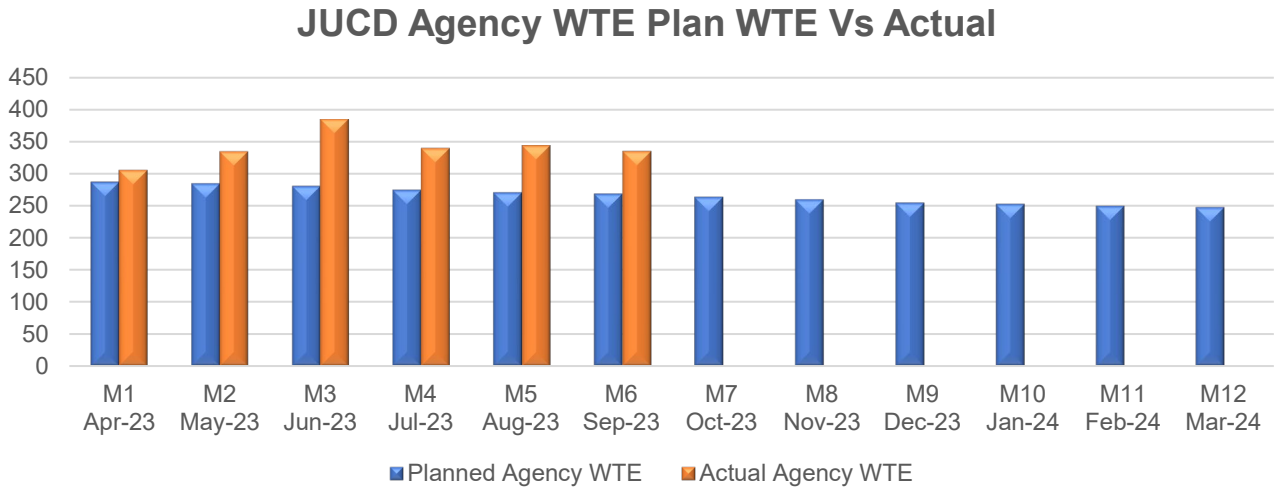
Summary:

- In M6 JUCD agency cost amounted to 2.8% of total pay costs, 0.9% under the national target of 3.7%
- YTD JUCD planned agency usage was £13.4m, the system has spent £22.4m which is an overspend £9m
- Off framework usage was 605 shifts in M6, 12.4% of total agency shifts (5.4% YTD).
- There were 2,780 non price cap compliant shifts, 57.2% of the total agency shifts (49.4% YTD).
- Admin and Estates came to 670 shifts in M6, 13.8% of total agency shifts (27.6% YTD). YTD the total Admin and Estates agency usage appears to be distorted due the EMAS position which equates to 7,276 out of a total of 10,640 for all providers. The YTD Admin and Estates position for EMAS is 68% of the total admin and estates usage.
- Further investigation is ongoing to understand the factors for the high-level of off framework and Admin and Estates usage (particularly EMAS).
- Further work is also underway to enable a more granular breakdown of the data to ensure consistency with regards to the highest paid/longest serving agency workers.

2023/24 Month 6 Joined Up Care Derbyshire Agency Breakdown

Derby and Derbyshire Integrated Care Board





- In M6 agency spend accounted for 2.8% of JUCD's total staff costs. This is a reduction of 0.1% from the previous month.
- JUCD planned to spend £2.2m on agency staff in M6. The actual spend was £3.5m. This is an overspend against plan of £1.3m, but a reduction of £400k on the previous month.
- As of the end of M6 JUCD have reached 85% of planned agency spend.
- To better understand the position, work is being undertaken to investigate the factors for the rise in agency usage and spend. This work will inform the system Agency Reduction Plan.

Note: Excludes EMAS paramedics (overtime and 3rd party) in the agency WTE and cost as they are funded separately (170.54 WTE)

Finance

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

M06 System Finance Summary – Financial Position

NHS
Derby and Derbyshire
Integrated Care Board

As of 30th September 2023, the JUCD year to date position is a £20.6m overspend against the plan

The forecast reported continues to be breakeven with growing material risks

Excess inflation impacting on CHC, RPI of contracts and Prescribing

The costs of industrial action

Unfunded pay award

Efficiency delivery

Revenue cost of capital

Operational pressures

Consequences of this is the acute providers could run out of cash before the year end

Month 6 System Finance Summary – Financial Position

Derby and Derbyshire Integrated Care Board

The YTD overspend is driven by unfunded pressures:

- Cost of living increases (YTD at £11.3m and risk could increase to £33.8m by end of year)
- The effect of industrial action £16.8m
- The system also has a pressure from the pay award (£0.6m YTD, likely to increase to £2.5m)

Other pressures are from efficiency slippage, high-cost patients and drugs, and Section 117 costs. Work continues to identify mitigations and accelerate delivery of the transformation programme

Increased costs for bank and agency staff to cover industrial action, higher levels of sickness and vacancies

Dealing with operational problems relating to strikes detracts focus from the important work on transformation, efficiencies and productivity

JUCD is committed to deliver a 2023/24 breakeven position on the assumptions made as part of the final submitted plan

I&E position by Provider Month 06 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	Notes
NHS Derby and Derbyshire ICB	0.0	(4.2)	**(4.2)**	0.0	0.0	**0.0**	
Chesterfield Royal Hospital	(3.9)	(8.4)	**(4.5)**	0.0	0.0	**0.0**	
Derbyshire Community Health Services	0.5	(1.9)	**(2.4)**	0.0	0.0	**0.0**	
Derbyshire Healthcare	1.0	1.1	**0.1**	0.0	0.0	**0.0**	
EMAS	(0.0)	1.9	**1.9**	0.0	0.0	**0.0**	
University Hospital of Derby and Burton	(13.2)	(24.7)	**(11.5)**	0.0	0.0	**0.0**	
JUCD Total	**(15.6)**	**(36.2)**	**(20.6)**	**0.0**	**0.0**	**0.0**	

Month 6 System Finance Summary – Risk

NHS
Derby and Derbyshire
Integrated Care Board

Likely Case Risks

The unmitigated most likely outturn position is £68m over plan, as shown in the table below and identifies the risks that could not have been envisaged when the Operational Plan was submitted and are driven by influences outside of the control of JUCD.

- Excess inflation is expected to cost the system £33.8m because costs are higher than the 2.9% growth included in 2023/24 allocations
- Industrial action across the system is an estimated net cost of £16.8m with an additional estimated cost of £6m to recover lost activity and £2.2m of increases in agency costs to provider cover. There is also the impact this distraction has had on the ability to deliver recurrent efficiency savings
- Providers have also identified pressures from the pay award
- There are increased costs in mental health and primary care services
- The likely case assumes full delivery of efficiencies, but there is still a risk this will not be achieved

Month 06 Position	2023/24 Organisations Forecast Range		
Organisation	Best Case £m's	Likely Case £m's	Worst Case £m's
NHS Derby and Derbyshire ICB	0.0	(18.8)	(34.9)
Chesterfield Royal Hospital	0.0	(14.9)	(20.2)
Derbyshire Community Health Services	0.0	(2.8)	(5.4)
Derbyshire Healthcare	(0.0)	(4.1)	(7.0)
East Midlands Ambulance Service	0.0	0.0	0.0
University Hospitals of Derby And Burton	0.0	(27.4)	(55.0)
JUCD Total Surplus/(Deficit)	0.0	(68.0)	(122.5)

Month 6 System Finance Summary – Worst Case/Emerging Risk

Derby and Derbyshire Integrated Care Board

Worst Case Risks

- Additional risks to the financial plan include efficiency, capacity pressures and reduction of patient related income which is a consequence of industrial action.
- The dental services underspend of £6m has been stripped out of the worst case. At National level NHSE/I have not yet confirmed whether the ring-fenced allocation will need to be reinvested in services, if this is the case then the ICB position will deteriorate.

Revenue Emerging Risks

- The activity information produced nationally shows UHDB are considerably below their ERF target, this is in part due to the baseline figures being used to assess performance. NHSE have advised that the opportunity to amend the baseline has passed which will increase the lost income that the underperformance is causing. The system's M6 forecast out turn position does not include the impact of this lost income as per national guidance.
- The system had been informed of an allocation to help fund the revenue cost of capital in 2023/24 and this was assumed in the Operational Plan submitted and agreed with NHSE. However, we have now been informed this has been revised and the allocation will now be £3.4m less than what we had previously been informed.
- Continuing Health Care costs are at risk of increasing due to patients that have moved into Derbyshire from other areas but Derbyshire is responsible for paying for the costs of providing the service. Based on capacity across the county this could be a net impact of £1m.

Capital Emerging Risks

- HMRC have rejected DHcFT'S first stage appeal for claims for zero rated VAT abatement on construction costs of three mental health units amounting to £12.4m, it is expected that a decision on the Alternative Dispute Resolution (ADR) will be reached by the end of November. If this fails, the mixed dormitory eradication programme will be at serious risk of delivery.

Month 6 System Finance Summary – Efficiencies

Derby and Derbyshire Integrated Care Board

The annual efficiency plan is to deliver £136m, year to date the achievement is £2.0m ahead of a planned £56.4m

£117m of plans are now fully developed or in progress, with £19m yet to be developed further

Progress has been made across the system adding efficiency schemes to the ePMO system which now captures £115.5m of 2023/24 plan

Only 45% of efficiencies have been delivered recurrently to date, which is £14m behind plan. Further work is therefore required to identify and deliver transformational change across the system

It was hoped that Programme Delivery Boards would be the main vehicle for delivering financial transformation across organisations, but the transformational recurrent efficiencies are not being identified to eliminate the recurrent financial deficit

There is a possibility that cash releasing efficiencies will not be achieved making it difficult to ensure sufficient cash is available to meet our contractual liabilities

Efficiencies by Provider Month 06 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	18.9	22.8	**4.0**	44.2	44.8	**0.5**
Chesterfield Royal Hospital	6.9	5.5	**(1.4)**	15.7	15.7	**0.0**
Derbyshire Community Health Services	4.6	4.2	**(0.4)**	9.2	9.2	**0.0**
Derbyshire Healthcare	4.4	4.1	**(0.3)**	8.8	8.8	**0.0**
EMAS	5.6	6.0	**0.4**	11.2	11.2	**0.0**
University Hospital of Derby and Burton	16.2	15.9	**(0.3)**	47.0	47.0	**0.0**
JUCD Total	**56.4**	**58.5**	**2.0**	**136.0**	**136.5**	**0.5**

Month 6 System Finance Summary – Capital

Derby and Derbyshire Integrated Care Board

- The capital plan is £160.3m, consisting of £102.2m from the National team, £58.1m from the Regional team.
- Despite the 2023/24 System overspend being acknowledged as excess inflation, the capital allocation has been reduced by £1.4m due to the final revenue position reported at year end. This will be reflected in month 7.
- Expenditure is behind plan to date for EMAS PTS transport vehicles, the Kings Treatment Centre and the Community Diagnostic Centre developments in UHDB. These are projected to achieve the plan by year end.
- The main overspend forecast is for DCHS relating to the Bakewell development.
- UHDB have a forecast underspend of £7.3m relating to IFRS 16 costs as the contract was due for renewal but this has been deferred (contract extended) and will now materialise in 2024/25.
- The System requires over £200m just to maintain its patient facing estates and equipment and this is on top of any investment required to improve the estate and equipment.
- Included in the plan is the dormitory irradiation programme which is at risk due to inflation and VAT abatement issue currently under review.

Funded Capital by Provider	YTD plan £'m	YTD Actual £'m	Variance £'m	Full year plan £'m	Full year forecast £'m	Variance £'m
Chesterfield Royal Hospital	3.8	2.5	1.3	9.9	10.2	(0.2)
Derbyshire Community Health Services	3.5	3.2	0.3	7.2	21.4	(14.3)
Derbyshire Healthcare	34.2	34.3	(0.1)	68.3	68.5	(0.3)
EMAS	6.2	5.2	1.0	16.3	22.8	(6.5)
University Hospital of Derby and Burton	15.6	6.3	9.3	58.5	51.2	7.3
Additional Capital less planning tolerance	0.0	0.0	0.0	0.1	0.1	(0.0)
JUCD Total	**63.3**	**51.5**	**11.8**	**160.3**	**174.3**	**(14.0)**

Month 6 System Finance Summary – Cash

Derby and Derbyshire Integrated Care Board

The table below describes the cash plan and balance, year to date and forecast outturn. DCHS and DHcFT have the largest cash balances disproportionately to their size.

In 2023/24 it was always going to be important from a cash management perspective that the delivery of efficiencies was imperative. The forecast year end cash balances in the table below assumes each Provider delivers the efficiencies in their plan

Based on the latest efficiency delivery forecasts and operational pressures, it could be that some JUCD organisations have cash difficulties in 2023/24

CRH have requested cash support from NHSE/DHSC and this has been approved up to and including quarter three requirements and is reflected in the below table

Provider Cash Month 06 Position	Opening Balance 01/04/23 £m's	Cash Plan Month 06 £m's	Cash Balance Month 06 £m's	Cash Variance Month 06 £m's	Plan year ending 31/03/2024 £m's	Forecast year ending 31/03/2024 £m's	Year End Variance 31/03/2024 £m's
Chesterfield Royal Hospital	20.2	12.0	17.1	5.1	19.9	20.1	0.2
Derbyshire Community Health Services	37.3	29.7	32.0	2.3	34.1	35.5	1.5
Derbyshire Healthcare	53.9	30.2	37.9	7.7	23.7	23.7	0.0
EMAS	18.2	19.9	30.7	10.8	13.7	13.7	0.0
University Hospital of Derby and Burton	48.4	36.3	48.1	11.9	35.6	33.3	(2.3)
JUCD Total	178.0	128.1	165.8	37.7	127.0	126.4	(0.6)

Appendix 2 – JUCD System Finance Report to 30th September 2023 (M06)

1. Introduction

This report details the JUCD System Financial Position as at 30th September 2023, focusing on the I&E position, delivery of efficiencies, capital, and cash. This is followed by details of the developing efficiency programme and the emerging risks across the submitted plan.

2. Executive Summary

Income and Expenditure Performance

As at 30th September 2023, the JUCD year to date position is a £36.2m deficit against a £15.6m planned deficit, a £20.6m overspend against plan. Driven by continued pressures outside of the plan from industrial action, excess inflation and pay award.

Table 2.1 below outlines the systems year to date and forecast position at month six. UHDB reports the largest overspend of £11.5m to date, of which £8.6m is being driven by industrial action and excess inflation. DCHS have a £2.4m overspend year to date due to a number of factors including pay pressures linked to service demand. CRH have pressures of £4.5m year to date, driven by industrial action and excess inflation. The ICB have an overspend of £4.2m with pressures in prescribing due to price increases and mental health relating to Section 117 costs, offset by underspends in dental and mitigations in CHC. DHcFT and EMAS are reporting small underspends to date.

The forecast outturn for all organisations continues to be breakeven, but this will require additional funding from Treasury. At the time of writing this is yet to be confirmed. Notwithstanding this, there is still the commitment to deliver on our obligations that were made when the plans for 23/24 were submitted in May and before the industrial action / pay award / inflation pressures could be predicted.

Table 2.1 *JUCD I&E Position Summary as at 30th September 2023*

I&E Position by Provider Type Month 06 Position	Month 6 Planned Variance £m's	Month 6 Actual Variance £m's	Month Variance to Plan £m's		Annual Planned Variance £m's	Annual FOT Variance £m's	FOT Variance to Plan £m's
Chesterfield Royal Hospital	(3.9)	(8.4)	(4.5)		(0.0)	0.0	0.0
Derbyshire Community Health Services	0.5	(1.9)	(2.4)		0.0	0.0	(0.0)
Derbyshire Healthcare	1.0	1.1	0.1		0.0	(0.0)	(0.0)
EMAS	(0.0)	1.9	1.9		0.0	0.0	0.0
University Hospital of Derby and Burton	(13.2)	(24.7)	(11.5)		0.0	0.0	0.0
Other NHS Acute	0.0	(1.2)	(1.2)		0.0	0.3	0.3
Other NHS Mental Health	0.0	(0.7)	(0.7)		0.0	(1.2)	(1.2)
Other NHS Community Services	0.0	(0.1)	(0.1)		0.0	(0.1)	(0.1)
Acute Independent Sector	0.0	0.9	0.9		0.0	(0.3)	(0.3)
Mental Health Independent Sector	0.0	(2.4)	(2.4)		0.0	(1.9)	(1.9)
Community Services Non NHS	0.0	(0.0)	(0.0)		0.0	(0.1)	(0.1)
Continuing Health Care	0.0	0.1	0.1		0.0	0.0	0.0
Primary Care Prescribing	0.0	(3.5)	(3.5)		0.0	(6.5)	(6.5)
GP Co-Commissioning	0.0	(0.4)	(0.4)		0.0	(1.9)	(1.9)
Other GP Primary Care	0.0	0.2	0.2		0.0	0.1	0.1
Pharmacy	0.0	0.6	0.6		0.0	0.0	0.0
Optometry	0.0	(0.1)	(0.1)		0.0	0.0	0.0
Dental	0.0	3.5	3.5		0.0	0.0	0.0
Other Programmed Services	0.0	0.9	0.9		0.0	3.5	3.5
ICB Running Costs	0.0	0.4	0.4		0.0	13.3	13.3
ICB Operational Costs Other Programme	0.0	(2.3)	(2.3)		0.0	(5.2)	(5.2)
Grand Total	**(15.6)**	**(36.2)**	**(20.6)**		**0.0**	**0.0**	**0.0**

ERF continues to be reported as cost neutral as per national reporting guidance and due to an ongoing investigation on the reported activity in UHDB. Further details are in the risk section.

Capital

The forecast position overall on capital is an overspend of £14.0m on a capital plan of £160.3m. The overspend is predominantly due to the Bakewell and Community Diagnostic schemes and EMAS's operating lease costs which were not identified by them at planning. In addition there is an emerging IFRS16 accounting change being discussed nationally which could affect capital and / or revenue plans to the level of £7m. Further details on the capital plan are set out below.

Cash

The System's reported annual cash flows reflect the expected delivery of cash-releasing efficiencies. The in-year cashflow will be significantly impacted if they do not occur. CRH have already requested cash support from DHSC which has been approved up to quarter 3. Further requests from our acute providers will be needed to cover quarter 4.

3. Income and Expenditure Performance

As at 30th September 2023, the year to date system position is a £36.2m deficit against a £15.6m planned deficit, driven by the cost of excess inflation, industrial action, and underfunding for the pay award.

Table 3.1 below shows the range of forecasts for the system outturn positions, highlighting the emerging risks. If these risks materialise, each organisation will need to provide mitigations.

The likely scenario considers cost pressures that were not anticipated in the planning phase, such as excess inflation and costs associated with industrial action. The worst-case scenario incorporates risks related to delivering the JUCD Operational Plan, including efficiency delivery, pressures from backlog of activity and capacity issues.

Table 3.1 *JUCD I&E position best, most likely and worst case forecast position.*

Month 06 Position	2023/24 Organisations Forecast Range		
Organisation	Best Case £m's	Likely Case £m's	Worst Case £m's
NHS Derby and Derbyshire ICB	0.0	(18.8)	(34.9)
Chesterfield Royal Hospital	0.0	(14.9)	(20.2)
Derbyshire Community Health Services	0.0	(2.8)	(5.4)
Derbyshire Healthcare	(0.0)	(4.1)	(7.0)
East Midlands Ambulance Service	0.0	0.0	0.0
University Hospitals of Derby And Burton	0.0	(27.4)	(55.0)
JUCD Total Surplus/(Deficit)	0.0	(68.0)	(122.5)

The year to date variances to plan are shown in the following table, these are predominantly made up of costs which were not a consideration at planning, mainly industrial action, pressure caused by underfunding of the pay award and excess inflation relating to non-pay areas such as utilities and drugs costs.

Table 3.2 *Year to date movement from plan*

JUCD Year to Date movement from plan Month 06 Position	ICB £m's	CRH £m's	DCHS £m's	DHcFT £m's	EMAS £m's	UHDB £m's	Total £m's
Industrial Action		(2.5)	(0.1)	(0.1)		(4.5)	**(7.2)**
Excess inflation above national guidance	(8.1)	(2.3)	(0.8)	(0.2)	(0.1)	(4.1)	**(15.6)**
Pay Award		(0.5)	(0.1)	(0.1)	0.1	0.0	**(0.6)**
Efficiencies	4.1	(1.4)	(0.4)	(0.3)		(0.3)	**1.7**
Other	(5.6)	0.0	(1.3)		0.3	(2.6)	**(9.2)**
Mitigations	5.4	2.2	0.3	0.8	1.6	0.0	**10.3**
Total	**(4.2)**	**(4.5)**	**(2.4)**	**0.1**	**1.9**	**(11.5)**	**(20.6)**

Risks

As the year progresses, there are risks to reaching the year-end position currently estimated at £122.5m. They are being categorised into two areas, those that are outside the system's control (excess inflation, industrial action and pay award costs) and those that might prevent the delivery of the Operational Plan, which includes efficiencies. Mitigating these risks is necessary to deliver a breakeven position and it is important for the risks deemed within our control that mitigations are identified as a matter of urgency to enable the delivery of the plan each JUCD Board approved.

The risks that add up to the worst case scenario for JUCD are shown in Table 3.3 below. It includes the costs outside the plan at a risk of £53.1m as well as the risks of £69.4m associated with delivering the Operational Plan. There is an improvement of £18.6m in month six in total with the main improvements in efficiencies.

Table 3.3 *System Identified Risks*

Risk Month 06 Position	ICB £m's	CRH £m's	DCHS £m's	DHcFT £m's	EMAS £m's	UHDB £m's	Total £m's
Outside Plan							
Excess inflation above national guidance	(18.8)	(4.6)	(1.9)	(0.4)		(8.1)	**(33.8)**
Industrial Action	0.0	(5.5)	(0.1)	(0.2)		(11.0)	**(16.8)**
Pay Award	(0.1)	(1.0)	(0.1)	(0.2)	0.1	(1.2)	**(2.5)**
Outside Plan Total	(18.9)	(11.1)	(2.2)	(0.8)	0.1	(20.3)	(53.1)
Efficiencies	(6.2)	(5.5)	(0.8)			(16.9)	**(29.4)**
Operational Pressures							
Baseline and non-recurrent Income			(0.6)			(4.3)	**(4.9)**
Capacity & Activity Pressures		(2.0)					**(2.0)**
Contract Payments							**0.0**
Drugs Costs	(2.7)	(1.0)					**(3.7)**
Increasing pathway to 103/107%						(1.7)	**(1.7)**
Cost of Cash Support						(1.8)	**(1.8)**
Other	(7.2)	(0.6)	(1.9)	(6.2)	(0.1)	(10.0)	**(26.0)**
Benefits							**0.0**
Operational Pressures Total	(9.8)	(3.6)	(2.5)	(6.2)	(0.1)	(17.8)	(40.0)
Total	**(34.9)**	**(20.2)**	**(5.4)**	**(7.0)**	**0.0**	**(55.0)**	**(122.5)**

Excess inflation because of costs being higher than growth included in the allocations received is a total risk of £33.8m across the system. Industrial action is estimated to cost the system £16.8m and this does not include the additional impacts it may have that have been detailed in previous reports. The forecasted impact of industrial action assumed to be one strike in each month until March 2024.The pay award pressures amount to £2.5m where funding has not covered the costs of the uplift.

Dental Benefit

The benefit in the forecast position being identified as a result of underperformance on dental has increased to £6m in September, from £5m in August. This is being used to offset the pressure created by an increase in very high cost mental health patients over the last couple of months. Whilst an increase is not unique, the 4 new patients that is estimated to cost £5m is. There remains a risk that NHSE reinvest this money in Dental services which would mean we would not be able to cover the pressure in mental health.

ERF

The system continues to report a cost neutral ERF position in month six, in line with National reporting guidance. The activity information produced nationally suggests UHDB are considerably below their target, however this has been challenged and it has been accepted that the data is inaccurate but a resolution is still awaited. Adjustments to the 2019/20 baseline have been submitted to the National team for approval, that will reduce the performance target. Either way, a significant increase in activity in the independent sector is diverting cash from NHS providers which could cause a financial challenge towards the year end.

Emerging Risks

Within the ICB CHC position there are forecast costs for fully funded care packages where patients have moved into Derbyshire from other areas and it is Derbyshire's responsibility to pick up these costs per the national 'who pays' guidance. Due to provider capacity across the county the net cost of this is expected to be £1m per year based on patients coming into Derbyshire compared to those leaving.

The JUCD Providers have a combined risk of £23.2m on their efficiency plans and £30.2m of operational pressures. We are developing a process to provide further information on these risks for month 7. The Boards of the JUCD providers need to identify actions to mitigate these risks. Until we have clarity on the mitigating actions that organisations are taking, there will remain limited assurance that they can deliver a breakeven position.

Efficiencies

The ability to deliver the planned level of efficiencies in 2023/24 remains a key risk for the system. The below table tracks the development of the schemes from month five to month six. The development of plans needs to continue to support the system's ability to deliver a breakeven financial position.

Table 3.4 *System Efficiency Plan Development*

System Efficiencies Month 06 Position	Fully Developed £m's	Plans in Progress £m's	Opportunity £m's	Unidentified £m's	Total £m's
Annual Total - at Month 5	70.1	28.0	30.4	7.5	136.0
Annual Total - at Month 6	103.4	13.2	12.0	7.4	136.0
Total Movement	**33.3**	**(14.8)**	**(18.4)**	**(0.1)**	**(0.0)**

The above table shows that at month six, there are plans developed / in progress to the value of £116m against the full year plan of £136m, meaning year there is £19.4m of efficiencies still

yet to be formalised into a plan. The Financial Sustainability Board continues to meet monthly to ensure focus across all organisations and to help increase assurance.

The table below sets out the month six efficiencies by organisation and the actual delivery against those plans. The year to date position includes an over-delivery for the ICB and an under-delivery for CRH, with others only a small variance from plan to date.

Table 3.5 *System Efficiency Delivery – NHSE Submitted Financial Report*

Efficiencies by Provider Month 06 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	18.9	22.8	**4.0**	44.2	44.8	**0.5**
Chesterfield Royal Hospital	6.9	5.5	**(1.4)**	15.7	15.7	**0.0**
Derbyshire Community Health Services	4.6	4.2	**(0.4)**	9.2	9.2	**0.0**
Derbyshire Healthcare	4.4	4.1	**(0.3)**	8.8	8.8	**0.0**
EMAS	5.6	6.0	**0.4**	11.2	11.2	**0.0**
University Hospital of Derby and Burton	16.2	15.9	**(0.3)**	47.0	47.0	**0.0**
JUCD Total	56.4	58.5	2.0	136.0	136.5	0.5

As the committee are aware, there is an expectation that the ePMO system is used for reporting on system efficiencies. Progress has been made across the system on updating and inputting into the ePMO system which now captures £115.5m of 2023/24 efficiency schemes across the system. The Financial Sustainability Board has requested that all organisations fully utilise the opportunities section of the ePMO system so that there can be greater assurance on the full 2023/24 efficiency plan being delivered. The ePMO reflects the current forecast delivery by organisation which is shown in the table below.

Table 3.6 *System Efficiency Delivery Forecast – ePMO*

Activity Type (Fin Year 2023-24) Month 06	Annual Target Value £'m	Annual Forecast Value £'m	Annual Forecast Variance £'m
NHS Derby and Derbyshire ICB	44.2	44.6	0.4
Chesterfield Royal Hospital	15.7	10.1	(5.6)
Derbyshire Community Health Services	9.2	8.6	(0.6)
Derbyshire Healthcare	8.8	7.2	(1.6)
East Midlands Ambulance Service	11.2	11.2	0.0
University Hospitals of Derby And Burton	47.0	33.9	(13.1)
JUCD Totals	**136.0**	**115.5**	**(20.5)**

The system is currently forecasting to deliver £115.5m against the £136m target, a shortfall of £20.5m. The target was to get to 90% of efficiency plans formalised by the end of September, the system is currently at 85%. As a result, whilst progress has been made, there remains a lack of assurance on the delivery of the 2023/24 efficiency target.

The below table shows the split of the YTD efficiency delivery between recurrent and non-recurrent.

Table 3.7 *YTD Efficiencies split recurrent and non-recurrent*

Efficiencies by Provider - YTD Month 06 Position	YTD Plan £m's		YTD Actual £m's		YTD Variance £m's	
	Recurrent	Non-Recurrent	Recurrent	Non-Recurrent	Recurrent	Non-Recurrent
NHS Derby and Derbyshire ICB	11.7	7.2	11.3	11.5	(0.3)	4.3
Chesterfield Royal Hospital	5.2	1.7	2.3	3.2	(2.9)	1.5
Derbyshire Community Health Services	3.5	1.1	1.1	3.1	(2.4)	2.0
Derbyshire Healthcare	3.3	1.1	0.6	3.4	(2.7)	2.3
EMAS	4.6	1.0	4.5	1.5	(0.1)	0.5
University Hospital of Derby and Burton	11.4	4.8	5.8	10.1	(5.6)	5.3
JUCD Total	**39.7**	**16.8**	**25.7**	**32.8**	**(14.0)**	**16.0**

There was an expectation that 70% of the efficiency plans would be delivered recurrently. However, only 45% of efficiencies delivered to date have been recurrent and this is £14.0m behind plan. This is a deterioration from the £11.2m reported in month five and highlights that non-recurrent efficiencies are supporting the in year position which will increase the pressure going into 2024/25. There is a need to identify and mobilise recurrent transformational change to move the system to a financially sustainable position.

4. Activity, Workforce and Finance Triangulation

Workforce

JUCD is over plan for WTE as detailed in table 4.1 below. At a system level, this is in line with the overspend of £13.2m year to date detailed in table 4.2. However, recognising that these two tables use information from 2 different sources, there remains discrepancies at an organisation level to what is included in the workforce return and the finance return, work is ongoing with workforce colleagues to understand and align these.

Table 4.1 *Workforce Plan for 2023/24 & WTE from Provider Workforce Return*

Workforce WTE M06	M6 Planned WTE	M6 Actual WTE	M6 WTE Variance
Chesterfield Royal Hospital	4,702.2	5,030.5	(328.3)
Derbyshire Community Health Services	3,850.9	3,801.4	49.6
Derbyshire Healthcare	3,114.4	3,128.7	(14.3)
EMAS	4,216.6	4,330.7	(114.1)
University Hospital of Derby and Burton	13,059.2	13,541.9	(482.7)
JUCD Total	28,943.3	29,833.2	(889.9)

Table 4.2 *Workforce Costs from Provider Finance Return*

Staff Costs by Provider Month 06 Position	2022/23 M12	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	Full Year Plan £m's	Full Year Forecast £m's	Forecast Variance £m's
Chesterfield Royal Hospital	253.4	122.5	128.8	(6.3)	239.9	232.5	7.4
Derbyshire Community Health Services	170.8	81.6	83.4	(1.8)	163.6	165.7	(2.2)
Derbyshire Healthcare	155.6	76.3	79.6	(3.3)	154.1	160.6	(6.5)
EMAS	198.0	103.0	94.0	9.0	207.6	202.7	4.9
University Hospital of Derby and Burton	750.5	367.4	378.1	(10.8)	724.5	725.9	(1.5)
JUCD Total	1,528.3	750.8	764.0	(13.2)	1,489.7	1,487.4	2.3

There is an element of agency and non-contractual pay behind the overspend due to industrial action and the under-delivery of pay efficiencies. The table below outlines the Agency Staff costs year to date and forecast outturn.

Table 4.3 *2023/24 Agency Staff Plan*

Agency by Provider Month 06 Position	2022/23 M12	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	Full Year Plan £m's	Full Year Forecast £m's	Forecast Variance £m's
Chesterfield Royal Hospital	15.5	4.8	7.1	(2.3)	9.1	9.1	0.0
Derbyshire Community Health Services	1.4	0.7	0.6	0.1	1.3	1.1	0.2
Derbyshire Healthcare	7.6	2.6	5.2	(2.6)	5.3	8.7	(3.4)
EMAS	0.7	0.4	0.6	(0.1)	0.8	1.2	(0.4)
University Hospital of Derby and Burton	14.5	4.9	8.9	(4.0)	9.8	9.8	0.0
JUCD Total	39.7	13.4	22.4	(9.0)	26.3	29.9	(3.6)

The year to date overspend of £9.0m is an increase of £1.2m compared with month five. The increase in year to date is for CRH, DHcFT and UHDB, and there is a total forecast overspend of £3.6m for all providers. Work to reduce the level of expenditure for agency has been impacted to date by industrial action.

5. Capital

The table below summarises the capital budget from NHSE of £160.3m this consists of £102.2m from the National team and £58.2m from the Regional team. We have recently been informed that JUCD will not retain £1.4m of the total available capital as a result of the Systems not delivering the agreed breakeven position in 2022/23. This will be reflected in month 7 reporting.

The system remains behind plan year to date relating to delays in delivery of EMAS PTS transport vehicles, as well as the Kings Treatment Centre and the Community Diagnostic Centre developments at UHDB. All of these developments are projected to be on plan by the end of the year.

Table 5.1 *Capital plan for the system*

Funded Capital by Provider	YTD plan £'m	YTD Actual £'m	Variance £'m	Full year plan £'m	Full year forecast £'m	Variance £'m
Chesterfield Royal Hospital	3.8	2.5	1.3	9.9	10.2	(0.2)
Derbyshire Community Health Services	3.5	3.2	0.3	7.2	21.4	(14.3)
Derbyshire Healthcare	34.2	34.3	(0.1)	68.3	68.5	(0.3)
EMAS	6.2	5.2	1.0	16.3	22.8	(6.5)
University Hospital of Derby and Burton	15.6	6.3	9.3	58.5	51.2	7.3
Additional Capital less planning tolerance	0.0	0.0	0.0	0.1	0.1	(0.0)
JUCD Total	63.3	51.5	11.8	160.3	174.3	(14.0)

Four out of the five Trusts are forecasting an adverse variance to plan, the overall overspend is mainly due to DCHS, relating to the Bakewell and Community Diagnostic schemes and EMAS, who did not identify operating leases in accordance with IFRS 16 requirements at planning stage. UHDB have forecast an underspend of £7.3m relating to Roche – IFRS16 costs. The contract was due for renewal in 2023/24 but this has been deferred (contract extended) and as a result these will now show in 2024/25.

6. Cash

The table below shows the cash balance to be £37.7m more than plan at the end of September and is expected to be £0.6m less than plan by the end of the financial year. The figures in the table below assume that the full planned level of cash releasing efficiencies are achieved. UHDB continue to project a £2.3m cash balance lower than plan.

Table 6.1 *Cash Balances (assuming full delivery of planned efficiencies)*

Provider Cash Month 06 Position	Opening Balance 01/04/23 £m's	Cash Plan Month 06 £m's	Cash Balance Month 06 £m's	Cash Variance Month 06 £m's	Plan year ending 31/03/2024 £m's	Forecast year ending 31/03/2024 £m's	Year End Variance 31/03/2024 £m's
Chesterfield Royal Hospital	20.2	12.0	17.1	5.1	19.9	20.1	0.2
Derbyshire Community Health Services	37.3	29.7	32.0	2.3	34.1	35.5	1.5
Derbyshire Healthcare	53.9	30.2	37.9	7.7	23.7	23.7	0.0
EMAS	18.2	19.9	30.7	10.8	13.7	13.7	0.0
University Hospital of Derby and Burton	48.4	36.3	48.1	11.9	35.6	33.3	(2.3)
JUCD Total	178.0	128.1	165.8	37.7	127.0	126.4	(0.6)

The probable cash balances are forecast below, this table takes into account the risks in the position and the possibility that cash releasing efficiencies will not be achieved. In order to manage the cash implications of the 2022/23 outturn and the 2023/24 current variance from plan, CRH have requested cash support from NHSE/DHSC. This has been approved up to and including Q3 requirements. Further applications will be required, per the national process, for Quarter 4 and the foreseeable future until a balanced I&E position can be achieved. UHDB will be in a similar position for quarter 4 of 2023/24.

Table 6.2 *Month by Month Cash Forecast*

Month 06 Position Organisation	September £m's	October £m's	November £m's	December £m's	January £m's	February £m's	March £m's
Chesterfield Royal Hospital	0.0	(3.0)	(7.0)	(11.0)	(15.0)	(19.0)	(23.0)
Derbyshire Community Health Services	31.9	31.1	30.2	29.4	28.5	27.7	26.8
Derbyshire Healthcare	37.9	35.4	32.7	30.1	27.7	25.3	23.7
East Midlands Ambulance Service	30.7	29.2	27.3	27.5	24.3	21.6	13.7
University Hospitals of Derby And Burton	49.0	39.1	21.9	14.2	5.4	(6.0)	(27.1)
JUCD Total Surplus/(Deficit)	149.4	131.7	105.1	90.1	70.9	49.6	14.1

7. Recommendations

The ICB Board are asked to **NOTE**:

- The variance to plan at the end of month six.
- The risks driving most likely and worse case forecast positions that requires urgent action to mitigate, that must be driven by the Boards of each JUCD organisation.
- The remaining gap on efficiency plans and the need to go further to mitigate operational risks.
- The potential impact of ERF performance.
- The cashflow problems facing our acute providers.
- Forecast overspends on capital and the expected reduction in allocation.

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NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 103

Report Title	Operational Plan – October 2023 to March 2024							
Author	Craig Cook, Director of Planning, Performance, Contracting							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer/Deputy CEO							
Presenter	Michelle Arrowsmith, Chief Strategy and Delivery Officer/Deputy CEO							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☐
Appendices	Appendix 1 – H2 Plan brief							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	ICB Board (confidential) – 19.10.2023 PHSCC – 9.11.2023							

Recommendations
The ICB Board is recommended to **NOTE** the Derby and Derbyshire NHS' Operational Plan for October 2023 – March 2024.
Purpose
The purpose of the report is to brief the ICB Board on what the NHS is doing to deliver operational performance with regards to urgent and emergency care and planned care and cancer, over the next six months.
Background
In early May 2023, the Derby and Derbyshire ICB submitted the health system's operational plan for the financial year 2023/24. This plan set out a series of objectives for the year ahead, mostly in relation to improving access to care across the acute planned, cancer, urgent and emergency care and mental health, autism and learning disability portfolio. In late July 2023, NHS England published its approach to winter and requested that systems review their operational plans and the core assumptions which underpinned them, particularly considering actual year to date delivery and any new risks emerging. Furthermore, all health systems were asked to ensure that the ten high impact interventions/areas to reduce hospital A&E demand and/or improve acute flow were going to be in place and delivery over the winter period.

Report Summary

The report attached provides a summary of how performance has gone in the first six months, relative to the NHS' planned performance trajectories within the Urgent and Emergency Care and Planned Care and Cancer portfolios. It also covers what we plan to do in the last six months of the year. The key points are as follows:

- the Derby and Derbyshire NHS' intent over the next six months is similar to that at the start of the year, in that we are planning to deliver the 76% 4 hr target, bring category 2 response times down, deliver more GP appointments this winter compared to last and reduce long RTT and cancer waits;

- there are new trajectories that we have established, specifically:
  - ensuring that no more than 2% of A&E waits are over 12 hrs; and
  - increasing the proportion of people aged over 65 yrs who are still at home 91 days after being discharged from hospital into reablement services (derby specifically have set a target of 84% by the end of 23/24 which is an improvement on the recent trend);

- the report highlights some of the interventions that we are delivering and/or plan to deliver over the next six months to secure these outcomes and it's worth highlighting some of them:
  - we are making good progress against 9 of the 10 high impact interventions as mandated by NHS England and we hope to have a plan to roll out Acute Respiratory Infection Hubs (the 10th item) once we have secured monies from NHSE;
  - expanding virtual ward capacity so that up to 255 patients are being managed in a non-admitted hospital setting at any one time;
  - introducing enhanced MDT input into the 'Clinical Navigation Hub' to ensure that people are advised to access the most appropriate service for their care;
  - expanding the falls recovery service – a PLACE Alliance led programme of work, involving NHS, Local Authority and VSCE to reduce the impact of level 1 and 2 falls;
  - utilising the private sector to support with elective recovery; and
  - protecting elective operating capacity over the winter period;

- we `go into the winter period clear of the risks that we face, and we are constantly reviewing our approach to managing them effectively. The key ones to note:
  - industrial action - this plan assumes no further IA takes place. If it does then we already have an operating procedure to respond to make sure that essential services can continue. However, any further IA events will significantly weaken our ability to deliver our waiting list reduction targets;
  - the fragility of the adult social care sector – whilst the number of people in delay from our hospitals is lower this year compared to last, we know that the position is still fragile and too many patients are ending up on pathways that are suboptimal;
  - COVID-19 and Influenza – this plan assumes that the impact of COVID and Influenza (both in terms of urgent care demand (across all sectors) and staff sickness) is similar to last year.

Identification of Key Risks

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

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

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒

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

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

There are no implications that affect the ICB's obligations.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable for this report

Derby and Derbyshire
Integrated Care Board

NHS Operational Plan

October 2023 – March 2024

Summary points for the
NHS Derby and Derbyshire ICB Board

Introduction

Derby and Derbyshire Integrated Care Board

Background

In early May 2023, the Derby and Derbyshire ICB submitted the health system's operational plan for the financial year 2023/24. This plan set out a series of objectives for the year ahead, mostly in relation to improving access to care across the acute planned, cancer, urgent and emergency care and mental health, autism and learning disability portfolio.

In late July 2023, NHS England published its approach to winter and requested that systems review their operational plans and the core assumptions which underpinned them, particularly considering actual year to date delivery and any new risks emerging. Furthermore, all health systems were asked to ensure that the ten high impact interventions/areas to reduce hospital A&E demand and/or improve acute flow were going to be in place and deliver over the winter period.

In response to this, a time limited task and finish group, drawing on the input of NHS Delivery Board leadership and Provider organisations, was established to:

- *Review how performance was going in relation to the operational targets for planned care, cancer, and urgent & emergency care.*
- *Establish a forecast delivery position for these targets, for the period October 23-March 24, which involved a review and revision to the underpinning demand and capacity assumptions, as necessary.*
- *Set out the 'how', by summarising the key actions that necessary to secure these forecasts.*

Purpose

Against the backdrop of the ICB delivering a continuous, dynamic planning cycle, this presentation briefs the ICB Board on the current state of the operational planning works for the next six months – with a specific focus on the urgent and emergency care, planned care & cancer agenda.

Key messages for the Board

We go into the final 6 months of the year following a period where we have seen improvement to various aspects of operational performance, within the urgent and emergency care and planned care & cancer programme

Derby and Derbyshire Integrated Care Board

1. **A&E 4hrs** - both Acute Trusts are delivering their plan and performance is better on a like for like basis too, in overall terms.

2. **Long acute stays** - there are have been fewer beds occupied by people staying longer than 7, 14 and 21 days on a like for like basis - with a respective reduction of 3%,5% and 7%.

3. **Ambulance turnaround –** there have been 1,980 fewer hours lost to ambulance handover delays on a like for like basis, despite there being more ambulance arrival demand.

4. **GP appointments –** overall GP appointment output has been 2.1% higher than plan so far this year. This is despite having fewer practice nurses and fully qualified GPs per head of population.

5. **Urgent Community Response –** over 80% of referrals that relate to an older person in crisis have been responded to within 2 hrs. This exceeds our target of at least 70% assumed in plan.

6. **Faster Cancer Diagnosis –** we've treated 7% more people in the process of diagnosing or ruling out cancer, with a greater proportion done within 28 days, on a like for like basis.

However, there are items where performance is not on track as planned - waiting lists...

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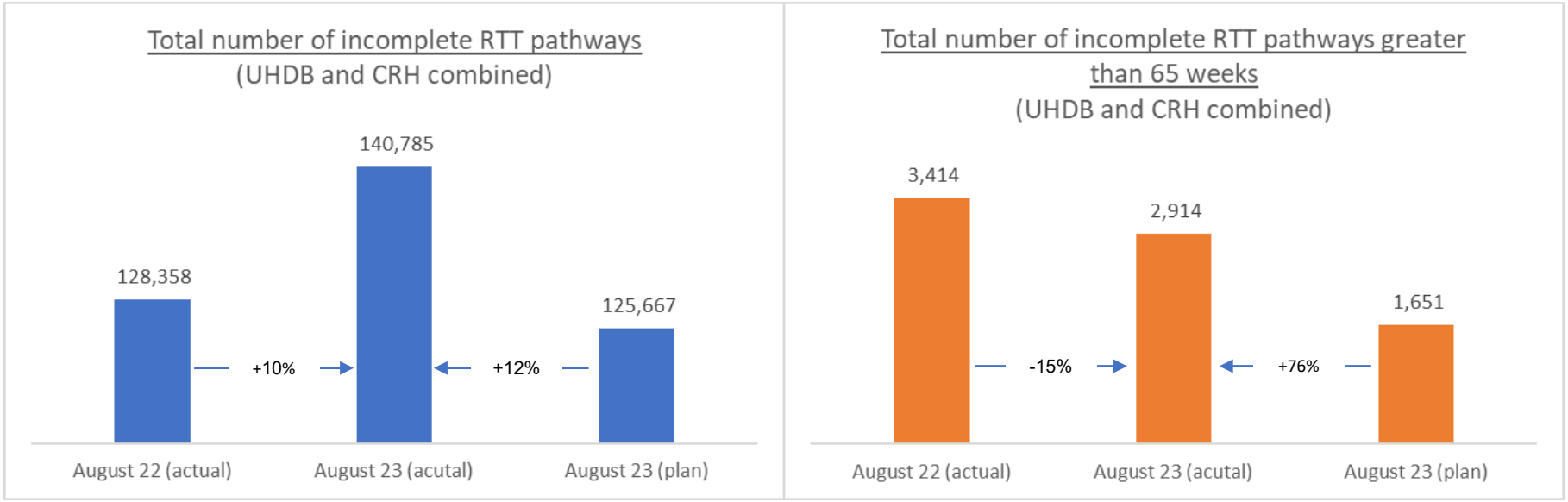
1 **RTT waiting list (overall size)** - at the end of August 2023, the RTT waiting list was ~12% larger than what we had originally expected it to be and ~10% larger than the position in August 2022.

2 **RTT long waits (65+ weeks)** - Whilst the number of people waiting longer than 65 weeks was ~15% lower as at the end of August 2023 compared to August 2022, we are behind plan with 1,263 more patients waiting longer than 65weeks than we had expected.



Long cancer waits…

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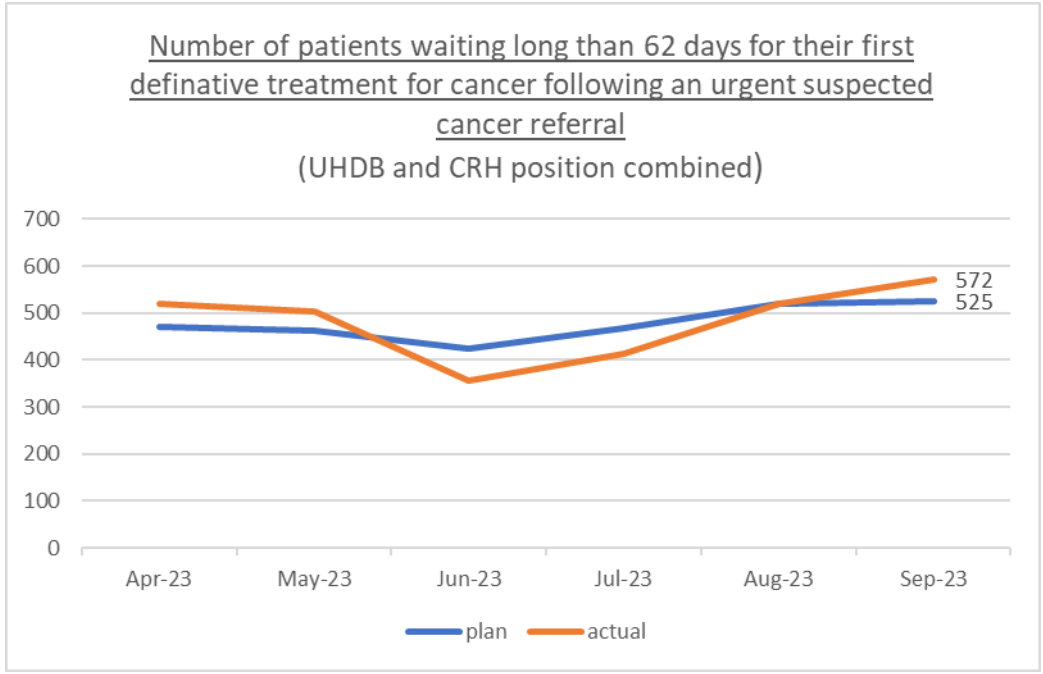
Number of patients waiting longer than 62 days for their cancer treatment - Performance which looked promising in June and July, where we were ahead of target, has deteriorated in the past two months and we are behind trajectory – equivalent to just under 50 patients.

Just over half of the total 62+ day wait volume sits in two cancer pathways – Lower Gastrointestinal and Urological.



…and Category 2 response times

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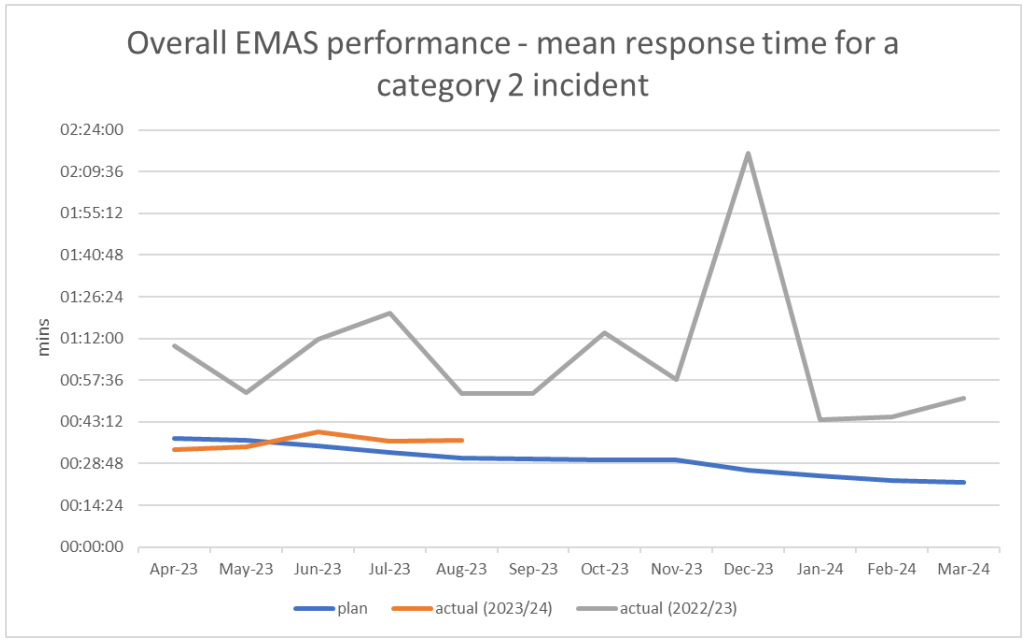
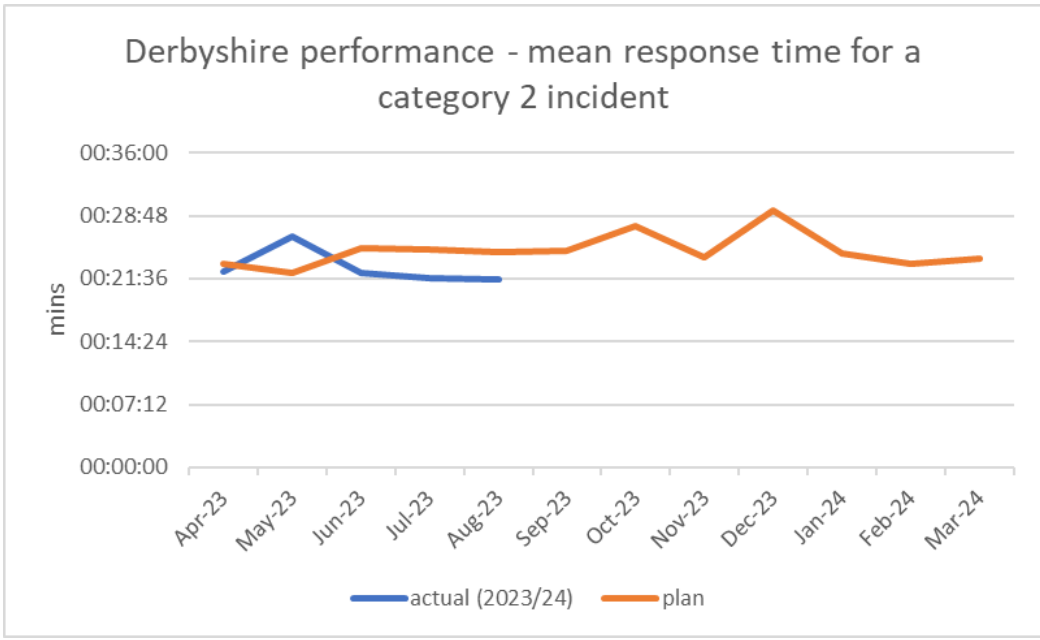
999 response (category 2 incident) - average response time from 999 call until the arrival of the ambulance at the scene. Whilst performance for EMAS' entire operation is currently operating higher than the 30-minute (mean) target level, the local position has held up reasonably well with performance operating within plan.





The ‘fundamentals’ of our plan for the next 6 months have not materially changed from that which was presented to the ICB Board at the start of the financial year. From an urgent and emergency care perspective this means…

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We are aiming to achieve the following objectives

By the end of March 2024, at least 76% of people attending A&E will be discharged or admitted within 4 hours.

EMAS’ response to category 2 incidents will be 30 mins on average.

At least 70% of referrals to the urgent community response service will be responded to within 2 hours.

By delivering a plan to…

- Provide **virtual ward** capacity so that up to 255 patients can be managed at any one time, with at least 80% of the capacity used, so as reduce the demand on general and acute beds.
- Enhance the current ‘**Clinical Navigation Hub**’ from November 23, by creating MDT input from health and social care, with the aim of ensuring that patient needs are being met by the most appropriate service.
- Expand the geographic coverage of the **Community Based Falls Recovery Service (FRS)**, so that more Level 1 and 2 falls are responded to by the FRS instead of EMAS.
- Enhance the **care and support offering to people experience a mental health crisis** – thus reducing the need for the A&E to be considered as a place of safety. Enhancements include (i) a crisis house in Chesterfield, opened in Sept-23, to provide 24/7 residential support; (ii) a safe haven in Chesterfield that will open in Oct-23 and offer out of hours support on a self-referral basis and (iii) three crisis drop-in centres in Buxton, Ripley and Swadlincote.
- Increase **reablement at home support packages (‘P1’)** by 17% over the next 6 months compared to what we had in the first 6 months of this year - with DCHS expanding its Community Response Team capacity and Derbyshire County Council changing its in-house service offering - with the aim of reducing delayed discharges from acute and community hospitals.
- For EMAS, increase core **Double Crew Ambulance capacity** by 13% on a like for like basis and use temporary private ambulance services whilst the organisation builds its workforce resource.
- Achieve at least an average 20% reduction in the amount of **time lost to ambulance handover delays** over the next 6 months, relative to last year.
- Keep overall **general and acute bed occupancy** at between 92-93% on average over the period by (i) bringing on additional medical bed provision and (ii) ensuring the efficient use of medical beds by enhancing same day (non-admitted) emergency provision and front door frailty assessment.

For planned and cancer care this means…

Derby and Derbyshire Integrated Care Board

We are aiming to achieve the following objectives

By the end of March 2024, there will be nobody waiting longer than 65 weeks for their treatment

By the end of March 2024, at least 75% of suspected cancers will be diagnosed or ruled out within 28 days.

By the end of March 2024, there will be no more than 311 patients waiting longer than 62 days for their first definitive treatment for cancer across both Trusts.

By the end of March 2024, 85% of people waiting for a diagnostic test will be waiting less than 6 weeks.

By delivering a plan to…

- **Protect elective inpatient bed capacity** over the next 6 months by ensuring better productive use of medical bed provision to reduce medical outliers.
- Achieve a minimum **theatre utilisation rate of 85%,** improving on the current situation (UHDB at 73.4% and CRH at 72.8% as at early September 23).
- Maximise the use of all available **outpatient capacity** – overbooking to mitigate the impact of DNAs.
- Use all the **independent sector's elective capacity** that is on offer.
- Utilise **consultant advice and guidance** to ensure that new acute RTT period demand is appropriate.
- **Insource endoscopy support** from the private sector to support with diagnostic waits.
- Utilise **premium rate incentives** for additional Echocardiography work in addition to insourcing physiologist capacity from the private sector.
- Continue the roll-out of the **Community Diagnostics Centre** programme.
- **Cancer Service capacity** will be **maintained** and **ringfenced** from operational pressures expected during the winter period.
- **Cancer specific pathway improvements** have been identified, specifically in relation to:
  - Urology – Straight to mp MRI diagnostics.
  - Upper and Lower GI – comprehensive use of the FIT in primary care.
  - Gynaecology – outsourcing activity to the private sector to reduce the Gynaecology ASI.

We are currently *active* in either preparing to deliver or delivering 9 of the 10 high impact interventions

Derby and Derbyshire Integrated Care Board

In NHS England's Winter Planning Letter (July 2023), all Health Systems were required to assess the relative level of maturity against 10 interventions/areas which contribute to reducing waiting times in A&E and improving flow in a hospital setting. As part of this exercise the Derby and Derbyshire health system has set two clear tests when it comes to assessing impact of these interventions (i) Do we plan to have additional capacity in place this year, compared to last; and (ii) Do we have a plan to improve the utilisation of this capacity over the next 6 months?

A summary of the national expectations and a local position statement is summarised below with supporting information at Appendix A.

At the time of writing, we currently do not have a plan to implement action 10 –Acute Respiratory Infection Hubs, due to financial constraints.

National expectations

Action	
1.	**Same Day Emergency Care**: reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2.	**Frailty**: reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3.	**Inpatient flow and length of stay (acute)**: reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
4.	**Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.
5.	**Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6.	**Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7.	**Virtual wards**: standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and help with discharge.
8.	**Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission.
9.	**Single point of access**: driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, eg home treatment
10.	**Acute Respiratory Infection Hubs**: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

Local position statement

Intervention	Does this intervention currently feature in our plan?	Do we plan to have additional capacity in place this year compared to last?	Do we have a plan to improve the utlisation of this capacity over the next 6 months?
Same Day Emergency Care	Yes	No	Yes
Frailty	Yes	Yes	Yes
Inpatient flow (Medical bed provision and productivity)	Yes	No	Yes
Community bed productivity	Yes	No	Yes
Care transfer hubs	Yes	No	No
Intermediate care capacity	Yes	Yes	Yes
Virtual wards	Yes	Yes	Yes
Urgent Community Response	Yes	Yes	Yes
Single Point of Access	Yes	Yes	Yes
Acute Respiratory Infection Hubs	No	No	No

However, there are specific issues and/or areas of risk arising over the next 6 months

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Demand

- Our current operating assumption is that non-elective demand - both in terms of volume and complexity - is no greater and/or complex than last year.
- This applies equally to COVID-19 and influenza inpatient hospitalisation rates, where we are assuming to mirror last year's position.

Capacity

- Our current operating assumption is that sickness absence over the next 6 months will be no worse than the same period last year.
- A series of interventions that are critical to this plan requires recruitment of staff to deliver the capacity - for example, the additional P1 capacity to be supplied by DCHS, the expansion of virtual ward capacity, the expansion of the FRS and the Clinical Navigation Hub.
- To deliver all the asks of the acute sector over the next 6 months requires a level of bed provision which goes beyond the core capacity of both Trusts. This means that an average occupancy rate of between 99%-106% needs to be lowered to around 92-93%. Whilst both Trusts have plans to bring on additional medical beds, over half of the medical bed provision required must be brought about by internal action to reduce utilisation - by fully utilising VW capacity and bolstering front door same day emergency care provision, amongst other measures.
- Despite additional 'P1' capacity over the next 6 months, we anticipate to still be operating at a deficit level – equivalent to an average of 73 starts per month across the county's provision and an average of 20 starts per month across the city's provision. We therefore anticipate there to be discharge delays over the period, albeit not at the scale of last year all other things being equal.

Prioritisation

- Over the next 6 months we will prioritise clinically urgent care need.
- From a hospital discharge perspective, our approach will be focussed on prioritising home care over using bedded care to reduce discharge delays.

Industrial action

- Our current operating assumption is that there will be no further episodes of industrial action. If we do have further events, there is a high likelihood that the RTT and cancer targets will not be met, given the hit to elective output that we've experienced during the previous four.

We will have a set of robust controls in place to help manage the situation

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The situation last winter provided learning about the relative value of 'system-based' co-ordination, control and support works. As preparation for the next period, several actions are being taken to strengthen our approach.

System Co-ordination Centre

Over the next six months, the Derby and Derbyshire System Co-ordination Centre (SCC) will build on the 'minimum viable product' that was put in place as part of the 2022/23 winter plan. The SCC will co-ordinate the ICS' response to the operational situation, using the Operating Pressure Escalation Level (OPEL) Framework alongside constituent ICS providers and ICB policies and will work to deliver three core outcomes:

- Improved visibility of operational pressures: senior operational and clinical leaders will have an aligned view of the operational pressures and risks across providers which will support collective action to improve patient safety.

- Real-time co-ordination of capacity and action: A system view of capacity across all providers will lead to a collaborative effort to improve performance to patients' benefit. In line with local policies and the OPEL Framework 2023/24, data sharing, as a core role of the SCC, will identify predictable and emergent activity to support forward planning and data will be visible to all key decision-making and co-ordinating personnel.

- Improved clinical outcomes: The SCC's unique position to oversee a suite of operational metrics in real time will enable it to provide a timely response at a system level, assisting local providers to deliver the right care at the right time.

Operational Pressures Escalation Levels (OPEL) Framework

NHS England have recently published a national NHS OPEL Framework which replaces the version that has been in operation since 2016 and provides a useful guide to assist us with refreshing our local OPEL framework. We are currently revising our local approach to ensure there is consistency with national expectations and expect to have finalised this work before the end of October.

Oversight of delivery

The work to specify and track the benefits of all related improvement work over the next six months and beyond continues and the pace of this work will quicken, as required. In addition, greater clarity will be sought on where accountability for delivery sits, particularly given the intersection of individual provider, the Provider Collaborative and PLACE.

Appendix A – Position statement against the 10 High Impact Interventions

High Impact intervention/area	What aspect of provision are we planning to operate differently over the next 6 months, compared to the same period last year?	What improvement impacts are we expecting over the next 6 months, compared to the same period last year?
Virtual Ward	We plan to have more virtual ward capacity in the second half of this year compared to the same period last year. As context, at the end of March 2023 we had capacity to manage up to 30 patients at any one time in a VW setting. During the second half of this year, we plan to have capacity to manage up to 255 patients at any one time.	The key focus for improvement is on enhancing the utilisation of the VW capacity available. This is a significant challenge to improve from the current utilisation (~60%) to achieve the 80% planned utilisation target in the last 6 months of the year. By enhancing utilisation, both Trust's overall G&A bed model assumes that G&A medical bed day demand will reduce (as a result of step-down length of stay reductions) equivalent to 14 G&A beds over the period (10 at UHDB and 4 at the CRH). This is a downgrade on the original assumption of 34 beds.
Medical bed provision and productivity	There is additional medical bed provision that is in place or planned to come into play at UHDB over the next 6 months, compared to the same time period last year. Specifically 23 overnight G&A medical beds at the FNCH. In addition, the Trust could bring on line up to 46 beds as part of its FCP but this is not additional given that FCP was in operation during the winter period last year. There is the potential to increase medical bed capacity at the CRH by 15 if funds can be found to support. The Trust is also planning to bring up to 28 beds on line as winter surge if required, but this is not additional as these beds were open during last winter.	Both Trusts have indicated a number of other improvement impacts over the period, with the CRH planning to make specialty LOS improvements (equivalent to 11 beds) and reduce internal delays (equivalent to 14 beds). The UHDB have indicated that they will increase MAU discharges which will result in less use of overnight beds (equivalent to 1 bed), reduce internal delays (equivalent to 2 beds) and also anticipate the impact of DCHS' bariatric unit at St Oswald's Hospital which will reduce LOS (equivalent to 4 beds).
Intermediate Care provision and productivity	We plan to bring on more reablement and rehabilitation capacity over the next 6 months, particularly across the County Council jurisdiction (as per the BCF plan). This will be a result of the Local Authority's in-house service reconfiguration combined with an enhancement to the DCHS Community Response Team offering. This also involves the continuation of the CHS offering for the remainder of the year. The combined effect of this action will create capacity to provide an additional 61 starts per month by the end of March 24, relative to the first 6 months of this year. There are risks to this plan, with the benefit of the inhouse change in the LA being pushed back to February 24 (the plan still assumes December 23) and the additional CRT capacity dependent on recruitment. However, despite this additional capacity, we anticipate there still to be a gap in provision relative to the demand expected. In terms of overall bedded care (P2a and P2b), we anticipate there to be a gap in provision – relatively small across the Derby City jurisdiction (a gap of ~4 starts per month over the period) and a bit bigger across the Derbyshire County (a gap of ~41 starts per month over the period).	The focus is on improving the reablement care offering for people discharged from hospital (acute and community), with reference made to the following action: (i) Continuing to secure the service of CHS Healthcare's brokerage input. This doesn't provide any additional carer capacity above and beyond what we have now. (ii) Investment in DCHS' Community Response Team to provide additional P1 care packages. (iii) The impact of Derbyshire County Council's change to P1 provision from January 24. (iv) Investment in VSCE provision to support patient's transition back home. Furthermore, both acute trusts are assuming that D2A delays reduce over the period so that the equivalent of 14 overnight G&A beds are 'freed-up' (3 across UHDB and 11 at the CRH).
Community bed productivity	There is currently no additional capacity planned to come on line in the second half of this year compared to the same period last year. The JUCD strategy over winter is focussed on increasing P1 provision and we are therefore not pursuing the procurement of additional P2 beds. We anticipate that with additional P1 capacity coming online, this will not only reduce delayed discharges from acute beds, but also from our community beds as well.	As we are not increasing the overall stock of beds available, the efficient utilisation of P2 bedded capacity is therefore required this winter. To that end several actions will be taken: (i) Our community hospital provider has developed a process to track all delays within the community hospital beds (rolled out this month) to have better oversight and control of flow through the beds, this is anticipated to reduce the number of delays out of our beds and enable earlier discharge planning. (ii) We are rolling out process to improve transport, so discharges take place earlier in the day within community hospitals, 75% of discharges now happen in the mornings (compared with 57% pre intervention), this is also reducing the number of failed discharges from the acutes into beds due to transport (since roll out at CRH all transport booked through new process have occurred, previously failed discharges due to transport were a daily occurrence leaving capacity in community beds unused). This is reducing the number of lost bed days within our community hospitals and supporting system flow (iii) In Q3 our Community hospitals are rolling out increased staffing at one unit to support the enhanced care needs of some patients. This will reduce delays out of the acute (as patients with enhanced needs tend to wait in delay until a bed in an increased supervision bay is available). These roles will also aim to reduce the LOS for this cohort, as often they have complex needs that require review for discharge. However, they will be staffed through agency staff as the funding is non-recurrent so this is a risk to delivery. (iv) Our P2a beds in residential settings were consolidated in Autumn this year, with the same number of beds over fewer units, improved staffing and better process of review. This is anticipated to reduce the LOS and increase the number of new starts per week (v) The Derbyshire Local Authority are recruiting into brokerage roles to support the discharge of patients out of bedded care into care at home, this is a main point of delay out of our community beds

High Impact intervention/area	What aspect of provision are we planning to operate differently over the next 6 months, compared to the same period last year?	What improvement impacts are we expecting over the next 6 months, compared to the same period last year?
Single point of access	A single point of access to UEC pathways will be operational in November 2024. Whilst we had the constituent services in play last year, we did not have the co-ordination of provision (delivered by a newly formed MDT) that the SPA is planning to give us this year.	From a service perspective, the benefit of moderated/managed demand is expected to arise with the flow of demand being recalibrated between services and providers. However, there is no detail of what type of demand the SPA is aiming to reduce/reassign/recalibrate over the period and it appears that key service activities e.g. ED attends, EMAS cat 3 and 4 calls, UCR contacts have not been adjusted.
Care transfer hubs	Both Acute Trusts will have care transfer hubs in place, operating at a scale and scope similar to last year and have been rated as 'mature' by NHSE.	There are no additional improvement impacts/benefits planned over the next 6 months.
Urgent community response	There is currently no additional capacity planned to come on line in the second half of this year compared to the same period last year.	The over-performance seen so far this year against the 2hr response target is assumed to continue for the rest of 2023/24.
Same day emergency care	Both Acute Trusts will continue to deliver SDEC services, operating at a scale and scope similar to last year.	The focus for improvement is on increasing the utilisation of SDEC services. UHDB are anticipating that this will reduce the demand for overnight beds (equivalent to 2 beds) over the period. The CRH anticipate a significant improvement to its frailty/SDEC offering over the next 6 months (equivalent to 19 beds).
Frailty	Both Acute Trusts will continue to deliver frailty assessment and streaming services, operating at a similar scale and scope to last year. From a community perspective, there will be an expansion of the Falls Recovery Service across the patch, although according to different timescales r.e. transition to full compliance with the Enhanced Falls Recovery Service Specification. These plans are currently being reviewed and ratified by the PLACE Executive. It is unclear at this stage as to what the plan is to reduce level 3 falls and the frailty inducted fracture falls rate as indicated.	From an acute perspective, the improvement focus is on enhancing access to frailty assessment teams. Both Trusts anticipate that their improvement work will bring about a reduction in the demand for overnight beds (either avoiding admission or reducing LOS) equivalent to freeing up 16 beds in total (14 at the CRH and 2 across UHDB). From a community perspective, it is assumed that the FRS will (i) contribute to delivering up to 90% of incidents that EMAS respond to in relation to L1 and 2 where they see and treat; and (ii) 50% for the see, treat and convey cohort. No Provider plans (UHDB, CRH, EMAS) have been amended to incorporate this impact. From a level 3 community falls perspective, UHDB are assuming that a downstream benefit of less acute admissions of patients with a frailty-induced fall - equivalent to freeing up 13 overnight G&A beds.
Acute Respiratory Infection Hub	We currently do not have a plan to implement an Acute Respiratory Hub. Last year, we had 8 'hubs' in operation to provide additional General Practice capacity, to service all types of demand - include respiratory. Between December 22-March 23, capacity was made available to provide up to 12,000 appointments, of which 9,000 were actually provided. This provision was supplied by DHU and cost £362,230, so approx. £40 per appointment (funded via non-recurrent COVID-19 monies). Whilst there is an intent to create a similar offering this year, no financial resource has been identified to fund it.	None - given that the intervention is not planned to come into play. The benefits which were reported to have been secured last year, e.g. providing additional GP appointments for practices operating at level 3/4 OPEL will presumably not be replicated.

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NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item:104

Report Title	Audit and Governance Committee Assurance Report – October 2023 and 2022/23 Annual Report							
Author	Fran Palmer, Corporate Governance Manager Sue Sunderland, Non-Executive Member (Audit & Governance)							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Sue Sunderland, Non-Executive Member (Audit & Governance)							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report Appendix 2 – Committee Annual Report 2022/23							
Assurance Report agreed by:	Sue Sunderland, Non-Executive Member (Audit & Governance)							
Which committee has the subject matter been through?	Audit and Governance Committee – 12.10.2023							

Recommendations
The ICB Board is recommended to **NOTE** the Audit and Governance Committee's: • Assurance Report (October 2023); and • Annual Report 2022/23
Items to escalate to the ICB Board
No matters of concern or key risks to escalate.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Audit and Governance Committee on the 12.10.2023, and the Committee's Annual Report for 2022/23, which has been presented to and approved by the Committee.
Background
The Audit and Governance Committee ensures that the ICB complies with the principles of good governance whilst effectively delivering the statutory functions of the ICB. 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.

Report Summary

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

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

The Audit and Governance Committee Annual Report 2022/23 (Appendix 2) provides the ICB Board with a review of the work that the Audit and Governance Committee has completed during the period 1st July 2022 to 31st March 2023.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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

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

Yes ☐	No☐	N/A☒

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

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

No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

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

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

Details/Findings
Not applicable to this report.

Appendix 1

NHS
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Board Assurance Report

Audit and Governance Committee on 12th October 2023

Matters of concern or key risks to escalate	Decisions made
The Committee received a detailed deep dive presentation on the ICB's organisational financial risks which highlighted a number of factors that contribute to our challenging underlying financial position including the: 1. impact of the national population-based funding mechanism which does not recognise the significant extent to which Derbyshire provider trusts operate within other ICB boundaries as well as extensive cross boundary activity and expenditure (a considerable proportion of which is cross regional); 2. impact of socio-economic factors particularly on primary care and other small independent providers; and 3. increasing effort needed to manage the system finances. The Committee welcomed the opportunity to discuss the issues raised but were concerned that there is no easy solution and also that it is likely that the Board and partner organisations are not sighted on these issues.	1. Agreed the recommendations regarding the ICB headquarters review that: a. a move to sharing accommodation with Derby City Council provides a better option for the future location of the ICB headquarters than remaining at Cardinal Square; and b. further exploration of the options regarding Scarsdale or an alternative is needed. 2. Approved the Audit & Governance Committee annual report for the period 1st July 2022 – 31st March 2023. 3. Approved the ICB Governance handbook. 4. Approved the following policies: a. Photographic Consent and Image Storage Policy; and b. Media and Social Media Policy.
Major actions commissioned or work underway	**Positive assurances received**
The Committee raised ongoing concerns regarding the issues flagged by the procurement update and have agreed a deep dive, including consideration of: 1. pre-work linked to the specification such as consideration of affordability and activity levels; 2. timeliness and level of extensions required; 3. approach to risk around potential compliance issues; 4. market knowledge and management; and 5. effectiveness of working between ICB & CSU teams.	1. Received internal audit progress report which included reference to specific reviews as follows: a. 2022/23 committee effectiveness review – advisory with recommendations; and b. Stage 1 Head of Internal Audit opinion memo. 2. Received a counter fraud progress report giving current and anticipated assessment of the ICB against the counter fraud standards which confirmed that the ICB is on track to retain its green status.

	3. Received the ICB Corporate Risk Register report and the risks responsible to the Audit and Governance Committee. 4. Received assurance from reviewing the regular reports on: a. Conflicts of Interest; b. Freedom of Information; c. Digital and Cyber Security; and d. Information Governance. 5. Received the pre-delegation assessment framework for specialised commissioning services which assessed the ICB as ready. 6. Received a positive update on the developing arrangements around the Freedom to Speak up plan in response to the verdict on Lucy Letby.

Comments on the effectiveness of the meeting
Although there were a lot of items on the agenda, all members were well prepared which enabled time to be focused on those items that warranted detailed discussion. The deep dive into the finance risks led to an excellent discussion on the issues and challenges facing the ICB and significantly increased the awareness of all members in this area.

Appendix 2

Audit & Governance Committee Annual Report 1st July 2022–31st March 2023

AUDIT & GOVERNANCE COMMITTEE ANNUAL REPORT

1st July 2022–31st March 2023

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Audit & Governance Committee and covers the period from 1st July 2022 to 31st March 2023.

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 9 times during the 1st July 2022 to 31st March 2023. All meetings were fully quorate. The quorum necessary for the transaction of business is two Independent 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 a confidential 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 2022/23 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 2022/23 delivered an unqualified opinion that the financial statements, which:

5.1 gave a true and fair view of the state of the ICB's affairs as at 31st March 2023 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 2022/23.

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 2022/23 Annual Accounts audit in accordance with the published NHS timetable.

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 2023 there were no areas of concern to report to the ICB Board.

6.3. Internal Controls

The following Audit Reports from the 2022/23 programme were considered by the Committee, together with the Head of Internal Audit Opinion:

Audit Assignment	Assurance Level/Comments
Governance and Risk Management	Significant
Transformation and Efficiency	Indicative opinion; limited
Financial Sustainability	Not applicable; no significant concerns raised
General Ledger and Financial Reporting	Indicative opinion; significant
Enhanced Services – Minor Surgery Claims	Not applicable
Committee Effectiveness Review	In progress

Any key risks which are highlighted within the reports were added to the ICB Assurance Framework.

6.4 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. From the 1st July 2022 the ICB had 4 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;
- Conflicts of Interest;
- Digital Development and ICT Assurance, including Cyber Security;
- Emergency Preparedness Resilience and Response;
- Estates;
- Freedom of Information;
- Health, Safety, Fire and Security;
- Information Governance;
- Organisational Development, including ICB Staff Survey;
- Procurement; and

- Research Governance.

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

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. CONCLUSION

The Audit & Governance Committee has previously confirmed to the ICB Board, based on its work between the 1st July 2022 and 31st March 2023, that it considers the internal control framework to be appropriate and effective. The committee extends its appreciation to the Finance and Corporate Delivery teams for their hard work and support to the committee's agenda.

Similarly, the committee has earlier noted and commended the achievement of the organisation's stretching financial targets, reflected also in the well-prepared set of annual report and accounts.

Sue Sunderland
Chair of Audit & Governance Committee & Non-Executive Member for Audit & Governance
September 2023

Appendix 1

Audit & Governance Committee Attendance Record 1st July 2022 to 31st March 2023

Audit and Governance Committee Member		19 Jul 2022	25 Aug 2022	13 Sep 2022	27 Oct 2022	24 Nov 2022	22 Dec 2022	9 Feb 2023	23 Mar 2023
Sue Sunderland	Chair – Non-Executive Member (Audit & Governance)	✓	✓	✓	✓	✓	✓	✓	✓
Richard Wright	Non-Executive Member (Finance & Estates)	✓	✓	✓	X	✓	✓	✓	✓
Dr Bukhtawar Dhadda	Non-Executive Member (Quality & Performance) (up to 31st January 2023)	X	✓	X	✓	✓	X		

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 105

Report Title	Finance, Estates and Digital Committee Assurance Report – September / October 2023							
Author	Jill Dentith, Non-Executive Member – Finance and Estates							
Sponsor (Executive Director)	Keith Griffiths, Chief Finance Officer							
Presenter	Jill Dentith, Non-Executive Member – Finance and Estates							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report (September) Appendix 2 – Committee Assurance Report (October)							
Assurance Report agreed by:	Jill Dentith, Non-Executive Member – Finance and Estates							
Which committee has the subject matter been through?	System Finance, Digital and Estates Committee – 26.9.2023 and 24.10.2023							

Recommendations
The ICB Board is recommended to **NOTE** the System Finance, Digital and Estates Committee – September/October 2023 Assurance Report.
Items to escalate to the ICB Board
There was a brief discussion on the 24th October on the roles and responsibilities of the committees and corporate governance structures which underpins the ICB Board. The committee discussed a suggestion that this matter should be further debated at Board to ensure clarity of purpose, reducing overlap and making best use of the assurance infrastructure. In addition, see Appendix 1 for more assurance and risks discussed by the Committee.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the System Finance, Digital and Estates Committee on the 26.9.2023 and 24.10.2023.
Background
The System Finance, Digital and Estates Committee ensures that the ICB effectively delivers the statutory functions of the ICB.

Report Summary

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

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

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £2.9bn available funding.	☒
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☒
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

Yes ☒	No☐	N/A☒

Details/Findings	**Has this been signed off by a finance team member?**
Significant risk of not delivering breakeven (with consequential cash issues) due to IA and other national financial pressures emerging in – year.	Yes.

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

None raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

Details/Findings
Not applicable to this report.

Board Assurance Report

System Finance, Digital and Estates Committee on 26th September 2023

Matters of concern or key risks to escalate	Decisions made
• As of 31st August 2023, the JUCD year to date position is £32.3m deficit against a £15.0m planned deficit, a £17.3m overspend against the plan. The main factors affecting this are industrial action, excess inflation, and efficiency slippage. Consequently, the unmitigated likely case year end forecast for 2023/24 is a deficit of £69.6m which reflects these pressures that were not known at the time of planning. It also includes a £5m underspend which relates to dental. • The system efficiency delivery is £2.8m under plan year to date, this is split into £11.2m behind plan on recurrent efficiencies and £8.3m over plan on non-recurrent efficiencies. Unless planned levels of recurrent efficiencies can be delivered, it will impact in future years. The efficiencies have been phased based on an increasing rate of delivery as the year progresses, therefore, it is important that the development of schemes gathers pace to support the delivery of the current forecast position of breakeven. At month five, there are £37.9m of schemes that are still in the opportunity phase or unidentified. As a result, the assurance on delivery of efficiencies is limited. • The JUCD Operational Plan set out the expectation the Provider Collaborative and Place be required to make a significant contribution to delivering the in-year and recurrent underlying position. There is limited assurance of their direct contribution towards the efficiencies that are planned to be delivered and work continues across the system to address this. • The forecast position overall on capital is an overspent £14.0m on a plan of £160.3m. • The System's reported annual cash flows reflect the expected delivery of cash-releasing efficiencies. The in-year cashflow will be	• A new risk would be added to the Risk Register relating to the unfunded pay award (KG). • Risk 8 on the Board Assurance Framework would be reallocated to relevant ICB committee (DG).

significantly impacted if they do not occur. Although temporary provider-to-provider monetary support is being considered, Trusts will ultimately need to apply to the department of health for interest-bearing loans if the position does not improve. • The ability to deliver the planned level of efficiencies in 2023/24 remains a key risk for the system. The development of plans in month five remains slow and, unless recovered with some urgency, will undermine the system's ability to deliver a breakeven financial position in 2023/24 against the construct of the plan. • Prescribing costs have increased again this month, which continues to be due to prices remaining at higher levels across several drugs. The planned budget for prescribing assumed a reduction in prices, following previously seen price concession trends over the last 6 years, however this reduction has not been seen in drugs prices so far, this financial year. This is a national trend and is recognised by NHSE.	
Major actions commissioned or work underway	**Positive assurances received**
• The updated wording of Risk 21 on the Risk Register was noted (following agreement at ICB board in September 2023). DG will liaise with corporate governance colleagues to ensure that the Risk Register has the correct wording. • In relation to prescribing NHSE have suggested focused work on certain areas to reduce prescribing costs. The recommendations that have been suggested are being reviewed by the Medicines Management team to understand the local scale of those opportunities. • There was a brief presentation in relation to the difference between spend and allocation. A summary report on this would be shared with colleagues to ensure clarity of the issue and key messages to share across the system (KG). • There was a presentation on the Medium-Term Financial Plan. A more detailed update will be presented to the October 2023 Committee.	• The Committee noted the providers position regarding Reinforced Autoclaved Aerated Concrete (RAAC) construction of buildings within their property portfolios, noting that currently no reports of RAAC buildings have been identified. However, further clarification is sought in relation to a few premises in the community and ambulance services. Additional information in relation to the primary care estate will follow. Post meeting note – the two ICB premises (Cardinal and Scarsdale) are both free from RAAC. • The system is still committed to delivering a breakeven position at year end and is reflected in the best case year end forecast. The achievement of this is totally dependant upon the receipt of additional funding to help cover the costs of industrial action and inflation. An announcement on this is imminent. • Although there is still significant work to do on delivery of efficiencies the updated ePMO report was well received and found to be very helpful in understanding the current position.

	• Positive assurances in relation to the position regarding workforce reporting were also noted, however work is ongoing on this and a deep dive has been commissioned which will be shared with the committee in October 2023. • It was noted that a national announcement of £200m to support organisations with the cost of industrial action has been made. Details of how this will be allocated have not yet been received. • Despite the pressures being experienced, the Derby system is the currently best performing system in the region given its size and complexity.

Comments on the effectiveness of the meeting

The meeting had excellent round table participation from all present and a good discussion was had in relation to the financial and efficiency positions across the system.

The meeting was well attended by Directors and officers across the system. The two Non-Executive Members from the ICB attended, however, due to a range of issues the two Non-Executive Directors from the provider trusts were unable to attend. This resulted in the meeting not being quorate under the new Terms of Reference. An attempt was made to resolve this position prior to the meeting but was unsuccessful. Discussions between ICB NEMs, the Chair of the ICB and the Chief of Staff are looking at possible longer-term solutions to this issue.

Appendix 1

NHS
Derby and Derbyshire
Integrated Care Board

Board Assurance Report

System Finance, Estates and Digital Committee on 24 October 2023

Matters of concern or key risks to escalate	Decisions made
• As of 30th September 2023, the JUCD year to date position is £36.2m deficit against a £15.6m planned deficit, a £20.6m overspend against the plan. The main factors driving this are industrial action, excess inflation and impact of pay awards. The unmitigated likely case year end forecast for 2023/24 is a deficit of £68.0m which reflects these pressures that were not known at the time of planning and also pressures on delivering the agreed plan, including planned efficiencies. • The System's reported annual cash flows reflect the expected delivery of cash-releasing efficiencies which will be significantly impacted if they do not occur. • There are risks to reaching the year-end position currently estimated at £122.5m. They are being categorised into two areas, those that are outside the system's control (excess inflation, industrial action and pay award costs) and those that might prevent the delivery of the Operational Plan, which includes efficiencies. Mitigating these risks is necessary to deliver a breakeven position and it is important for the risks deemed within our control that mitigations are identified as a matter of urgency to enable the delivery of the plan Board approved. • The system continues to report a cost neutral Elective Recovery Fund (ERF) position in month six, in line with national reporting guidance. The activity information produced nationally is being assessed to ensure an accurate position is reported. Adjustments to the 2019/20 baseline have been submitted to the national team for approval, that will reduce the performance target. • The Committee considered key factors including the forecast overspends on capital and the expected reduction in allocation.	• A further report on the workforce position would be presented to the committee, subject to a review of committee roles and responsibilities (LG / SM). • The Committee noted a helpful tool looking at an “Ideal Approach” to workforce which considered affordability and productivity. The Committee also considered the element of safety in relation to some roles and agreed to consider this as an element to the model as this progressed to implementation phase (LG / SM). • The Committee discussed a new risk (No. 22) relating to unfunded pay awards and agreed that this should be further refined to clarify the risk to the financial position and workforce (KG). • Despite the ePMO report indicating significant progress, there was concern that there was little evidence of real transformation releasing recurrent savings. Provider CFO's were asked to take this back to the Provider Collaborative with some urgency.

Major actions commissioned or work underway	Positive assurances received
• Deep dive on Shared Care Records to be presented to December 2023 meeting (JA). • Deep dive on ePMO efficiency to be presented to December 2023 meeting (TH/CB). • Further work to clarify the roles and responsibilities of committees in supporting the Board to deliver its key targets (CC working with Chief of Staff).	• Progress has been made across the system on updating and inputting into the ePMO system which now captures £115.5m of 2023/24 efficiency schemes across the system. • The system efficiency delivery is £2.0m over plan year to date, this is split into £14.0m behind plan on recurrent efficiencies and £16.0m over plan on non-recurrent efficiencies. Unless planned levels of recurrent efficiencies can be delivered, it will impact in future years. • At month six, there is a total of £19.4m of schemes that are still in the opportunity phase or unidentified. As a result, the assurance on delivery of the planned £136.0m of efficiencies is increasing but we do not yet have full assurance. • The system is still committed to delivering a breakeven position at year end and this is reflected in the best-case year-end forecast. • The Committee received the system estates report which gave a positive position in relation to the role of the Strategic Estates Group (SEG) and the development of the Estates / Infrastructure Strategy for the Derby and Derbyshire ICS. • The Committee received the Data and Digital Report and noted positive progress in relation to Electronic Patient Record, cyber resilience and Optimised Patient Tracking and Intelligent Choices Application (Optica). • The Committee noted the challenges in relation to workforce data but acknowledged the significant work undertaken to get to a more robust report.

Comments on the effectiveness of the meeting
The meeting was quorate and well attended by the majority of members. The meeting had a focus on estates and digital in addition to a deep dive on workforce.

There was a brief discussion on the roles and responsibilities of the committees and corporate governance structures which underpins the ICB Board. The committee discussed a suggestion that this matter should be further debated at Board to ensure clarity of purpose, reducing overlap and making best use of the assurance infrastructure.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 106

Report Title	Derbyshire Public Partnership Committee Assurance Report – October 2023 and 2022/23 Annual Report							
Author	Sean Thornton, Deputy Director Communications and Engagement Fran Palmer, Corporate Governance Manager							
Sponsor (Executive Director)	Helen Dillistone, ICB Chief of Staff							
Presenter	Sue Sunderland, Non-Executive Member (Audit and Governance)							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report Appendix 2 – Committee Annual Report 2022/23							
Assurance Report agreed by:	Sue Sunderland, Non-Executive Member (Audit and Governance)							
Which committee has the subject matter been through?	Public Partnership Committee – 31.10.2023							

Recommendations
The ICB Board is recommended to **NOTE** the Public Partnership Committee's: • Assurance Report (October 2023); and • Annual Report 2022/23.
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 a summary of the items transacted for assurance, from the development meeting of the Public Partnership Committee on the 31st October 2023. The Committee alternates its monthly meetings between business, through which project and programme schemes are reviewed for assurance, and development, where the Committee discusses structural and process issues in greater depth to support Committee establishment and role; the October meeting was a business meeting. The report also provides the Committee's Annual Report for 2022/23, which has been presented to and approved by the Committee.
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.

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.

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.

The Committee Annual Report 2022/23 (Appendix 2) provides the ICB Board with a review of the work that the Committee has completed during the period 1st July 2022 to 31st March 2023.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☐	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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

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

Yes ☐	No☐	N/A☒

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

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

No conflicts of interest were raised.

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

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

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

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None raised as a result of the items reviewed at these meetings.

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

Appendix 1

Derby and Derbyshire
Integrated Care Board

Board Assurance Report

Public Partnership Committee on 31st October 2023

Matters of concern or key risks to escalate	Decisions made
No matters of concern or risks to escalate.	<u>Evaluation Framework</u> This framework is one of five identified in the Engagement Strategy. It will seek to outline how we will measure and appraise the range of engagement methods we develop and support ongoing continuous improvement. This work would be done by the agreed Lay Reference Group, a sub-group of the PPC. A workshop was held with colleagues across the system including people who have used services, VCSE partners, system-wide lay representatives and other stakeholders to come together to co-design the approach. PPC were keen to understand the metrics to be deployed in assessing engagement, and also wished for further distinction on the roles of the Lay Reference Group and PPC. <u>PPC Role in Delivery of NHS Provider Engagement</u> The PPC has discussed the ICB's role in assuring or supporting the work of NHS Trusts in achieving their legal duties on engagement in service change. PPC has agreed that except for when formal public consultation is required, assurance is not the role of the ICB in this area, and that a supportive and informal mechanism of sharing guidance and good practice is appropriate. <u>Fertility Update</u> PPC was briefed on latest developments with the East Midlands-wide review of fertility policies. A desk-top exercise has been undertaken to review all ICB policies, current guidance and the existing evidence base. Recommendations are being drafted from this review, which will result in a case for change and subsequent public engagement. NHS Derby and Derbyshire ICB are leading the engagement on behalf of all East Midlands ICBs.

	PPC Membership Update It was noted that progress had been made in seeking to recruit to two of three vacant lay member roles on the PPC. These roles would strengthen representation from Derby City and from our Public and Patient Partners group. Multiple expressions of interest were received for each position and the appointment process continues. A third vacancy will be recruited to one the Lay Reference Group is established. All lay members of PPC are now or will be appointed to a specified term of office.
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
	Insight Framework
	PPC welcomed the update on this framework, which seeks to capture feedback from citizens and service users on a continuous basis and enable them to be fed into decision-making processes. A tool has been co-created with system partners to assess existing work, and 15 pilots ranging from community partnerships to GP practices have been agreed to help test the tool.
	
	Board Assurance Framework
	A comprehensive Q2 progress update was provided on actions to mitigate risks identified in the BAF. Most work remained in progress

Comments on the effectiveness of the meeting	
The committee reviewed a series of assurance questions and agreed that the meeting had been effective.	

Joined Up Care Derbyshire

NHS
Derby and Derbyshire
Integrated Care Board

Public Partnership Committee Annual Report

1st July 2022–31st March 2023

PUBLIC PARTNERSHIP COMMITTEE ANNUAL REPORT

1st July 2022–31st March 2023

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Public Partnership Committee and covers the period from 1st July 2022 to 31st March 2023.

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
  - Chief Executive, 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 7 times during the reporting period. All meetings were fully quorate. The quorum necessary for the transaction of business was 2 Non-Executive Members, 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 monthly before every ICB Board meeting to ensure all Quality and Performance 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 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.	• Eating Disorders Procurement • Glossop Services Engagement Approach • LD Short Breaks • GP Access – Deep Dive • Buxton Colposcopy Outpatient Service • Non-Surgical Oncology • Clinical Policy Advisory Group Engagement Assessment
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.	• Integrated Care Strategy Engagement Plan • End of Life Strategy • Insight Framework • Governance Guide Testing • Primary Care Legal Duties • Development, role and purpose of the committee • Compliance Report Process
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. CONCLUSION

Partnership with the public of Derby and Derbyshire is fundamental to the success of the ICB's Joint Forward Plan. If the public are not involved in how we shape the future of health care, and if we don't understand our own effectiveness in supporting public involvement, then we will miss a fundamental source of capability and insight from our system.

Over the past year, the Public Partnership Committee has overseen the development and introduction of a number of frameworks, including engagement, insight and evaluation, that will guide our approach to public partnership. The frameworks, which will be guided by dedicated task and finish or reference groups, will bring coherence to our approach and ensure that we will are clearly monitoring and understanding our impact.

To enable the Public Partnership Committee to provide more strategic leadership, we are refreshing its membership and focusing more of its time on strategy and implementation, alongside the vital work of assuring compliance with statutory public engagement requirements.

Julian Corner
Chair of Public Partnership Committee
September 2023

APPENDIX ONE

Public Partnership Committee Attendance Record 1st July 2022–31st March 2023

Public Partnership Committee Member		2 Aug 2022	20 Sep 2022	18 Oct 2022	29 Nov 2022	24 Jan 2023	28 Feb 2023	28 Mar 2023
Voting Members								
Julian Corner	Chair – Non-Executive Member (Population Health & Strategic Commissioning)	✓	✓	✓	✓	✓	✓	✓
Sue Sunderland	Non-Executive Member (Audit & Governance)	X	X	✓	✓	✓	✓	✓
Steven Bramley	Lay Representative	✓	✓	X	✓	✓	X	✓
Tim Peacock	Lay Representative	✓	✓	✓	✓	✓	✓	✓
Jocelyn Street	Lay Representative	✓	✓	✓	✓	✓	✓	✓
Margaret Rotchell	Lead Governor, CRHFT (up to 31st December 2022)	✓	✓	✓	✓			
Carol Warren	Lead Governor, CRHFT (from 1st January 2023)					X	✓	✓
Maura Teager	Lead Governor, UHDBFT	✓	X	X	✓	✓	X	X
Lynn Walshaw	Deputy Lead Governor, DCHSFT	✓	X	✓	✓	✓	✓	✓
Christopher Mitchell	Public Governor, DHcFT	X	X	✓	✓	X	X	✓
Kim Harper	Chief Officer, Community Action Derby	✓	X	X	X	X	X	X
Non-Voting Members								
Beth Fletcher	Strategy & Engagement Manager, Healthwatch Derby (up to 30th September 2022)	✓	X					
Michelle Butler	Strategy & Engagement Manager, Healthwatch Derby (from 1st October 2022)			✓	X	X	X	X
Harriet Nicol	Engagement & Involvement Manager, Healthwatch Derbyshire (up to 28th February 2023)	X	✓	✓	✓	✓	X	
Helen Henderson	Chief Executive Officer, Healthwatch Derbyshire (from 1st March 2023)							X
Helen Dillistone	Executive Director of Corporate Affairs, ICB	✓	✓	✓	✓	✓	✓	✓
Sean Thornton	Deputy Director Communications & Engagement, ICB/JUCD	X	✓	✓	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

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 107

Report Title	Population Health and Strategic Commissioning Committee Assurance Report – October/ November 2023 and 2022/23 Annual Report							
Author	Dr Deji Okubadejo – Clinical Other Member and Deputy Chair of the Population Health and Strategic Commissioning Committee Fran Palmer, Corporate Governance Manager							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer / Deputy CEO							
Presenter	Dr Deji Okubadejo – Clinical Other Member and Deputy Chair of the Population Health and Strategic Commissioning Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☒
Appendices	Appendix 1 - Committee Assurance Report Appendix 2 - Committee Annual Report 2022/23							
Assurance Report agreed by:	Dr Deji Okubadejo – Clinical Other Member and Deputy Chair of the Population Health and Strategic Commissioning Committee							
Which committee has the subject matter been through?	Population Health and Strategic Commissioning Committee – 12.10.2023 / 9.11.2023							

Recommendations
The ICB Board is recommended to **NOTE** the Population Health and Strategic Commissioning Committee's: • Assurance Report (October/ November 2023); and • Annual Report 2022/23
Items to escalate to the ICB Board
As detailed within the report.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Population Health and Strategic Commissioning Committee on the 12th October and 9th November 2023, and the Committee's Annual Report for 2022/23, which has been presented to and approved by the Committee.
Background
The Population Health and Strategic Commissioning Committee ensures that the ICB effectively delivers the statutory functions of the ICB.

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

Report Summary

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

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

The Committee Annual Report 2022/23 (Appendix 2) provides the ICB Board with a review of the work that the Committee has completed during the period 1st July 2022 to 31st March 2023.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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

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

Yes ☐	No☐	N/A☒

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

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

None raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

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

There are no implications or risks which affect the ICB's obligations under the Public Sector Equality Duty.

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

Details/Findings
Not applicable to this report.

Derby and Derbyshire
Integrated Care Board

Board Assurance Report

Population Health & Strategic Commissioning Committee on 12th October and 9th November 2023

Matters of concern or key risks to escalate	Decisions made
None to report.	All decisions were confidential.
Major actions commissioned or work underway	**Positive assurances received**
None to report.	**12th October Strategy meeting:** **Board Assurance Framework (BAF)** • **APPROVED** the revised Strategic risk description in respect of Strategic Risk 9; • **AGREED** the proposed removal of Threats 2 and 4 from BAF Strategic Risk 9; • **AGREED** a slight wording change under Strategic Threat 1: *The breadth of requirements on the system outstrips/ surpasses our ability to prioritise our resources (financial/capacity) towards reducing health inequalities.* • **RECEIVED** Strategic risk 8 which has transferred from the Finance, Estates and Digital Committee. **9th November meeting:** **Risk Register Reports** • **RECEIVED** and **DISCUSSED** the risks responsible to the Committee. The following items were received for information: • Monthly updates, minutes & bulletins: o CPAG updates: - Update to operating model for NICE Medtech mandate - Update to CPAG Terms of Reference - Update to the East Midlands fertility Policy review

	○ Derbyshire Prescribing Group report/minutes for August & September 2023 & ToR ○ JAPC Bulletin, August & September 2023 ○ CPLG minutes, September 2023 ○ NHSE National Medicines Optimisation Opportunities 23-24 The Committee **DISCUSSED** and **NOTED** the DDICB System Level Access Improvement Plan for its onward transmission to the ICB Board in November. Committee members discussed areas of focus for the plan going forward including the secondary/ primary care interface; the potential in standardised triage, digital channel shifting; the need to mitigate against digital exclusion and the potential to use library services to do so; further work on the retention of experienced GPs; the need to set this plan within a wider context and within the broader GP model discussed by PHSCC in October.
Comments on the effectiveness of the meeting	
No comments provided.	

Appendix 2

Derby and Derbyshire Integrated Care Board

Population Health & Strategic Commissioning Committee Annual Report

1st July 2022–31st March 2023

POPULATION HEALTH & STRATEGIC COMMISSIONING COMMITTEE ANNUAL REPORT

1st July 2022–31st March 2023

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Population Health & Strategic Commissioning Committee and covers the period from 1st July 2022 to 31st March 2023.

1.2 The report provides the ICB Board and Accountable Officer with evidence relevant to their delegated responsibilities of:

- overseeing the preparation and publication of the commissioning plan with the involvement of the Health and Wellbeing Boards and aligned to the strategy developed by the ICP;
- developing and implementing the commissioning strategy and policy of the ICB and to help secure the continuous improvement of the quality of services, including the specified duties under the Mental Health Act;
- retaining a focus on health inequalities, improved outcomes and quality and ensure that the delivery of the ICB's strategic and operational plans are achieved within financial allocations;
- commissioning consistently with the duties of the Secretary of State and NHSEI objectives, having regard to the Constitution;
- making decisions within the limits as set out in the ICB's Scheme of Reservations and Delegation; and
- further delegating to sub-committees relating specifically to primary care medical services but will retain oversight and accountability.

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 Population Health and Strategic Commissioning and Public Partnerships (Chair)
- Non-Executive Member for Quality and Performance
- Non-Executive Member for Audit and Governance
- Non-Executive Member for People and Culture
- 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
- Executive Director of Strategy and Planning
- Executive Director of Nursing and Quality
- Executive Medical Director

- Executive Director of Finance
- Director of GP Development
- Director of Medicines Management and Clinical Policies
- Chief People Officer

2.2 The Committee met 8 times during the reporting period. All meetings were fully quorate. The quorum necessary for the transaction of business was 5 members, which included 2 Non-Executive Members, 1 Executive Director and 4 other members including two clinical. The full membership attendance can be found at Appendix 1.

3. FREQUENCY OF MEETINGS

The Committee met monthly before every ICB Board meeting to ensure all information submitted to the ICB Board has been 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.	• Clinical Governance Model • Derby City North PCN & Friar Gate Surgery – change to practice membership • General Practice Update and Overview of Key National Documents • General Practitioner with Extended Role Service Pilot to support the prescribing of Hormone Treatment for Gender Dysphoria – adults • Primary Care Sub-Group Terms of Reference and Updates
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.	• Clinical Policy Advisory Group updates and policy ratification • Developing the next steps in our "Integrated Commissioning" approach • Draft 2023/24 NHS Operational Plan/Joint Forward Plan • Health Inequalities Strategy • Management of commissioning resources and prioritisation • Strategic Priorities • Urgent and Emergency Care Priorities • Winter Pressures: COPD focus
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.	

Roles and Responsibilities	Reporting mechanism
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 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> • Derby and Derbyshire Clinical Navigation Hub • Derbyshire Orthopaedics Centre Project Centre • Neurodevelopmental Community Assessment Hub <u>Procurements</u> • AQP Audiology • Community Mental Health Transformation – Lived Experience Engagement Service • Derbyshire Hard of Hearing Service • Employment Advisors in Improving Access to Psychological Therapies • Mental Health Crisis Alternatives • Musculoskeletal Triage and Therapies • Non-Emergency Patient Transport Services <u>Contract Awards</u> • AQP Homecare Support • Commissioning of Non-Scalpel Vasectomies • Derby Safe Haven • Discharge to Assess Pathway 3 Nursing Beds
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.	

Roles and Responsibilities	Reporting mechanism
	• Recovery and Peer Support Services <u>Contract Extensions/Arrangements</u> • Out of Hours and Derby Urgent Treatment Centre • Independent Community Advocacy Service • Orthotics • Ophthalmology Independent Sector (IS) provider • Regional 111 • Voluntary, Community and Social Enterprises
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 • 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. CONCLUSION

Over the past year, the PHSCC has attempted to shift from the case-by-case commissioning of the CCG to a more strategic and coherent approach that focuses on population level outcomes and health inequalities. We have laid the foundations for this by delegating a large proportion of decision making to sub-groups, with agreed terms of reference and reporting lines to the PHSCC. We have also agreed strategic priorities and committed to population health management (PHM) as a framework that will guide our philosophical and practical approach. The next phase of our work will include the development of clear milestones and indicators to tell us how successful we are being in embedding PHM into all of our work as a committee.

Julian Corner
Chair of Population Health & Strategic Commissioning Committee
September 2023

APPENDIX ONE

Population Health & Strategic Commissioning Committee Attendance Record 1st July 2022–31st March 2023

Population Health and Strategic Commissioning Committee Member		14 July 2022	8 Sep 2022	6 Oct 2022	10 Nov 2022	8 Dec 2022	12 Jan 2023	9 Feb 2023	9 Mar 2023
Julian Corner	Chair – Non-Executive Member (Population Health & Strategic Commissioning)	✓	✓	✓	✓	✓	✓	✓	✓
Dr Bukhtawar Dhadda	Non-Executive Member (Quality & Performance) (up to 31st January 2023)	X	✓	✓	X	X	✓		
Sue Sunderland	Non-Executive Member (Audit & Governance)	✓	✓	✓	✓	✓	✓	✓	✓
Margaret Gildea	Non-Executive Member (People & Culture)	✓	✓	✓	✓	✓	✓	✓	✓
Richard Wright	Non-Executive Member (Finance & Estates)	X	✓	✓	X	✓	✓	✓	✓
Dr Penny Blackwell	Representative for Provider Collaborative at Place	✓	✓	✓	✓	X	X	✓	✓
Dr Avi Bhatia	Representative for Clinical & Professional Leadership Group	X	✓	X	✓	✓	✓	✓	✓
Dr Emma Pizzey	GP Clinical Lead	X	X	✓	✓	✓	✓	✓	✓
Dr Suneeta Teckchandani	Secondary Care Doctor	X	X	✓	✓	X	✓	X	X
Dominic Fackler	Allied Health Professional Representative	X	X	X	✓	X	✓	✓	✓
Robyn Dewis	Director of Public Health, Derby City Council	X*	✓	X*	✓	✓	✓	✓	✓
Ifti Majid	Representative for Provider Collaborative at Scale, DHcFT (up to 30th November 2022)	X	X	X	X				
Carolyn Green	Representative for Provider Collaborative at Scale, DHcFT (from 1st December 2022)					X	✓	✓	X
Zara Jones	Executive Director of Strategy & Planning, ICB	✓	✓	✓	✓	✓	✓	✓	✓
Brigid Stacey	Executive Director of Nursing & Quality, and Deputy Chief Executive Officer, ICB	X*	X*	✓	✓	X*	✓	✓	✓
Dr Chris Weiner	Executive Medical Director, ICB	✓	✓	✓	✓	✓	✓	✓	✓
Keith Griffiths	Executive Director of Finance, ICB	X	✓	✓	✓	✓	✓	✓	✓
Clive Newman	Director of GP development, ICB	✓	✓	✓	✓	✓	✓	✓	✓
Steve Hulme	Director of Medicines Management & Clinical Policies, ICB	✓	X	✓	✓	✓	✓	✓	✓
Amanda Rawlings	Chief People Officer, ICB	✓	X	X	✓	✓	✓	✓	✓

For those items with * above please note that a deputy was present to ensure quoracy.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 108

Report Title	Quality and Performance Committee Assurance Report – September 2023 and 2022/23 Annual Report							
Author	Jo Hunter, Director of Quality Fran Palmer, Corporate Governance Manager							
Sponsor (Executive Director)	Professor Dean Howells, Chief Nurse Officer							
Presenter	Dr Adedeji Okubadejo, Clinical Non-Executive Member and Chair of Quality and Performance Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report Appendix 2 – Committee Annual Report 2022/23							
Assurance Report Signed off by Chair	Dr Adedeji Okubadejo, Clinical Other Member and Chair of Quality and Performance Committee							
Which committee has the subject matter been through?	Quality and Performance Committee – 28.10 2023							

Recommendations
The ICB Board is recommended to **NOTE** the Quality and Performance Committee's: • Assurance Report (September 2023); and • Annual Report 2022/23
Items to escalate to the ICB Board
No matters of concern or key risks to escalate.
Purpose
As reported in previous reports the ICB is currently not compliant with any statutory operational targets relating to the urgent care and planned care, and cancer programme. The 2023/24 NHS Operational Plan developed by the Derby and Derbyshire System addresses these issues of underperformance. Safeguarding performance across JUCD is a very positive story, the progress of the Virtual Wards should be noted although the impact needs to be assessed and the programmes' scalability against the winter plan. The Committee continues to have significant concerns regarding maternity and neonatal services across JUCD but particularly at UHDBFT, the impact of delayed discharges across the system, continued increases in incidents relating to infection prevention and control and the ongoing fragility of Primary Care.

This report also provides the Board with a copy of the Committee's Annual Report for 2022/23.

Background

This report provides the Board with a brief summary of the items transacted at the meeting of the Quality and Performance Committees on the 28th September 2023.

It is also 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, which has been presented to and approved by the Committee

Report Summary

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

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

The Quality and Performance Committee Annual Report 2022/23 (Appendix 2) provides the ICB Board with a review of the work that the Committee has completed during the period 1st July 2022 to 31st March 2023.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☐	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒

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

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

No conflicts of interest were raised.

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

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

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

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

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

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

Details/Findings
Not applicable to this report.

Appendix 1

Derby and Derbyshire Integrated Care Board

ICB Board Assurance Report

ICB Quality and Performance Committee on 28th September 2023

Matters of concern or key risks to escalate	Decisions made
The ICB is currently not compliant with any statutory operational targets relating to the urgent care and planned care & cancer programme. The 2023/24 NHS Operational Plan developed by the Derby and Derbyshire System addresses these issues of underperformance. The Committee continues to have significant concerns regarding maternity and neonatal services across JUCD but particularly at UHDB. Other areas of concern are the continued fragility of Primary Care and the high levels of reported Infection Prevention and Control incidents across JUCD.	The Quality & Performance Committee Annual Report 1st July 2022 to 31st March 2023 was virtually approved as the Committee was not quorate.
Major actions commissioned or work underway	**Positive assurances received**
Deep Doves will be regularly presented to the Committee:	The following papers were presented for assurance: • Integrated Quality and Performance Report • Deep Dive – Infection Prevention and Control and Cdiff. • Board Assurance Framework (BAF) • System Quality Group Assurance Report
Comments on the effectiveness of the meeting	
Those present agreed that the meeting had been effective, with sufficient opportunity for discussion and that the papers presented were appropriate.	

Derby and Derbyshire
Integrated Care Board

Quality & Performance Committee Annual Report

1st July 2022–31st March 2023

Derby and Derbyshire
Integrated Care Board

QUALITY & PERFORMANCE COMMITTEE ANNUAL REPORT

1st July 2022–31st March 2023

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Quality & Performance Committee and covers the period from 1st July 2022 to 31st March 2023.

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:

- 3 x ICB Non-Executive Members;
- ICB Executive Director of Nursing and Quality;
- ICB Medical Director;
- ICB Executive Lead for Performance;
- NHS Executive;
- Provider Representatives;
- Primary Care Representatives; and
- Local Authority Representatives.

2.2 The Committee met 9 times during the reporting period. Meetings were often quorate, except the meetings on the 28th July, 27th October, 24th November 2022, 23rd February and 20th March 2023. The quorum necessary for the transaction of business was 2 Non-Executive Members, including the Chair or Vice Chair, plus at least the Executive Director of Nursing and Quality, or Medical Director from the ICB, one provider representative and one Local Authority representative. The full membership attendance can be found at Appendix 1.

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 has 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 • System Oversight Framework • Risk Stratification and Harm Review update • Industrial Action 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 • Winter Plan • ICB Escalation Policy • Assessment of the Winter Plan from a Quality and Safety Perspective • Child Death Overview Panel Annual Report 2021/22 • Serious Violence Duty • Healthcare Safety Investigation Branch • Appointment Slot Issue Waiting List
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.	• Response to the Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services Letters • Transforming Care Programme progress
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.	• Deep Dive into Discharge and Outflow
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.	
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. CONCLUSION

The above provides a good summary of the areas of work that the Quality and Performance Committee have carried out in the past 12 months. This year we continued to see significant challenges to the whole of the NHS with the backlog of elective activity as a result of the COVID pandemic and the effects of this is reflected in our performance data which is in line with what has been seen nationally. There continue to be additional challenges around the 4 hour A&E target, Referral To Treatment, Cancer Targets and EMAS but in addition to these we now have a significant challenge around 52 week waits. Again this is something which is a national issue and we will continue to work with all our providers to ensure we have a robust restoration and recovery process agreed and in place. In addition to this there remain ongoing challenges around workforce which has further impacted the performance data. The Committee has ensured that the ICB Board have been sighted on these and robust challenge has been offered around these and other areas that we cover.

A number of deep dives have also been requested around these and other areas, and the Committee have continued to seek assurance around both quality and performance as a result.

The Committee has also had assurance that the ICB is fulfilling its statutory obligation around safeguarding in the way of quarterly updates by both children's and adult's safeguarding teams. This has continued to be a very significant challenge following the COVID pandemic and our safeguarding teams have functioned exceptionally well to ensure and assure us of the processes that have been in place to mitigate any safeguarding risks that have emerged. We have also continued to seek assurance around a range of additional corporate assurance processes as outlined above.

I would like to extend my personal thanks to the hard work of both the Quality and Performance teams led by Brigid Stacey and Zara Jones, without whom our job as a Committee would be made far more challenging, particularly in the last 12 months that has seen the NHS function under such difficult circumstances due to the COVID pandemic. The confidence that I as Chair and the Committee as a whole have in them means that we are able to reflect on so much positive work that has been highlighted in this report despite facing significant challenges.

I would also like to thank everyone for being able to adapt to different ways of working remotely whilst continuing to maintain such high standards, both from the Quality and Performance teams and all Committee members. It has been an absolute pleasure to work with such professional and dedicated people in difficult, demanding circumstances and you all have my gratitude as Chair.

On a personal note I made the decision to step down as Chair of this Committee in January 2023. It has been a privilege to have been Chair over a number of years and I wish my successor Dr Adedeji Okubadejo the very best going forward.

Dr Buk Dhadda
Chair of Quality & Performance Committee (for reporting period)
September 2023

APPENDIX ONE

Quality & Performance Committee Attendance Record 1st July 2022–31st March 2023

Quality and Performance Committee Member		28 July 2022	25 Aug 2022	29 Sep 2022	27 Oct 2022	24 Nov 2022	22 Dec 2022	26 Jan 2023	23 Feb 2023	30 Mar 2023
Dr Bukhtawar Dhadda	Chair – Non-Executive Member (Quality & Performance) (up to 31st January 2023)	✓	✓	✓	✓	✓	✓	✓		
Margaret Gildea	Non-Executive Member (People & Culture) (Chair from 1st February 2023)	✓	✓	X	✓	✓	X	✓	✓	✓
Richard Wright	Non-Executive Member (Finance & Estates)	✓	✓	✓	✓	✓	✓	✓	✓	X
Brigid Stacey	Executive Director of Nursing & Quality, and Deputy Chief Executive Officer	✓	X*	X*	✓	✓	✓	✓	✓	X
Dr Chris Weiner	Executive Medical Director	✓	✓	✓	✓	✓	✓	✓	X	✓
Zara Jones	Executive Director of Strategy & Planning	✓	✓	X*	X*	X*	X*	X*	X*	✓
Christine Fearns	Non-Executive Director, UHDBFT	✓	X	✓	✓	X	X	✓	✓	X
Jayne Stringfellow	Non-Executive Director, CRHFT	✓	X	X	✓	X	X	✓	X	X
Sheila Newport	Non-Executive Director, DHcFT (up to 8th January 2023)	✓	✓	X	X	✓	X			
Lynn Andrews	Non-Executive Director, DHcFT (from 9th January 2023)							✓	X	✓
Kay Fawcett	Non-Executive Director, DCHSFT	X	X	✓	✓	X	✓	X	✓	✓
Robyn Dewis	Director of Public Health, Derby City Council	X	X	X	X	✓	✓	✓	X	X
Gemma Poulter	Assistant Director Adult Social Care, Derbyshire County Council	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

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 109

Report Title	People and Culture Committee 2022/23 Annual Report							
Author	Fran Palmer, Corporate Governance Manager Margaret Gildea, Senior Independent Director / Chair of the People and Culture Committee							
Sponsor (Executive Director)	Helen Dillistone, ICB Chief of Staff							
Presenter	Margaret Gildea, Senior Independent Director / Chair of the People and Culture Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☒
Appendices	Appendix 1 – Committee Annual Report 2022/23							
Assurance Report Signed off by Chair	Margaret Gildea, Senior Independent Director / Chair of the People and Culture Committee							
Which committee has the subject matter been through?	People and Culture Committee – 6.9.2023							

Recommendations

The ICB Board is recommended to **NOTE** the People and Culture Committee's 2022/23 Annual Report.

Purpose

It is also 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, which has been presented and approved by the Committee and provided to the Board for assurance purposes.

Background

The People and Culture Committee ensures that the ICB complies with the principles of good governance whilst effectively delivering the statutory functions of the ICB. 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.

Report Summary

The People and Culture Committee Annual Report 2022/23 (Appendix 1) provides the ICB Board with a review of the work that the People and Culture Committee has completed during the period 1st July 2022 to 31st March 2023.

Identification of Key Risks					
SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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

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

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

A representative and supported workforce	☒	Inclusive leadership	☒
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?			
There are no implications or risks which affect the ICB's obligations under the Public Sector Equality Duty.			
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?			

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable to this report.

NHS
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People & Culture Committee Annual Report

1st July 2022–31st March 2023

PEOPLE & CULTURE COMMITTEE ANNUAL REPORT

1st July 2022–31st March 2023

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the People & Culture Committee and covers the period from 1st July 2022 to 31st March 2023.

1.2 The report provides the ICB Board and Accountable Officer with evidence relevant to their delegated 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 Quality and Performance;
- ICB Chief People Officer;
- Chairs of Trust People Committees;
- Chief People Officers/HRD's 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 3 times during the reporting period. All meetings were fully quorate. The quorum necessary for the transaction of business was 50% of the members. The full membership attendance can be found at Appendix 1.

3. FREQUENCY OF MEETINGS

The Committee met quarterly 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.

4. 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 People and Culture 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 • Project Derbyshire – Digital Work Programme • Workforce Priorities in Local Authorities / Social Care • Annual Workforce Plan Progress • Five-Year Workforce Plan • Winter Preparedness • Agency Spend • One Workforce Strategy Plan • Retention Work Programme
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 Priorities in Local Authorities/ Social Care • Annual Workforce Plan Progress • Five-Year Workforce Plan • One Workforce Strategy Plan
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 • One Workforce Strategy Plan
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 • Annual Workforce Plan Progress • Five-Year Workforce Plan
Ensuring plans are in place to develop, support and retain the health and care workforce, adopting a "one workforce" approach with all partners across the ICS, promoting collaborative recruitment,	

Roles and Responsibilities	Reporting mechanism
education and training of existing and future health and care staff where appropriate.	• Winter Preparedness • Agency Spend • One Workforce Strategy Plan • Industrial Action updates • Retention Work Programme
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
Producing and presenting to the ICB Board a Committee Assurance Report, following each meeting.	
Managing conflicts of interest.	

5. CONCLUSION

Between July 2022 and March 2023, the committee was forming, understanding its purposes and defining its agenda and the BAF risks it was accountable for. We had excellent engagement from the sovereign trusts and other parts of the system, and have focused on making a difference to those areas where the system as a whole should be bigger than the sum of its parts. There is more work to be done to ensure that we are not duplicating the work of other committees and to ensure that the many people-related initiatives across the various functions are effectively linked together. I would like to thank everyone who has worked on improving the quality of our data, the quality of our reports and the quality of our assurance discussions.

Margaret Gildea
Chair of People & Culture Committee
September 2023

APPENDIX ONE

People & Culture Committee Attendance Record 1st July 2022–31st March 2023

People and Culture Committee Member	7 Sep 2022	7 Dec 2022	8 Mar 2022
Margaret Gildea *Chair – Non-Executive Member (People and Culture)*	✓	✓	✓
Dr Buk Dhadda *Non-Executive Member (Quality and Performance)* *(up to the 31st January 2023)*	X	X	
Amanda Rawlings *Chief People Officer*	✓	✓	✓
Kaye Burnett *Non-Executive Member, DCHSFT* *(up to 31st December 2022)*	✓		
Janet Dawson *Non-Executive Member, DCHSFT* *(from 1st January 2023)*	✓	✓	✓
Ralph Knibbs *Non-Executive Member, DHcFT*	✓	X	✓
Joy Street *Non-Executive Member, UHDBFT*	X	X	X
Jeremy Wight *Non-Executive Member, CRHFT*	X	✓	✓
Darren Tidmarsh *Chief People Officer, DCHSFT*	X	✓	✓
Ifti Majid *Partner Member – Derbyshire Healthcare NHS Foundation Trust* *(up to the 30th November 2022)*	X		
Carolyn Green *Partner Member – Derbyshire Healthcare NHS Foundation Trust* *(from the 1st December 2022)*		X	X
Jaki Lowe *Director of People and Inclusion, DHcFT*	✓	✓	X
Kerry Gulliver *Director of HR and Organisational Development, EMAS*	X	X	✓
Caroline Wade *Director of HR and Organisational Development, CRHFT*	X	X*	✓
Linda Garnett *Programme Director, People Services Collaborative*	✓	✓	✓
Penelope Blackwell *Chair of Integrated Place Executive*	✓	X	X
Emma Crapper *HR Director, Derbyshire County Council*	X	X	X*
Liz Moore *Head of HR, Derby City Council*	✓	X	✓
Vijay Sharma *Non-Executive Director, EMAS*	✓	X	X
Susie Bayley *Medical Director, General Practice Taskforce Derbyshire*	✓	✓	X
Zahra Leggatt *Derbyshire Health United 111 (East Midlands) Community Interest Company representation*	X	X	✓

For those items with * above please note that a deputy was present to ensure quoracy.

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NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 110

Report Title	Freedom to Speak Up – Update on arrangements							
Author	Helen Dillistone – ICB Chief of Staff							
Sponsor (Executive Director)	Chris Clayton – ICB Chief Executive Officer							
Presenter	Margaret Gildea – ICB Non-Executive Member							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Update on arrangements for Freedom to Speak Up							
Which committee has the subject matter been through?	Audit and Governance Committee – 12.10.2023							

Recommendations

The ICB Board is recommended to **NOTE** the report.

Purpose

The Paper is presented to the Board to ensure that members are sighted on the content, and to note the actions underway related to the arrangements for Freedom to Speak Up.

Background and Summary

The arrangements for Freedom to Speak Up (FTSU) are essential to support and create an environment where everyone in the health service feels safe to speak up – and confident that any concerns will be followed by a prompt response. It also emphasises the importance of NHS leaders listening to the concerns of patients, families, and staff.

All NHS organisations are to adopt the updated national FTSU policy by January 2024.

The ICB has already adopted the national FTSU Policy, which received approval from the Audit and Governance Committee.

At the last meeting of the ICB Board, the Board received a letter sent to all NHS organisations in response to the verdict in the trial of Lucy Letby. The letter placed a further emphasis on the importance of FTSU and requested that several arrangements were put in place, if not already.

Attached at Appendix 1 is the update on those arrangements and key areas.

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	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐

	Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.				
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒

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

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

None identified

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☐	**Summary:**

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

Better health outcomes	☒	Improved patient access and experience	☐

A representative and supported workforce	☐	Inclusive leadership	☒

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

There are no implications that affect the ICB's obligations

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable for this report

Appendix 1 – ICB – Update Arrangements for Freedom to Speak Update

Area	ICB Status Update
1. All staff have easy access to information on how to speak up.	• The ICB has adopted the national FTSU Policy, which received approval from the Audit and Governance Committee on 8 June 2023. • The Audit and Governance Committee has responsibility for FTSU. • The FTSU Policy and FTSU Managers Handbook was promoted at the weekly ICB Team Talk and in the all staff bulletin in July 2023. • There is a section of the staff intranet dedicated to FTSU and how to speak up by contacting the FTSU Ambassadors. • Online form on intranet page for staff to submit concerns, anonymous and does directly to FTSU Ambassadors. • The FTSU Ambassadors are promoted in each issue of the bi-weekly Human Resources publication – People Matter that is circulated by email to all staff. • Access to FTSU Ambassadors and speaking up is also promoted during FTSU week. • The induction checklist refers to the FTSU Ambassadors and intranet page. • When the staff FTSU Guardian has been appointed, there will be a further promotion of FTSU to all colleagues. <u>Next Steps:</u> 1. Induction checklist needs to be updated to refer to the FTSU Policy and Guardian role (when appointed). To be actioned by December 2023 2. There are no posters promoting FTSU at either of our ICB sites. To be actioned by December 2023

		3. Include reference to FTSU on the log in screen. - December 2023 4. Mandate FTSU e-learning for managers and staff. - April 2024
2.	Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.	• The Human Resources team are aware of the National Speaking Up Support Scheme and this was communicated to all staff via the People Matter bulletin on 16 June 2023. • The ICB has appointed a staff FTSU Guardian and is from a background black and minority ethnic background. • The ICB has two FTSU Ambassadors. EOI's have been received from additional colleagues and following selection/confirmation will undergo the appropriate national training.
3.	Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.	• The ICB has two female FTSU Ambassadors in place, one of whom is from a black and minority ethnic background. <u>Next Steps</u> 1. Requirement for additional FTSU Ambassadors to cover a wider cross section of ICB staff – January 2024. 2. Explore whether ICB staff can access FSU Ambassadors/ Champions in other Derbyshire health care organisations – December 2023. 3. Explore approach providers have in place to support people with cultural barriers to speak up.- December 2023
4.	Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.	• ICB has a nominated Non-Executive Director lead for FTSU, Margaret Gildea. • ICB has a nominated Executive Lead, Helen Dillistone • The Audit and Governance Committee are responsible for reporting FTSU updates to the ICB Board via their Committee Assurance Report.

	• FTSU regularly features in staff bulletins and announcement at TT with details of the staff guardian. Further promotion now be required. <u>Next Steps</u> 1. FTSU Ambassadors to collate details of contact with them and report to AG Ctee and to Board. Throughout the year and report biannually
5. Boards are regularly reporting, reviewing and acting upon available data	• The Audit and Governance Committee receive the FTSU Reports in line with the Committee Forward Planner. • The Audit and Governance Committee are responsible for reporting FTSU updates to the ICB Board. This is reported through the Committee their Committee Assurance Reporting process.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th November 2023

Item: 111

Report Title	Derbyshire County Council Director of Public Health Annual Report 2023							
Author	Ellie Houlston, Director of Public Health, Derbyshire County Council							
Sponsor (Executive Director)	Dr Chris Clayton, ICB Chief Executive Officer							
Presenter	Ellie Houlston, Director of Public Health, Derbyshire County Council							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1 – Derbyshire County Council Director of Public Health Annual Report 2023							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Not Applicable							

Recommendations
The ICB Board is recommended to **NOTE** the Derbyshire County Council Director of Public Health Annual Report 2023 for information.
Purpose
To build a positive and ongoing conversation about mental health across Derbyshire.
Background
Detailed within the report.
Report Summary
This year's report focuses on the mental health and wellbeing of the people in Derbyshire. It reflects on the ongoing challenges from the Covid-19 pandemic recovery and the growing cost-of-living pressures.

Identification of Key Risks

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

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

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒

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

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

Not applicable for 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?

There are no implications that affect the ICB's obligations

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not relevant to this report.

DERBYSHIRE County Council

Let's Chat about Mental Health and Wellbeing

Director of Public Health

Annual Report 2023

Contents

1 Foreword from Director of Public Health

I am delighted to be sharing with you my first annual report as Director of Public Health for Derbyshire, which considers the theme of mental health and wellbeing.

Emotional health and mental wellbeing affects all aspects of our lives. Mental wellbeing is about feeling good and functioning well, both as individuals and as communities. It is also about our ability to cope with life's challenges and making the most of life's opportunities.

Supporting mental health and wellbeing is a personal passion and I want to do all I can in this role to promote this area of work. I am a trained mental health first aider which means that I can offer support to colleagues in the workplace. Outside of work I regularly take time to reflect on my own mental health and wellbeing and find spending time outside in green spaces is something that particularly helps me.

The last year has been challenging for many people in Derbyshire due to cost-of-living pressures and these have impacted on health and wellbeing in many ways. Colleagues across Public Health have worked tirelessly, often in partnership with a range of local organisations to make sure that mental health advice and support is widely available. This report showcases some of those initiatives, as well as considering some of the drivers of poor mental health that currently exist in Derbyshire.

It is important that we all take time to reflect and talk about our mental health during these tough times. In 2022 we launched the Let's Chat campaign which you can find out more about in this report. We have placed signs on benches throughout Derbyshire to encourage people to think about their mental wellbeing, to make connections with others and to seek support. The campaign has seen 700 Let's Chat bench signs in place and 120 organisations have signed up to support the initiative. We have included images of some of these benches throughout the report and we have received feedback that people have used this shared space to start conversations about their mental wellbeing with others.

Building on the momentum of that campaign my message in this report is simple – let's build a positive and ongoing conversation about mental health across Derbyshire by everyone committing to the following: Let's Chat, Let's Ask, Let's Listen. You can find out more about these pledges and the steps you can take to support them at the end of this report.

Thank you for taking the time to read this report.

Best Wishes
Ellie Houlston
Director of Public Health - Derbyshire County Council

2 Update on last year's report

Last year, the 2022 Director of Public Health Annual Report considered the impact of the Covid-19 pandemic on communities in Derbyshire. The report explored themes of health inequalities in relation to the Coronavirus and outlined how partners would continue to step up to the challenge together of living with the virus. Below is a summary of the 2022 recommendations and what we did. Here you can see the full details of what we did.

We said we would:
Embed ongoing prevention activity from Covid-19 as part of an all-hazard approach to prevention of infectious diseases.

Since the report was published
We have worked with partners to encourage the uptake of all vaccinations and promote infection prevention control.

We said we would:
Utilise information known about pre-existing inequalities and the impact of Covid-19 to focus on improving health outcomes for those groups that have experienced the greatest impact in Derbyshire.

Since the report was published
We have highlighted the differences in the underlying health of people adversely affected by Covid-19 in the most deprived communities.

We said we would:
Work collaboratively with system partners to build a shared understanding of health inequalities across the system to make sustained progress in reducing these longstanding and worsening inequalities.

Since the report was published
We have worked with partners to support the development of a Health Inequalities Strategy for Derby and Derbyshire, and we are working with the Health and Wellbeing Board to influence partners to develop actions to address health inequalities.

We said we would:
Retain learning from the Covid-19 pandemic to ensure Local Authority Public Health is in a position to hit the ground running again in the event of a future pandemic, Covid-19 or other disease.

Since the report was published
We have completed a lessons learnt exercise to inform future planning and developed our Health Protection Team. Derbyshire is working alongside the Local Government Association to share information as part of the Public Inquiry so that lessons can be shared nationally.

We said we would:
Maximise the opportunities created by the positive role of Derbyshire Public Health to influence pieces of work that improve health outcomes.

Since the report was published
We have continued to utilise one off funding to support additional community-based activity, which has increased community resilience, tackled cost-of-living pressures, and promoted better mental health.

We said we would:
Co-produce solutions with partners and communities to help design initiatives and services that contribute towards reducing health inequalities.

Since the report was published
We have worked with people recovering from addiction via the GRID voices project, strengthened the public health co-production community of practice so our team can share skills and knowledge. We have also secured external funding to work alongside communities to understand their needs with an academic partner. This is an ongoing journey, and we are further committed to strengthening co-production in Derbyshire Public Health and with our partners.

We said we would:
Maximise the opportunities created by the launch of the Integrated Care System to ensure there is a renewed focus on health inequalities within NHS, the broader Public Sector and voluntary sector.

Since the report was published
We have worked with colleagues to develop the NHS Core 20PLUS5 approach for addressing health inequalities and ensure key preventative messages are included in the Integrated Care Strategy.

We said we would:
Work with partners to place health inequalities into their work and tackle social deprivation at root cause via investment from upstream preventative interventions.

Since the report was published
We have further developed Feeding Derbyshire work to tackle issues relating to food insecurity and provided enhanced support in this time of cost-of-living pressures. We have also enhanced our Derbyshire Discretionary Fund and advisory services to prevent people becoming more financially vulnerable.

We said we would:
Facilitate the more systematic use of a population health management approach within Derbyshire to systematically identify and target health inequalities.

Since the report was published
We have coordinated a programme which has engaged primary care and the NHS to test preventative clinical actions that reduce health inequalities.

3 Aims and objectives of the report

This year's report focuses on mental health and wellbeing of people in Derbyshire. It will reflect on the ongoing challenges from the Covid-19 pandemic recovery and the growing cost-of-living pressures.

The report will do this by:

- Outlining key facts and figures in relation to mental health and wellbeing in Derbyshire.
- Considering how your mental health can be impacted across the life course.
- Describe how Covid-19 and cost-of-living pressures have shaped mental health and wellbeing in Derbyshire.
- Summarising how Public Health supports mental health and wellbeing in Derbyshire.
- Describing a range of practical actions you can take to support your own mental health and wellbeing and how to support others.

Throughout the report you will see various images of benches. Last year the #LetsChat campaign raised awareness of the importance of talking about mental health.

Local photographer Tony Fisher travelled around the county taking pictures of the benches being used. These images are being shared in the report alongside a range of stories from professionals and local people to reaffirm the message that talking openly about your mental health is important. The case studies featured throughout the report showcase local actions and interventions that contribute to a wider systematic approach to promoting mental wellbeing. The report concludes with a range of recommendations about how we can strengthen our approach further in Derbyshire.

Finally, we recognise that for many people mental health is a key area of concern at present so we have included a number of links and information about where you can find further help, advice, and support.

4 Introduction

What is mental health and wellbeing?

Mental health plays an essential role in everyone's life and is more than mental ill health. There are many ways to describe mental health and wellbeing. One of them is described as how we feel or cope with life. Another more detailed definition is a state of wellbeing where a person can work productively, cope with stresses in life and contribute to their community. We can define poor mental health and wellbeing as when we can't cope with challenges in life and contribute to our community. Good mental health and wellbeing has a direct link with good physical health, better quality of life and employment prospects. Therefore, good mental health is essential for us to live well and thrive.

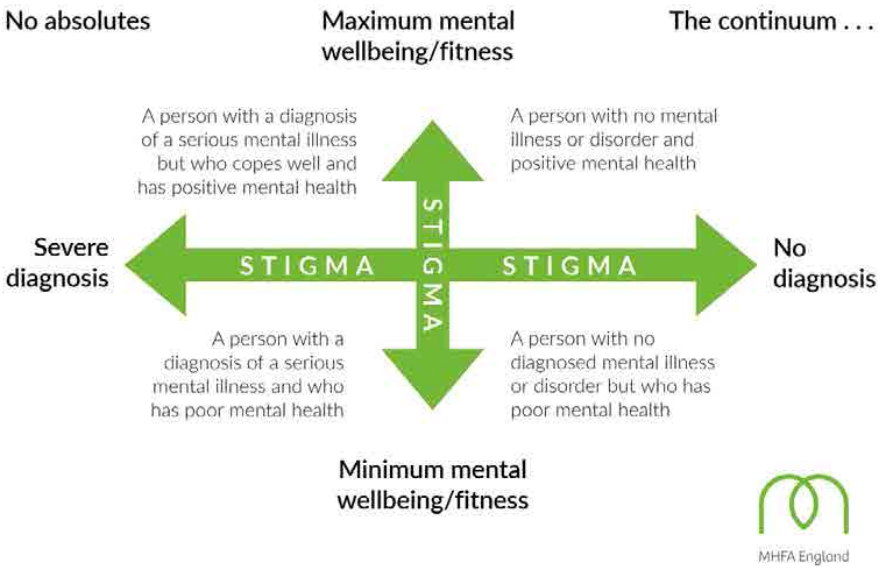
Research shows why good mental health and wellbeing is so important:

- People with good mental wellbeing are 1.14 times more likely to recover from a physical illness than those with poor mental wellbeing.
- A person with a serious mental health condition could live 15 to 20 years less than the people without a condition.
- A person who has a long-term illness, can have more complications if they also have a mental health condition. This could impact on the cost of their care, which could be around 50% more.

Mental illness or mental ill health are broad terms and can include a range of conditions like mild depression to schizophrenia. Many people are impacted by mental ill health at some point in their life. One in four people will experience a mental health issue in a year and 2 in 100 people will experience severe mental illness. The most common conditions are depression and anxiety.

Good mental health and wellbeing is essential to everyone's health and is a priority for Public Health in Derbyshire. Public Health has an important role in promoting good mental wellbeing and supporting people who may need additional advice, guidance, or information. The Mental Health First Aid (MHFA) England infographic below summarises the complexity of mental health and how stigma needs to be addressed at all points. Public Health's work in Derbyshire is to create conditions for positive mental wellbeing and challenge stigma and negative perceptions of mental health.

Figure 1. The Mental Health Continuum



The infographic shows that mental wellbeing can range from not having a diagnosis to having a severe diagnosis. It also shows that even if you are diagnosed with mental illness, you can still live a positive life. You can also have no diagnosis but have poor mental health. The infographic highlights that stigma can be a barrier which can prevent a person from obtaining a diagnosis or seeking help.

Image used with permission of MHFA England®. For more information on how to spot signs of mental ill health and how to support others on a first aid basis, please see www.mhfaengland.org to find your Mental Health First Aid course.

What can impact mental health and wellbeing?

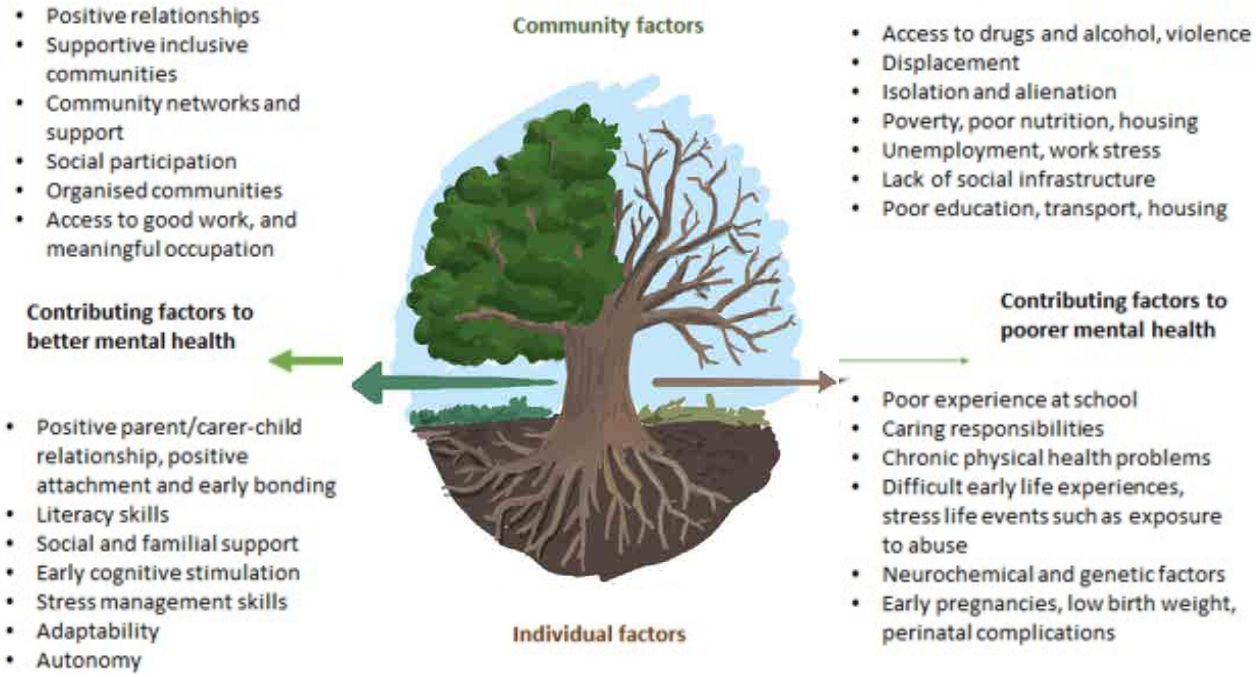
The above section summarised what mental health and wellbeing is and how we can visualise it as a continuum. This next section explores what can positively or negatively support our mental health and wellbeing.

There are many factors that can affect mental health. The factors that contribute to good or better mental health are called protective factors. Protective factors include personal attributes like problem-solving skills, coping skills, good physical health, strong cultural identity, social support, and positive relationships.

There are also factors that contribute to poorer mental health and these are called the risk factors. Risk factors can include biological factors, like the human body's brain chemistry or genes, long term physical health problems and personal life experiences like trauma or abuse.

The tree diagram below shows examples of protective factors that contribute to better mental health and risk factors that contribute to poorer mental health. The diagram also shows that some of these factors relate to an individual's situation and others relate to the community and environment around us. A key aim for Public Health is reducing risk factors and increasing protective factors, so that good mental health and wellbeing can be promoted.

Figure 2. Factors that influence mental health



5 Mental health through the life course

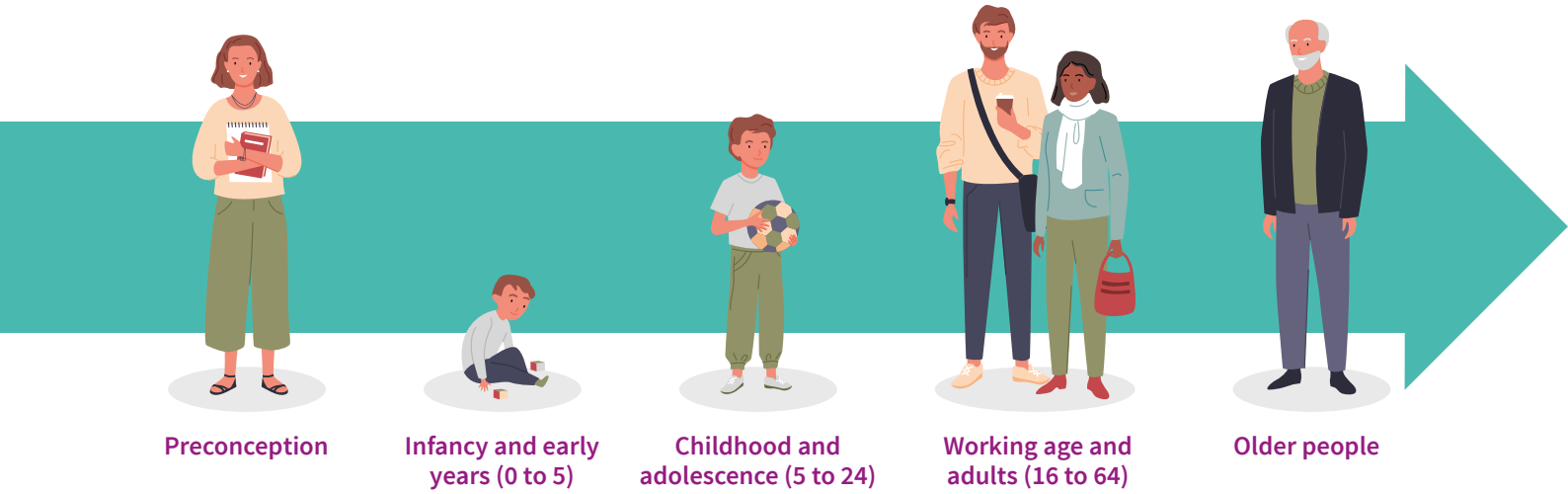
The introduction discussed the broad range of factors that can influence mental health and wellbeing. This next section will go into more detail on these factors.

The tree diagram, in the previous section, showed that mental health is impacted by individual and community factors, which are often called the wider determinants of health and influence health across the lifespan. The wider determinants of health are defined as the environmental, economic, and social conditions in which people are born, grow up, live, and work in. Some of these factors are protective, whereas others are risks for poor mental health and wellbeing.

A life course approach is a tool used in Public Health to look at the impact of health across the whole lifespan. The approach looks at points in life where people can be supported to live longer and healthier lives, for example supporting people in the early years of life can have an impact for the rest of that child's life. The approach considers how the wider determinants of health can be changed to support longer, healthier lives. Changes can be through improving the environments in which people live, such as a child having enough food and a safe home. The approach helps to identify how the health and wellbeing of current and future generations can be improved. A life course approach is different to a disease-oriented approach, which often focuses on a single condition at a single stage of life. The life course approach considers when, where and how someone can be supported in all aspects of their health.

The life course approach is not just for physical health, and it can be used for mental health and wellbeing. As described before, everyone has mental health and people can experience problems with mental health at any stage of life. The life course approach can identify points in time where the risks of mental health issues can increase and when action can be taken. These points can be linked to transitions like leaving home, the menopause or the loss of close relationships. Some key transition points for mental health and wellbeing are shown in the infographic below:

The life course approach



Source: Public Health England

Preconception and the perinatal period

Preconception health is a woman's health before she becomes pregnant. Perinatal mental health refers to the emotional and psychological wellbeing of parents during pregnancy and up to two years after having a baby. These are important times during the life course and can have an impact on future generations.

The most common perinatal health problems are depression, anxiety, postpartum psychosis, and postpartum post-traumatic stress disorder. Around 10-20% of women and 10% of men will experience some form of mental ill health when having a baby.

Perinatal mental health issues can affect the parents' ability to bond with the baby. For example, poor attachment as a baby can affect a baby's brain leading to delays in their thinking, language and social skills. It can affect a baby's relationship formation which can lead to behavioural issues and can continue into adulthood.

Early identification, support and treatment is vital and can help improve the mental health outcomes for both the parent and the baby.

What support is available in Derbyshire?

The NHS Health Visiting Service is a universal offer for all families. The NHS Health Visitors support women with their mental health and wellbeing and can support them with perinatal mental illness. The offer is not just for women. The health Visiting Service will also support men. A popular option for men in Derbyshire is access to the DadPad app. This free app provides practical support from how to hold your baby to supporting your own health and wellbeing. If men need some more help, the app also provides details of local support groups and services, and guidance on how to seek help when needed for their partners and themselves.

More information can be found on the Derbyshire Family Health Service website.

The NHS also provides a specialist Perinatal Mental Health Service in Derbyshire that supports women with severe mental health issues. Midwives, GPs, Health Visitors and other professionals can refer mothers and their babies to these services.

Infancy and early years

The previous section showed that experiences before birth and during the first few years of life can influence physical and emotional development during childhood and into adulthood.

Research suggests that during the first 1,000 days of a child's life the brain has an exceptional ability to develop, adapt to its environment, and learn information. Early life experiences, such as developing positive relationships with caregivers, are central to a child's development and building good infant mental health.

For some young children they may have poor relationships and emotional wellbeing that can lead to behavioural and developmental problems. In later childhood this can result in poor mental health outcomes such as anxiety, depression, and self-harm.

When taking a life course approach, it is clear that supporting families early is key. Public Health will continue to support parents and caregivers with their own emotional wellbeing and relationship with their baby as this has an impact on a child's wellbeing in their early years. The case study below describes how this happens in Derbyshire through emotional wellbeing support groups for new parents.

Let's chat to Vicky about emotional wellbeing postnatal support groups

Vicky is a Specialist Health Visitor at Derbyshire Community Health Services.
She is the project lead for the Derbyshire pilot for emotional wellbeing support groups.

Can you tell us about the support groups and why these were introduced?

Supporting parents with their emotional wellbeing in the perinatal period is very important for the whole family. Health Visitors reported that due to the restrictions and lockdowns during the pandemic parents were experiencing poor mental health, social isolation and had challenges accessing the support they needed. Recognising this, these groups were set up to provide early support with emotional wellbeing to all new parents. They also aimed to help reduce the need for onward referral to specialist mental health services.

The groups were held at a Children's Centre and were facilitated by a health visitor, an early years' worker and a parent volunteer. Topics discussed included becoming a parent, sleep, understanding your baby and emotional wellbeing.

What difference did this make to parents in Derbyshire and what are the next steps for this project?

There was positive feedback from facilitators and parents. The group provided a safe space where parents could share their experiences, allowing them to reflect on being a parent and their relationship with their baby. The groups also strengthened links within the community as volunteers partnered with health and early years staff to deliver the sessions. Due to the success of these groups, there are plans to roll them out to other areas across Derbyshire.

Children and Young People

As children and young people grow and develop, they face new experiences, transitions, and challenges. Protective factors for children and young people to have good mental wellbeing include:

- Having freedom and time to play.
- Eating a balanced diet and getting regular exercise.
- Going to a school that looks after the wellbeing of its pupils.
- Feeling loved, trusted, understood and safe.

There are risk factors that can cause mental health problems for children and young people. These can include traumatic events and changes such as moving home or changing school. Making the transition to adulthood can also be difficult for young people and some may experiment with alcohol and drugs, which can affect mental health.

Half of adult mental health problems start before the age of 14. This means that it is beneficial for investment across the health and social care system to focus on younger children to prevent mental health and emotional wellbeing issues that can have long-lasting impacts across an individual's life.

Nationally, since 2017 mental health issues are increasing across England, so there is work ongoing locally to monitor current patterns of mental health problems in children and young people to ensure that services are planned, and appropriate support is put in place.

Every year we ask the young people of Derbyshire about their views on a wide range of issues in the My Life, My View Survey.

What is the My Life, My View Survey?

My Life, My View is the name of a confidential online survey of young people in Years 8-11 attending Derbyshire secondary schools. It asks young people about emotional health and wellbeing and looks at their perceptions, beliefs and opinions on behaviours, relationships and communities. The survey is developed with colleagues from Public Health Nursing, Education Psychology, Education Improvement, Safeguarding, Schools, and with feedback from students. 13 of 45 mainstream secondary schools participated in 2022. The 2023 survey aims to reach more children and young people and those who are elective home educated.

What did young people say about mental health and wellbeing?

- **63%** of Derbyshire students who participated in the survey responded that they are happy with their life, however, there is a group of students with poor emotional wellbeing, with important findings being:
  - **35%** of students said they have been feeling depressed or hopeless at least sometimes in the last two weeks
  - Worried young people may engage in risky coping strategies, with **11%** saying they 'hurt myself' 'usually' or 'always'
  - **15%** of students responded that feeling worried, sad or upset often makes it hard to do or enjoy anything
  - **23%** of students said they have been feeling lonely 'often' or 'always' in the last two weeks
- **49%** of Derbyshire students who responded to the survey stated that they find it easy to talk to parents, carers or trusted adults (including teachers) about things that bother them.
- **65%** of students said that if they were concerned about a friend's mental health, they would know where to get help.

The findings of this survey help Public Health and partners in education and Children's Services to raise the profile of, and act on, specific issues surrounding mental health and young people in Derbyshire. One approach to this currently ongoing in Derbyshire is the Whole School Approach Project below.

Adopting a whole school approach to mental health and wellbeing in Derbyshire

What is a whole school approach and what does this involve?

The whole school approach programme commenced in Derbyshire in September 2021. The Children's Services Education Improvement Team and Derbyshire Schools are working alongside Public Health as part of the project. A whole school approach involves all parts of the school, including pupils, leadership team and teachers working together and being committed to mental health and wellbeing. The commitment goes beyond learning and teaching in the classroom by involving parents, carers and the wider community working together.

A whole school approach enables schools to:

- Develop peer support for children and young people, teachers and school staff as well.
- Undertake coaching and supervision.
- Improve transition for children between home, early years' settings and school.
- Develop a clear action plan for improving wellbeing, focusing on building on their strengths as a school.
- Develop mental health and wellbeing pathways and policies.
- Attend regular network events to share good practice, support one and other, and receive training.
- Support the Smilers programme, which targets primary school aged children.

In 2022, over 50 schools in Derbyshire engaged with the whole school approach. The programme has received positive feedback from all schools involved and from other partners.

Working-age adults

A focus on promoting good mental health and wellbeing early in the life course does not mean that support and actions later in the life course are not needed. Adulthood is an important time for building resilience for later life but also a time when mental health problems are common. One in four adults experience at least one diagnosable mental health problem in any given year, including depression and anxiety.

Protective factors like reducing stress at work, long-term unemployment and social isolation can contribute to improved mental wellbeing in working-age adults.

There are many examples of promoting mental health and wellbeing into adulthood in Derbyshire. Below are two case studies focussing on men's emotional wellbeing and those working in the Voluntary, Community and Social Enterprise sector (VCSE).

Let's chat to James about Mentell:

James is the Public Health Lead for Mental Health and has been part of a team that has partnered with Mentell:

James, can you tell us about Mentell and why it is important?

We know research suggests men are less likely to discuss or seek help for their mental health problems. Studies also show the valuable role that men can have by providing informal support to each other with emotional wellbeing. The Public Health team is working on behalf of Joined Up Care Derbyshire with Mentell to provide emotional wellbeing support through a network of peer support groups for men.

Groups are open to all men aged 18 and over living in Derbyshire wanting to make positive changes to their emotional wellbeing in a peer support group environment. The groups, known as circles, are based on sharing feelings and thoughts, however small. Mentell also raises awareness and engages with communities through campaigns such as 'Turn Your Bar/ Business/Borough Blue' which encourages businesses to raise awareness of men's mental health and to signpost staff and customers to Mentell.

How many people have been involved so far?

It has been really successful and over 300 men have attended circles, and 500 referral partners have engaged. Finally, over 650 businesses have engaged in the Turn Your Bar/Business/Borough Blue campaign.

Let's chat to Mel about the mental health and wellbeing support available to the voluntary, community and social enterprise sector

Mel is a Public Health Wellbeing Counsellor who works closely with voluntary sector partners in relation to mental health:

Can you tell us a bit about what you do to support mental health and wellbeing?

The voluntary sector, known as the VCSE, is a key partner in helping people to live fulfilling lives and maintain their health and wellbeing. The VCSE has a strong understanding of community needs and reaches the most vulnerable in society. Due to current climates, demands for many services have increased and the complexity of issues has increased, which has impacted the mental health and wellbeing of some volunteers and employees from the sector. Some of these organisations do not have employee assistance programmes or mental health support offers so we wanted to fill that gap by doing three things.

Firstly, providing health and wellbeing support for all employees and volunteers from the VCSE sector, including a one-to-one wellbeing support service. Secondly, promoting ways that employees and volunteers can improve their health and wellbeing. Finally, we are connecting VCSE organisations together for peer-to-peer support.

What difference has this support made?

In a one-year period from November 2021 to October 2022

- 128 individual VCSE employees and volunteers accessed the wellbeing service.
- 14 bespoke wellbeing groups were delivered.
- 84 group sessions were delivered.
- 200 individuals and 50 VCSE organisations registered for wellbeing support.

There has been lots of positive feedback from the programme. There were examples where people had reached a point where they intended to leave their jobs, but after they accessed the wellbeing intervention they did not.

Older people: Ageing well and long-term conditions

Our physical health and mental health are closely connected, and poor physical health can lead to or worsen mental health. As people get older and they are more likely to have long-term health conditions like cardiovascular (heart) disease and diabetes. For example, in England 58% of people over 60 have one or more long-term physical conditions, compared to 14% of people under 40.

More than two in three people with a heart condition report that their emotional health suffers because of their physical condition, with anxiety being the most common symptom. Also, mental health symptoms can then make dealing with the physical symptoms more difficult.

This does not mean mental ill health is inevitable later in the life course though as physical conditions become more common. There are ways in which mental health can be promoted and support is available.

As people age, the connections with others including family, friends and the wider community is important for mental health and wellbeing and can increase feelings of happiness and self-worth. Time Swap allows older people with different skills, knowledge, and experience to support their wider community. The case study below explores Time Swap Derbyshire.

Time Swap Derbyshire

Time Swap is a time banking programme. This is where people swap their time to help others and in return receive help for themselves or donate their time. The programme started in Derbyshire in 2015 and is part of the Timebanking UK scheme.

Since 2015 Time Swap has helped hundreds of Derbyshire residents to share their skills and talents and almost 17,000 hours of time has been swapped. Derbyshire Time Swap helps bring individuals and groups together, it helps people to feel more connected to their community and can enrich lives with meaning and purpose. This can promote or support good mental health.

An example of Time Swap supporting an older person's mental wellbeing can be shown in the following case study:

A resident wanted to get her garden ready for spring and was struggling to manage on her own. A very kind gentleman, also part of Time Swap, offered to help and brought along his lawn mower and other gardening tools to complete the job. A couple of hours later the garden was transformed! Now that the garden is more manageable for the Time Swap member, she will be able to go out more and enjoy the fresh air and see the bulbs and plants come through in spring.

Stuart who manages the project in South Derbyshire & Erewash commented: "This is a perfect example of the difference Time Swap can make to individuals and communities in our local area and has a real impact on reducing loneliness and supporting our Time Swap members to improve their health and wellbeing".

6 The impact on mental health from Covid-19

The impacts of the pandemic continue to be seen across communities in Derbyshire. One of the legacy factors of the pandemic includes a lasting impact on mental health and wellbeing for some people. During the pandemic many people faced long periods of loneliness and isolation and for some it has been challenging to re-establish networks of support as society re-opened. The lockdowns and disruption to education throughout the various Covid-19 waves is likely to have impacted people's mental wellbeing, the evidence for this impact is developing (as it can take a while from the event for issues to be identified in research and data). Early indications are that some children, young people, and adults experienced poorer mental wellbeing and this will be explored in more detail in the following section. The evidence for impact across the life course is also developing. Some examples that many people in Derbyshire have experienced include:

Short term impacts

- Anxiety over outbreak and possible illness
- Loneliness due to isolation and social distancing
- Stress caused by adjusting to new routines, financial and employment insecurity
- Depression caused by lack of activity, loss of normal routine, increased caring responsibilities

Medium term impacts

- Post traumatic stress
- Depression caused by loneliness and isolation
- Increased risk of suicide and self-harm
- Relationship breakdown

Long term impacts

- Grief caused by bereavement
- Reoccurrence of previous mental health problems
- Developmental and behavioural issues in children and young people from isolation or social distancing at key milestones
- Development of mental health disorders as a result of the stress.

Source: Derbyshire Observatory.

The Public Health Knowledge and Intelligence Team have estimated that an extra 80,000 people in Derbyshire would require support for mental health. This estimate shows the scale of need for people who may require services, support, and interventions to address their mental health issues.

The following sections provide an overview of the evidence for the impacts of Covid-19 on mental health.

Impact on children and young people

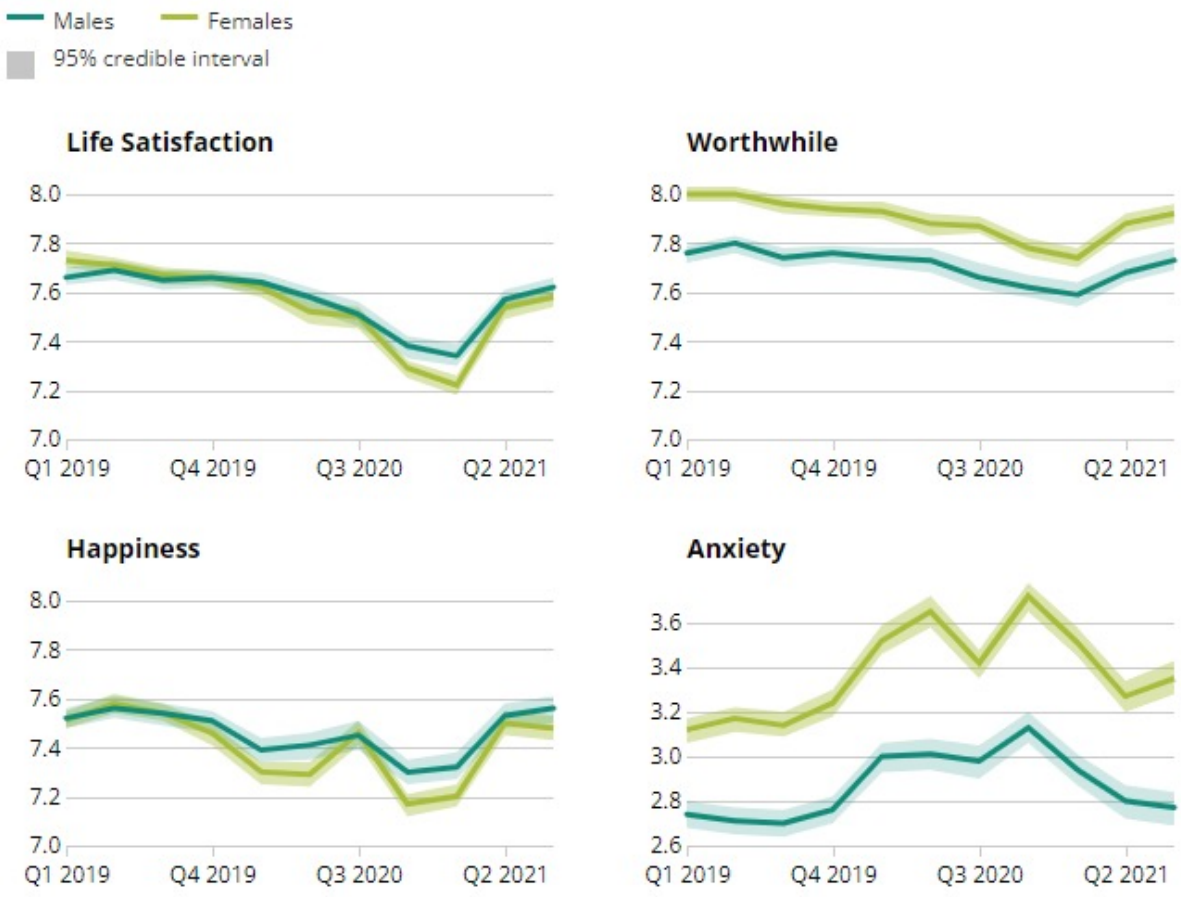
During and after the pandemic there have been changes to the mental health and wellbeing of children and young people. The Mental Health and Young People Survey looked at the mental health of children and young people in England from February and March 2021. The results from this survey were compared to the previous survey that took place in 2017 with over 3,600 of the same children and young people. Key findings included:

- The proportion of children and young people with possible eating problems increased since 2017. This went from 6.7% to 13.0% in 11- to 16-year-olds, and from 44.6% to 58.2% in 17- to 19-year-olds.
- Rates of probable mental disorders increased since 2017. In 6- to 16-year-olds there was an increase from one in nine (11.6%) to one in six (17.4%), and in 17- to 19-year-olds from one in ten (10.1%) to one in six (17.4%). Rates in both age groups remained similar between 2020 and 2021.

Impact on adults

The Office for National Statistics (ONS) measures wellbeing of people in the United Kingdom. The graphs below show how measures of wellbeing significantly worsened at the start of the pandemic. By the third quarter of 2021 these had moved back towards 2019 levels although levels of self-reported anxiety remained higher than before the start of the pandemic in part due to higher anxiety among women. This can be seen in the graph below.

Graph 1: Personal wellbeing in the UK January 2019 to September 2021



Source: Office for National Statistics

As more data and information becomes available it's likely more impacts from worry, anxiety and social isolation will be seen. The risks of social isolation are high and have been estimated to be as damaging to health as smoking 15 cigarettes a day. Research also shows that loneliness is associated with a greater risk of inactivity, heart disease, stroke, depression, low self-esteem, sleep problems and dementia.

As a result of these emerging issues Public Health recognised the potential short, medium, and long-term impact of the pandemic. Public Health have invested additional resources to provide practical help, support, and advice to residents. A particular area of focus is social connectedness as the pandemic changed the way in which everyone was able to interact with each other for long periods of time. The following case studies described how Public Health has brought people together. Connect Derbyshire was created to support people to feel less lonely and isolated, Let's Get Creative brought people together to allow social bonds to form and Swanwick Men's Shed helps to make friends while making things.

Connect Derbyshire

Connect Derbyshire has involved creating local social connectedness groups across Derbyshire, which provided a tailored approach to supporting social isolation. The groups are hosted by local voluntary sector organisations.

Different partners and members of the community have come together through the work of these groups to understand what makes residents feel isolated and identify what can make people feel more connected. The groups have highlighted issues including digital poverty, fear of crime, cost-of-living pressures, a lack of friends and poor transport connections. Each area has developed an action plan to focus on key issues for local communities and put practical preventative solutions in place. The groups have played a key part in recovery from the pandemic. For example, some groups have set up befriending support, food banks and general community groups to re-engage people after the pandemic.

In addition to local groups a county-wide 'Connect Derbyshire Forum', led by Public Health, helps to share good practice, and look at what works well and what needs to be improved. The Forum organised a conference in 2022, which was attended by 130 partners, to highlight the impact of loneliness and isolation and showcase local action to tackle the issue. 100% of participants said that their understanding of loneliness and isolation had improved as a result of the conference and all participants reported they felt motivated and more confident in trying to reduce loneliness and isolation.

Connect Derbyshire has resulted in a range of activities which enables people within communities in Derbyshire to feel better connected and well supported.

Let's Get Creative

Public Health has supported a programme for young people with special educational needs and disabilities to come together and develop digital skills. The project provided the space for young people to come together and develop social connections after they had experienced increased isolation during the lockdowns.

In summer 2021 an event was held in Chesterfield to recognise the achievements of the 'Let's Get Creative' team. The team are an exceptional group of young people who are contributing towards an app promoting local walks in the Chesterfield area.

The app can be accessed by using the QR code below and enables you to link in with a local walk in the Chesterfield area. Taking time to be outside and a break from our busy days will support our mental health and wellbeing, and the app makes this easy to plan and do.

The group was facilitated by staff from Derbyshire Education Business Partnership (DEBP) in collaboration with Kakou CIC, and supported by Chesterfield College's Digital, Media & Graphics department.

Swanwick Men's Shed

Tucked away on a farm on the outskirts of Swanwick in Amber Valley the Men's Shed provides a safe, friendly place to meet and join in a variety of projects ranging from building garden benches to making picture frames and reviving old furniture. Since its establishment it has won both regional and national awards.

The shed is a vibrant community space and is providing a lifeline to local men, and women, who would otherwise be socially isolated or experiencing poor mental health. Charles Parkes helped to set up the Men's Shed and explains: "The original idea was to deal with isolation for older males. A lot of men who've finished work for whatever reason - whether they've retired, been made redundant or finished due to ill health - don't have the social network that their wives would probably have through schools, playgroups, Women's Institute and all sorts of things".

"We've had a few people move into the area and then become widowed so they're in a new place with no social contact at all. They have found new friends and a family in the shed. They enjoy coming and helping out, making items for their grandchildren or cooking the sausages on a Saturday. We get new members to buddy up with a shedder on a project. It is good to see them smiling and enjoying the banter. It's something to do and keeps them physically fit and mentally active".

"We support each other. We've got two or three at the moment who've got health problems within their family and we're rallying around speaking and supporting each other. We closed over Christmas, and we kept in contact with people who needed contact and help".

To summarise the impact of the project Charles said:

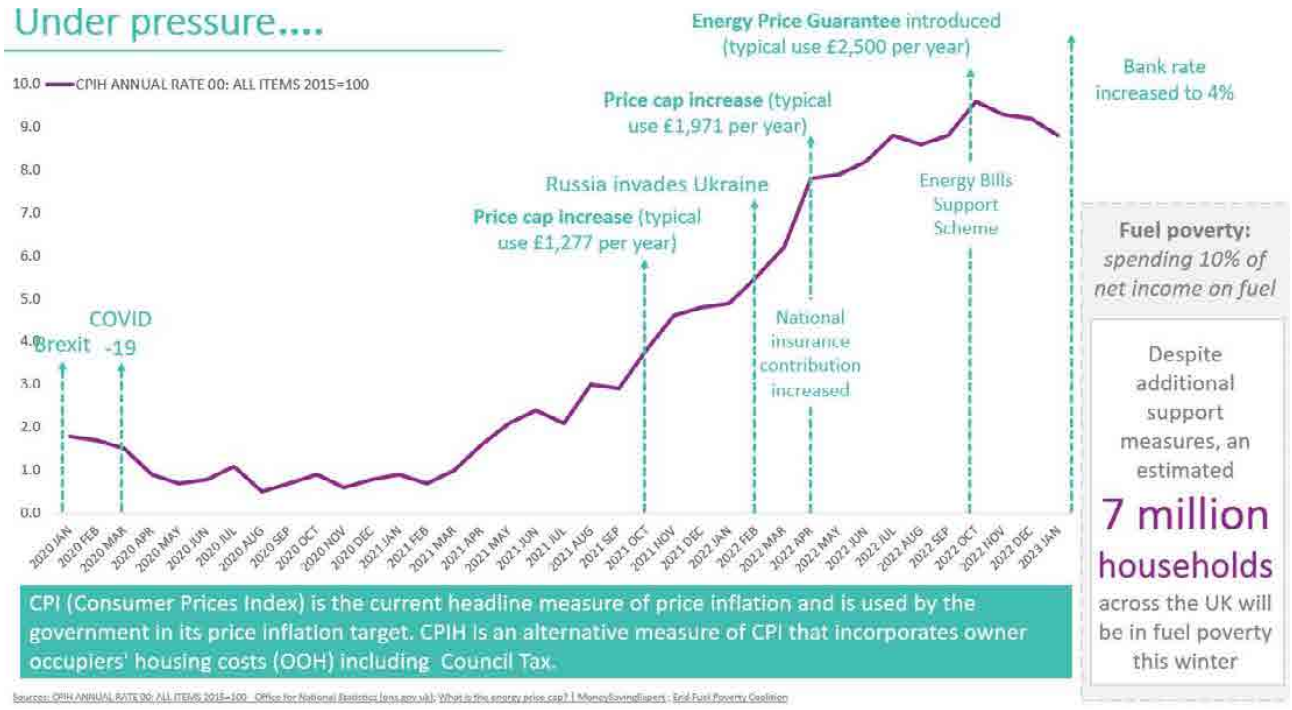
"I get a lot of satisfaction out of it in terms of what we've achieved. When you hear their stories it's great to see the effects it's had on other people being there. We've got people there who would readily openly admit it's saved their lives."

7 The impact of cost-of-living pressures on mental health

As the main Covid-19 pandemic restrictions eased, the cost-of-living in the UK increased sharply during 2021 and 2022. The costs of petrol, food, utility bills and housing increased rapidly. These pressures, combined with the longer-term impacts of the pandemic represent a challenge to mental health and wellbeing. A further challenge is that the pandemic may have reduced resilience, or how individuals adapt to difficult situations.

The graph below shows how key events impacted the cost-of-living. It uses the Consumer Price Index, which is a key indicator when considering the cost-of-living for people in the UK. The graph also shows how several big global and national events have linked together. Public Health recognises that the cost-of-living pressures can impact our mental health and wellbeing as many people struggle to adapt to these increased costs.

Graph 2: Consumer Price Index January 2020 to January 2023



Source: Derbyshire County Council, Public Health Knowledge and Intelligence Team

These cost-of-living pressures, as shown in the graph above, have impacted on millions of households across the UK and in Derbyshire, affecting peoples' ability to:

- buy enough food.
- heat their homes.
- access support to live healthier lives.
- save money for the future and manage bills.
- increase their risk of having problems with debt.

These issues can all have significant negative impacts on mental health and wellbeing. Spikes in mental health distress have been seen in previous periods of economic stress. As data emerges there may be similar patterns of mental health distress as a result of the current cost-of-living pressures.

Impact on mental health and wellbeing

National surveys that have asked a cross section of the population about their mental health during the current cost-of-living pressures have shown a negative impact on their mental health and wellbeing. For example, one survey conducted from December 2022 to January 2023 by the mental health charity Mind showed that 78% of people surveyed said that cost-of-living pressures was impacting their mental health.

Other research carried out by the Office for National Statistics and Money and Mental Health Policy Institute in 2022 found a link between the current cost-of-living pressures and levels of mental health distress. The graphic below shows some of the key statistics from this research:

Figure 3. Impacts of cost-of-living on mental health

The longer-term impacts of pressures on our finances and struggling to make ends meet can cause people to be living in poverty and could result in chronic stress, depression or anxiety.

Chronic stress is also linked with an increased risk of physical health problems such as circulatory (heart) system problems and increased fatigue. On top of this, poverty can result in difficulties in managing long-term conditions, such as meeting the cost of prescription charges.

The Mental Health Foundation suggests the effects of the cost-of-living pressures on public mental health could be on a scale similar to the Covid-19 pandemic.

Public Health are concerned about these impacts on mental health, so have responded by increasing support to our residents. In Derbyshire there are existing services and advice to help residents with their finances, energy efficiency, sourcing good quality food, family support and many more aspects of life relating to the current cost-of-living pressures, and Public Health have enhanced these. Public Health, alongside partners, have created information for the public, supported people with money for emergencies with the Derbyshire Discretionary Fund (DDF), helped people claim benefits that they are entitled to with the Welfare Rights Service and set up warm and welcoming spaces.

Derbyshire Discretionary Fund

The Derbyshire Discretionary Fund (DDF) helps provide grants or emergency cash payments for those in urgent need of financial help following a crisis. The fund aims to support people in such situations to continue to live independently or cope with exceptional pressure when they have no other source of funding. The fund can also put individuals in touch with other services and support to help make sure it is less likely to happen again.

In 2022 the DDF made:

- **31,003** Emergency Cash Payments for food and heating – over twice as many as in 2021.
- **775** awards for Exceptional Pressure Grants providing essential furniture, white goods, and other items for residents in need.

88% of applicants who received funds felt that the award helped them to feel less stressed.

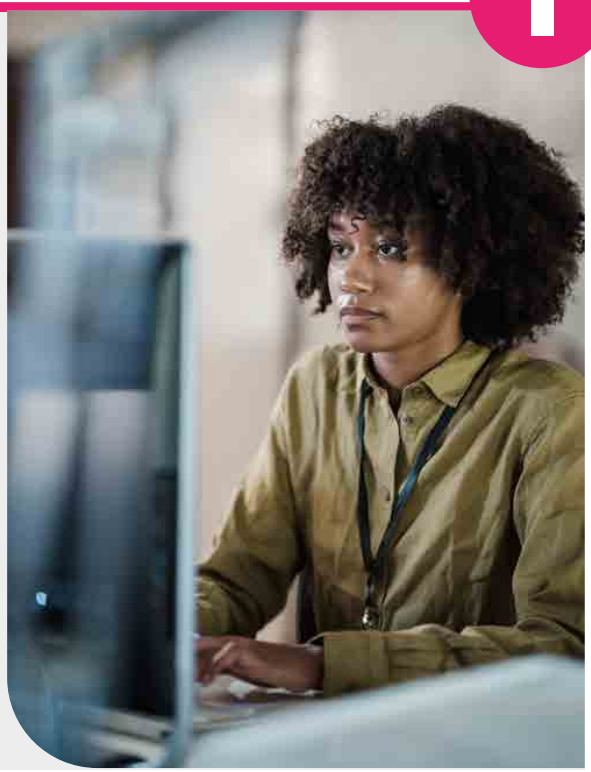
One applicant was supported with rent in advance, white goods, furniture and help with carpets after being resettled from emergency accommodation following domestic abuse. They explained: "I'm so pleased that DDF could help as I don't know what I would have done without you as it was a very stressful time for all the family. I'd like to thank everyone in DDF for their support and help. I feel like I can breathe again."

Welfare Rights Service

The Welfare Rights Service provides benefits information and advice to individuals and families across Derbyshire. For many the benefits system is complex and overwhelming and can worsen existing mental health difficulties, which can result in financial worries. The team provides an advice line, casework support for adult social care clients, and representation at benefit appeals.

In 2022 the service responded to over 19,000 requests for support and helped residents to access a confirmed £26.2 million of additional benefits income. Here are some quotes from Derbyshire residents about their experiences:

- "The advisor was extremely friendly and helpful. They stopped my anxiety levels from increasing. I was having suicidal thoughts as I had no money"
- "The Advisor provided confidence to continue with the appeal – changed day to day life for the better"



There is also targeted support for those households with someone who is living with cancer or a terminal illness, and a project to improve Pension Credit uptake for those who are missing out. The service supports clients and their families by ensuring they have their full entitlement and can navigate the benefit system.

Gwen Sandford from the Welfare Rights service team describes the support one client received: "The service helped a father with his son's Disability Living Allowance claim. Both father and son had chronic anxiety problems and found completing the form for the claim challenging and overwhelming. They were supported through the process by the Welfare Rights Service (including looking at a range of other benefit problems) with advice tailored to their needs. The Welfare Rights Service removed barriers and empowered this gentleman – this helped improve mental health and the family's ability and resilience to respond to issues in the future".

Let's chat to Sam about Warm Spaces in Derbyshire

Sam works in Public Health and has been part of a team that has grant funded Warm Spaces across the county.

Tell us more about the project and what it aimed to achieve?

A Warm Spaces fund was launched in Derbyshire to support organisations to provide a warm refuge for residents who might be struggling to heat their homes over last winter. VCSE organisations in Derbyshire could apply for a grant towards the cost of opening up community venues or to extend their opening hours during the colder months.

What difference did this make to people in Derbyshire, especially in relation to their mental health?

Venues offered a heated space, provided seating, offered refreshments such as a warm drink, and were free of charge. People visiting these warm spaces are offered information to help them with cost-of-living support, as well as advice on looking after their mental health and wellbeing.

Staff and volunteers at organisations and groups running Warm Spaces in Derbyshire are also supported with their own mental health. Public Health developed a short film to provide advice to help people look after their wellbeing, and Derbyshire Voluntary Action developed and circulated a Mental Health Support Pack. Support is also offered by a Public Health Wellbeing Counsellor who could provide more specialist help and advice. People valued the social connections of a warm space which can help with mental health and wellbeing.

8 Population mental health

This report has described different ways of providing individual support for mental health and wellbeing. However, there are other ways to support Derbyshire residents. One of these is by taking a population health approach to mental health.

A population health approach looks at promoting mental health across the whole population by looking at the needs of different groups of people. For some groups of people, this may be support that enables them to recover and thrive whilst they are experiencing a mental illness. For other groups who are not currently experiencing mental health problems, this may be about promoting mental health to prevent mental illness from developing. A population health approach aims to improve health across the entire population and to reduce health inequalities.

Health inequalities are ultimately about *differences in the status of people's health*. The term is also used to refer to other differences that can contribute to a person's health status such as:

- Access to care (e.g., availability of treatments)
- Quality and experience of care (e.g., levels of patient satisfaction)
- Behavioural risks to health (e.g., smoking rates)
- Wider determinants of health: the environmental, economic, and social conditions in which people live (e.g., quality of housing).

There are inequalities in mental health. Some groups of people are more likely to have poor mental health and less likely to get the support that they need. For example:

People in urban areas have better access to services

Young women experience higher rates of reported self-harm

Black and Asian males have much higher rates of psychotic disorder

Those with poorer mental health may also have poorer physical health problems and social issues. For example:

People with severe mental illness die 15-20 years earlier than people without severe mental illness

People with mental illness are less likely to be employed

Adults with depression are twice as likely to smoke as adults without depression

A population health approach can be used to help reduce these health inequalities by responding to the mental health needs of different groups of people.

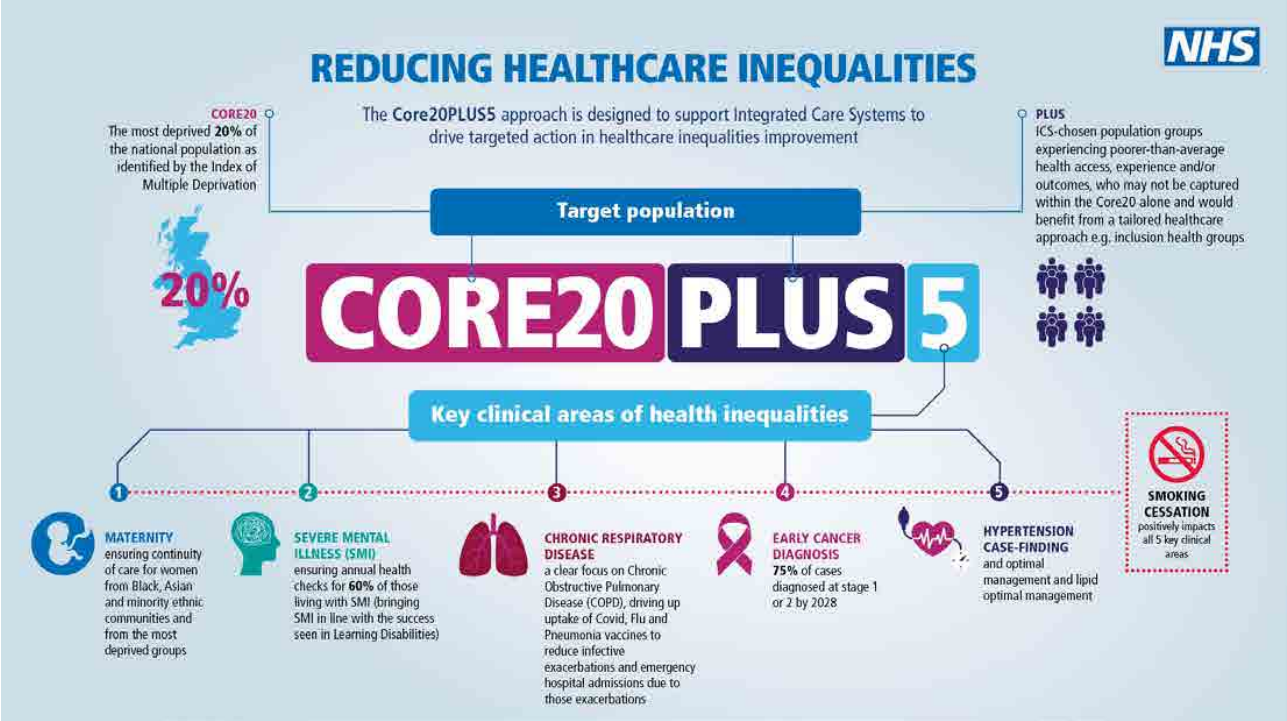
What work is ongoing in Derbyshire?

In 2023 Public Health started a Health Needs Assessment (HNA) or a deep dive into the data, experiences, and services for deaf people, and for black people. These two groups are impacted by mental health illness in different ways than other people in the population. Public Health want to understand why this is and how changes can be made to services to reduce this difference.

Core20PLUS5

The NHS has developed the Core20PLUS 5 approach, which aims to reduce inequalities in healthcare across the population. The infographic below identifies how we reduce inequalities in access, experience and outcomes in health services.

Figure 4. Core20PLUS 5 approach infographic



Source: NHS England

The CORE20PLUS5 approach focusses on specific population groups who are known to experience health inequalities. These include:

- The most deprived 20% of the national population, identified by the national Index of Multiple Deprivation (IMD).
- Population groups, decided locally that are experiencing poorer-than-average health access, experience and/or outcomes. This could include ethnic minority communities, people with a learning disability and autistic people, and people with multiple health conditions.

The NHS has identified five clinical areas of attention for this approach. One of these is specifically related to mental illness and focuses on annual health checks for 60% of those living with Severe Mental Illness (SMI). This is important as people experiencing SMI are more likely to have poor physical health and live on average 15 to 20 years less than the general population. Other areas of focus are maternity, respiratory disease, cancer, and hypertension (high blood pressure).

Public Health will continue to work with NHS partners in Derbyshire to reduce inequalities in healthcare for those experiencing mental and physical illness by working through the CORE20PLUS5 approach.

9 Working together to support people with their mental health and wellbeing across Derbyshire

This report has discussed how Public Health has taken an individual approach and a population approach to mental health and wellbeing. Public Health teams can't do this on their own and need to work with lots of different organisations so more people can be helped and supported more of the time.

Let's chat with James, the Public Health Lead again.

James, can you tell us how we can all work together to support people with their mental health and wellbeing?

We all have mental health, we all have experience of mental health in ourselves and others and we can all play a positive role. We are all mental health aware which is an important yet simple skill. Inherently we all have kindness and empathy, and we all have a built-in desire to help others. We want to help people develop this skill and desire to help each other.

How can we become more aware of other's mental health?

Understanding emotional distress is a key starting point. Emotional distress can manifest in different ways. In children it may be a tantrum, in teenagers it may be self-isolation and in adults it could be a risky behaviour. To think beyond the behaviour, to realise that someone is struggling and to support with compassion in a non-judgmental way is something that we all can do.

We can also create a culture and an environment at home, at school, in the workplace, in other settings and on social media that is one where people feel comfortable talking about mental health. We can develop our awareness and our skills to be confident to ask people about how they are feeling and the listening skills to truly hear what people are saying.

There is a lot of information, support and services out there, but sometimes the simplest interactions can make all the difference or be the first step to seeking help. Don't underestimate the difference that you could make. Mental health is everyone's business!

So, everybody can have a part in supporting others with their mental health and creating an environment that promotes mental wellbeing to improve the lives of individuals and communities.

The 'Let's Chat' campaign in Derbyshire is a method of improving our mental health awareness and supporting others. It launched in 2022 to start conversations about mental health, helping people connect and reducing isolation. Luke, from the Public Health team talks about this project below.

Let's Chat to Luke about getting people talking

Luke, can you tell us about the Let's Chat project?

Derbyshire County Council have put up 700 Let's Chat bench signs across the county, aiming to get people talking about mental health and making connections with others in the community. The signs also give information via a QR code and link to mental health support.

The signs are on benches in parks, town centres, community venues and other locations such as Chatsworth, Hardwick Hall, and the Chesterfield Royal Hospital. A map of locations can be found here.

Resources were also developed for the winter months including posters, window stickers and table cards. Over 120 organisations have signed up for indoor resources and over 3000 resources have been sent out to Derbyshire organisations. In 2023 bench signs will be produced to reflect Joined Up Care Derbyshire branding and will include Derby City. Smaller gate post and signpost signs are also in development.

Local photographer Tony Fisher supported the campaign by taking pictures of the benches being used and had conversations with people across Derbyshire about their emotional health and wellbeing. Some of these have been printed on canvas to exhibit around the county.

What difference has this project made to the mental health of Derbyshire residents?

From April 2022 to January 2023 the Let's Chat online map had 11,500 views and the Tackling Loneliness webpage had 1,500 page views.

There has been good feedback from the public and employees about how they are helping people to have conversations about mental health and wellbeing. One resident explains:

"I was out taking photos of the signs and a member of the public came and spoke to me, we got chatting and she said they were such a good idea, she never had the confidence to ask for help as she's really struggling, she rarely leaves the house unless to drop her child off at school or nip to the corner shop. As she was walking back from the school drop off she saw the sign, scanned the QR code and found the contact details for the Derbyshire mental health support line number. She rang them that afternoon after building up the confidence and found it really helped speaking to someone and getting support from them and signposting to other services".

There are other ways Public Health is working in partnership with the goal of making mental health and wellbeing everyone's business. These include:

- Increasing awareness and reducing stigma, for example through campaigns.
- Helping people to become more confident and competent, for example through training.
- Providing information such as via websites about services and support.

Increasing awareness and reducing stigma

Not everyone will understand mental health problems and some people may have misconceptions or negative attitudes towards people experiencing mental health problems. It is important to reduce this stigma. Ways to do this include raising awareness about mental health problems and how they can affect anyone, individuals speaking out and sharing their stories, and social marketing campaigns.

One way this has been done across Derbyshire is by using football to connect with people and raise awareness about mental health.

Football and mental health, a winning match

Football is England's national game, and it has a powerful impact on many people's lives. As well as the fans who attend matches every week and those who watch it on television, there are also those who talk about it in daily conversations and follow it though different formats including via social media. Football has the power to reach and connect with people especially men and boys. Evidence shows that more men die of suicide than women with three quarters of deaths by suicide being men. As football is so important to many men it's a great way to start a conversation around mental health and wellbeing.

In recent years Public Health has partnered with Chesterfield FC, Alfreton Town FC, Belper Town FC, Matlock Town FC and Sheffield FC to host World Suicide Prevention Day events at their matches. On this day volunteers have handed out club-specific leaflets, raised awareness and engaged in conversations with fans. Awareness has also been raised with activity on social media. Derby County FC have provided support for the suicide prevention agenda using films and social media messaging.

How many people in Derbyshire do these events reach?

The World Suicide Prevention Day events directly reach over 10,000 fans at matches each year and thousands more via social media and communications.

Building on this success, Derbyshire County Council are piloting a project with Chesterfield Football Club by using the club's stadium facilities and media channels to share crucial messages relating to mental health. The messaging will reach several thousand fans on match days or at other events and those who connect on social media.

Helping people to become more confident and competent

As well as reducing stigma and raising awareness, helping people to become more confident and competent supporting others with their mental health is an important approach. This can be achieved by activities such as training. For example, in the work environment this can build resilience amongst colleagues and increase recognition of when others need support. Mike works in the mental health and suicide prevention team and describes a workforce training approach in Derbyshire.

Let's chat to Mike about Let's Talk Mental Health: A workforce training approach in action

Mike, tell us about the workforce training approach in Derbyshire?

The project has been running since 2015 and aims to upskill volunteers and paid staff so they can raise awareness about mental health and deliver messages about positive mental wellbeing at work.

The training reflects that mental health is everyone's business so anyone can take part. Training is adapted to suit the needs of the workforce. There are free places for the VCSE and public sector organisations. There is ongoing support with a regular newsletter that provides practical tips and information on events, resources, campaigns and other mental health news.

A key part of this project is the nationally promoted MHFA training. This two-day course provides attendees with a deeper knowledge and practical skills to identify and support people. A community mental health first aider network has been set up to provide ongoing peer support.

What difference has this approach made to people in Derbyshire, especially in relation to mental health?

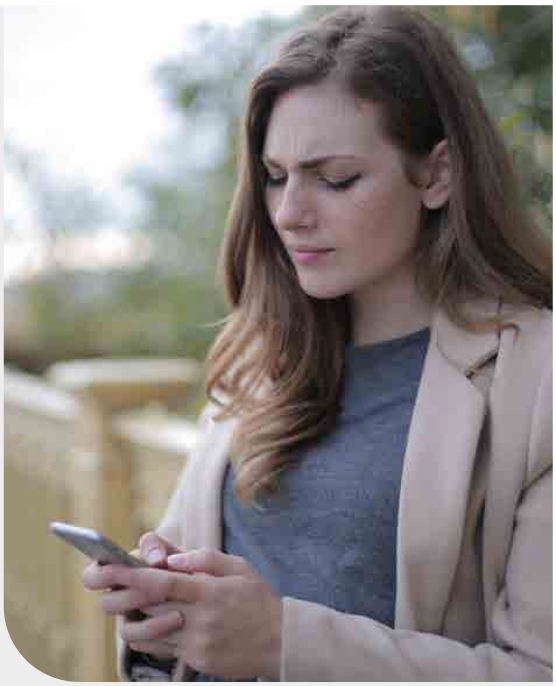
In 2022 more than a hundred mental health courses were delivered with over 500 hours of live training time. These mental health courses were attended by over 1,000 participants from over 300 different Derbyshire organisations and 350 individuals gained the nationally recognised MHFA training qualification.

Providing information

Having access to information about support and services is another key part to ensuring mental health is everyone's business. This allows everyone, whether they are seeking support for themselves, a friend, a colleague, or a client to access advice and resources. Public Health have worked in partnership to create a website as a single point of access for residents and professionals to find this information and support.

Log on for more information, advice and support

Launched in April 2020, the Derby and Derbyshire Emotional Health and Wellbeing website is a central point for local information, signposting and resources, so that it is easier for people to find the information they need. It is used by people of all ages living, visiting and working in Derbyshire and Derby City.



This website has been designed collaboratively with specialists and people with lived experience. The site provides access to information about local services including urgent support and helplines in case of crisis. It includes information about training and national links for mental health, suicide prevention and wellbeing. The site is continuously evolving and regularly updated with new information as the demand for support changes over time.

There are several partners involved including NHS Derby and Derbyshire Integrated Care Board, who fund the project, Derby City Council, Derbyshire Voluntary Community Partners and Derbyshire Deaf Alliance.

From April 2020 to 31 January 2023, the number of users reached 50,735, with 221,103 pages viewed.

10 Do you need further advice or support?

You may be reading this report and reflecting about your own mental health and wellbeing or looking at it because you are concerned about a friend, family member or loved one. Often, talking to someone who is not involved in your situation can help. You might find it easier to contact someone in writing, by email or by text. Let's have a look at some contact details for organisations that can support.

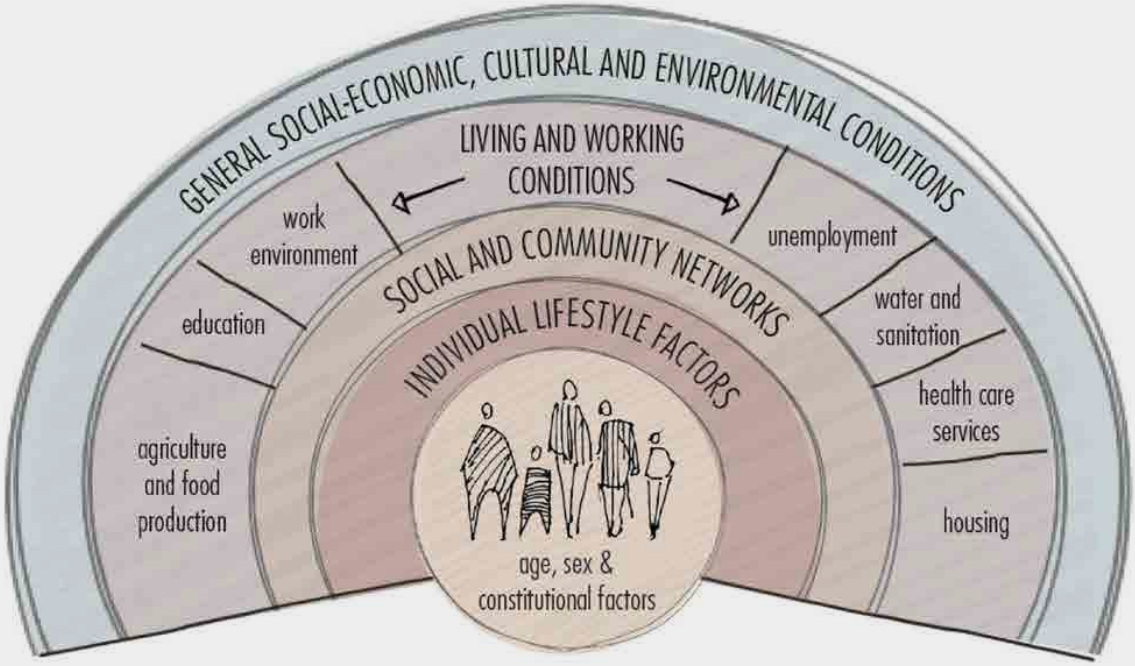
- **Derbyshire Mental Health Support Line:** 0800 028 0077 – Free, 24h
- **Carers UK helpline:** 0800 808 7777; Contact form: www.carersuk.org/about-us/contact-us
- **Samaritans helpline:** 116 123 – Free, 24h; email jo@samaritans.org or write a letter to Freepost SAMARITANS LETTERS
- **SANEline:** 0845 767 8000; email: support@sane.org.uk
- **Mind Info Line:** 0300 123 3393 and for callers with a hearing or speech impairment: 18001 0300 123 3393; email: info@mind.org.uk Text: 86463
- **Campaign Against Living Miserably (CALM) helpline:** 0800 58 58 58; webchat - www.thecalmzone.net/get-support
- **National Bullying helpline:** 0845 22 55 787; email: help@nationalbullyinghelpline.co.uk
- **Refuge Domestic Abuse helpline:** 0808 2000 247 – Free, 24h and Refuge
- **Domestic Abuse BSL helpline:** www.nationaldahelpline.org.uk/en/Contact-us
- **Respect Men's Advice helpline:** Freephone 0808 8010327. For male victims of domestic abuse.
- **999 BSL – UK Emergency Video Relay Service - About :** 999 BSL
- **Support Line:** 01708 765200; email: info@supportline.org.uk
- **Derbyshire Victim Support helpline:** 0800 612 6505 and Derbyshire Victim Support BSL helpline; Live Chat - www.victimsupport.org.uk/resources/derbyshire/
- **SHOUT – Free Mental Health Text Messaging Service:** Text SHOUT to 85258; if you are deaf, text DEAF to 85258
- **Cruse Bereavement Derby and South Derbyshire helpline:** 01332 332098 email: derbyshire@cruse.org.uk
- **Cruse Bereavement Chesterfield helpline:** 01246 550080
- **Hope Again helpline:** Freephone 0808 808 1677 for young people (from Cruse Bereavement Support)
- **Child Bereavement UK helpline:** 0800 02 888 40 email: helpline@childbereavementuk.org
- **The Survivors of Bereavement by Suicide (SOBS) helpline:** 0300 11 5065 email: email.support@uksobs.org
  - o **Chesterfield SOBS helpline:** 07507 692029
  - o **Derby SOBS helpline:** 07930 096112
  - o **Ilkeston SOBS helpline:** 07538 796867
  - o **Swadlincote SOBS helpline:** 07399 552142
- **NHS 111** is also available for urgent, non-life-threatening medical help and advice, and NHS BSL 111 for British Sign Language users.

11 Next steps and recommendations

A need for a whole system approach to mental health

This report has described and shown how mental health and wellbeing is an important part of everyone's life, no matter what age. Mental health and wellbeing are influenced by the conditions in which people are born, grow up, live, and work in and the Covid-19 pandemic and current cost-of-living pressures highlighted this. These wider determinants of health have been described in this report and more joined up action is needed.

The diagram displays the wider determinants and how the conditions people live in, can contribute to mental health and wellbeing. Some of these factors are protective factors and contribute to good mental health, whereas others are risk factors and contribute to poorer mental health.



Source: Dahlgren and Whitehead 1991 and Sustainability Journal

To promote good mental health and wellbeing an approach is needed that looks at all of these factors. This is called a whole system approach. A whole system approach to mental health recognises that the conditions people live and work in are as important as individual factors to shaping someone's mental health and wellbeing. This means that action and support is focussed not just on individuals but within communities, businesses, schools, housing services and many other areas. It is about mental health being everyone's business.

This report has described a snapshot of how Derbyshire County Council's Public Health Team and partners, alongside communities, have worked together to support people with their mental health and wellbeing. Public Health have worked in collaboration across many different areas and organisations in Derbyshire including in schools, at workplaces, and at football matches. More work is needed, and the following recommendations identify the next steps for 2023/24.

Recommendations

1) Across the System, Public Health recommends a whole system approach to mental health is adopted in Derbyshire.

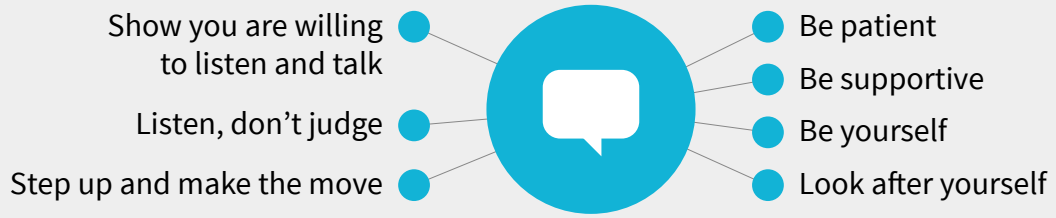
2) Locally, Derbyshire Public Health alongside partners and communities will build on this positive work over the next 12 months by:

- Continuing to utilise a life course approach to mental health, with a focus on children and young people's support and projects, including reviewing their impact. The aim is to give children and young people the best start in life and positively influence wellbeing into adulthood.
- Monitoring and responding to the mental health effects of the Covid-19 pandemic in Derbyshire, with a recognition that medium and longer-term impacts may yet be seen.
- Continuing to support those who are facing the greatest challenges from the cost-of-living pressures. Winter 2023/24 may be equally as challenging for many as winter 2022/23.
  - This requires a focus on financial and mental health support in the short term as well as embedding early intervention approaches to help prevent potential mental health impacts longer term.
- Using the Core20PLUS5 population approach to focus action for the 20% most deprived communities and those experiencing SMI, with the aim of reducing health inequalities in mental and physical health.

3) Individually, everyone can have a positive role to play in supporting others with their mental health and wellbeing. So, the call to action in this report is simple, we want as many people as possible across the county to do the following:

• Let's Chat • Let's Ask • Let's Listen

Let's Chat 1 – Tips on how to start the conversation



Let's Chat 2 – How to support or check in on someone

Let's Chat 3 – Spotting signs of poor mental health

Let's Chat 4 – People with good emotional and mental health

Many people with good emotional and mental health are able to:

12 Acknowledgements

With thanks to:

- Annette Appleton, Project Officer (Strategic Intent)
- Andrea Barber, Health Improvement Practitioner (Health Improvement)
- Lauren Bird, Advanced Public Health Practitioner (Knowledge & Intelligence)
- Rosanna Brown, Public Health Practitioner, (Localities Team)
- James Creaghan, Public Health Lead (Health Improvement Team)
- Michael Davie, Health Improvement Practitioner (Health Improvement Team)
- Shirley Devine, Group Manager (Knowledge & Intelligence)
- Helene Denness, Assistant Director of Public Health
- Thom Dunn, Assistant Director of Public Health
- Carol Ford, Public Health Lead (Best Start)
- Marina Fournier-Farmer, Website & Information Coordinator (Mental Health and Suicide Prevention Team
- Richard Flint, Advanced Public Health Practitioner (Knowledge & Intelligence)
- Jo Hall, Principal Clinical Psychologist/ Clinical Lead (Psychological Insights Team)
- Melanie Hani, Public Health Wellbeing Counsellor (Mental Health and Suicide Prevention Team)
- Ellie Houlston, Director of Public Health
- Victor Jeganathan, Behavioural Scientist (Psychological Insights Team)
- Claire Jones, Public Health Lead (Health Protection)
- Amelia Kwan Su Yin, Junior Doctor (F2)
- Ellen Langton, Group Manager (Commissioning and Strategic Intent)
- Iain Little, Assistant Director of Public Health
- Caroline Mackie, Public Health Lead (Healthcare Public Health and High Peak Locality)
- Jo McGarrigle, Healthcare Public Health Practitioner (Best Start Team)
- Nicky Mount, Project Manager (Prevention Team)
- Louise Noon, Public Health Lead (Health Improvement)
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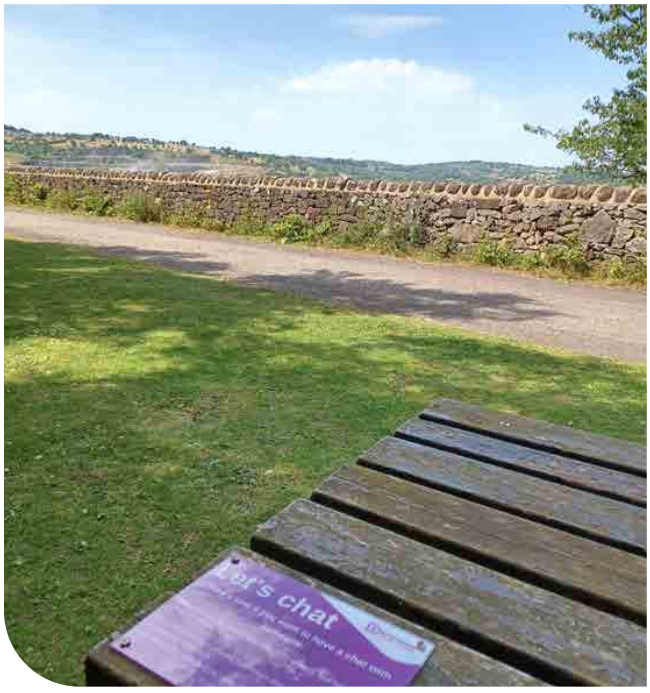
- Rebecca Symes, Speciality Registrar in Public Health
- Jon Townshend, Service Manager (Commissioning Team)
- Luan Wilde, Advanced Public Health Practitioner (Localities)



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Contact:

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Derbyshire County Council, County Hall, Matlock, Derbyshire DE4 3AG
Email: asch.public.health@derbyshire.gov.uk

DERBYSHIRE County Council

Time Commenced: 13:00pm
Time Finished: 15.00pm

Health and Wellbeing Board
7 September 2023

Present:

Statutory Members Chair: Councillor Martin (Chair), Sue Cowlishaw (Derby Healthwatch),Richard Wright (Chair of ICB), Robyn Dewis, Director of Public Health

Elected members: Councillors Ashby & Care

Appointees of other organisations: Amjad Ashraf (Community Action Derby), Denise Baker (PV and Dean College of Health Psychology and Social Care University of Derby) Stephen Bateman (CEO Derbyshire Healthcare United), Paul Brookhouse (Derby Poverty Commission), Lucy Cocker (Derbyshire Community Healthcare Services), Helen Dillistone (Rep for Chris Clayton CEX DDICB), NHS Foundation Trust), James Duffield (Derby Poverty Action), James Joyce (Head of Housing and Homelessness & rep for Clare Mehrbani), Perveez Sadiq (Director Adult Social Care Services), Clive Stanbrook (Derbyshire Fire & Rescue Service)

Non board members in attendance: Denise Crouch (Derby Community Trust), Sharon Dale (Derby Community Trust), Rob Smitthers (Livewell Treatment Manager)

10/23 Apologies for Absence

Apologies were received from Cllr Emily Lonsdale, Emma Aldred (Derbyshire Constabulary), Chris Clayton (CEO Derby & Derbyshire ICB), Gino Distefano (Director of Strategy Derby Hospitals), Ian Fullagar, (Head of Strategic Housing, City Development and Growth DCC, rep for Health, Housing & Homelessness Board), Margaret Gildea (ICB) Clare Mehrbani (Director of Housing Services, Derby Homes Ltd), Rachel North (Director of Communities & Place), Mark Powell, (CEO Derbyshire Healthcare NHS Trust), Andy Smith (Strategic Director of Peoples Services), Alison Wynn (Assistant Director of Public Health)

11/23 Late Items

There were none.

12/23 Declarations of Interest

There were none.

13/23 Minutes of the meeting held on 27 July 2023

The minutes of the meeting on 27 July 2023 were noted and agreed.

15/22 Supporting Behaviour and Lifestyle Change

15/22a Derby County Community Trust's Health Provision

The Board received a report from the Director of Public Health, Derby. The report informed the HWB of the health programmes delivered through Derby County Community Trust's (DCCT) Health Department.

The officer reported that DCCTs health programme aimed to work collaboratively across the city to improve the health and wellbeing of residents in the city by reducing health inequalities, promoting healthy lifestyles with focus on early intervention, prevention and health promotion.

It was explained that DCCT was funded through external partners including Public Health (city and county), Macmillan, English Footbal League (EFL), amongst many others. They offer free 6 to 12 month lifestyle services for people (and families) aged 3 to 90 plus. Their three key priorities were:

- Supporting children and families
- Enabling active living
- Eating healthier

The DCCTs health team had 24 specialist workers who offer targeted intervention services for children and adults. Examples of programmes were given and include:

- Children and young people
    - Weight management
    - Emotional and mental wellbeing for CYP
    - Dental Hygiene
    - Early Years

- Adults
    - Cancer pre-hab, rehab and palliative care
    - Long term health conditions
    - Menopause
    - Pain Management

The Health programme links to 4 outcomes in the HWB outcome indicators

- Increase the number of children and adults who are a healthy weight
- Reduce harmful alcohol consumption
- Improve participation in physical activity
- Improve mental health and emotional wellbeing

People can self refer to the programmes (except for substance misusing), or they can be referred through a range of partner organisations working with DCCT, such as DCCs Livewell Service, School Nursing Teams, Schools, University Hospitals of Derby and Burton (UHDB).

There are social elements to the programmes like themed lunches, day trips away, intergenerational activities and Green gym. Currently DCCT delivers 45 community bases

session each week across the city.

The key focus for DCCT for next 12 months was to develop a chronic disease plan, widen the green offer programme and to continue diversifying their approach.

The Chair stated that it was good to hear about the work being done which meant health improvement for all in preventative areas. The Board commented on the report and presentations. They were concerned about childrens dental treatments.

The officer highlighted that the service was working with schools and had teaching programmes for school assemblies about childrens dental hygiene. Information packs on oral health are provided to parents. A recent donation of a large quantity of toothbrushes will be given out to children. The service was also working with the Schools Nursing Team. A councillor gave an example of a pilot programme in Manchester schools where a significant reduction in dental health issues had been noted. The officers would investigate this programme.

Councillors were concerned that the programmes provided in Derby were known about and were available to all schools. It was explained that although they were a small team (24), for wider community trust delivery they have trained approximately 70 key deliverers about dental hygiene, so they were linked in to most schools across the city. Each school would have different needs, for some just an Assembly would be sufficient, but others would need additional support like workshops. A councillor asked if the service could be linked to staff in Derby's maintained schools to make them aware of programmes on dental hygiene. The DoPH highlighted the Oral Health Promotion Group and its work across the city and suggested that a report on the full detail of their work could be brought to the Board's next meeting.

Another Board member commented that oral health particularly in young people was one of the key clinical areas being considered. In deprived communities in particular the engagement of the core 20 plus group and of ethnic minorities was the biggest barrier. Larger organisations and statutory partners offer a traditional approach so perhaps there was a need for changing this approach slightly. Derby Health Inequalities Partnership (DHIP) offered their support for programmes like weight management or dental health where young people don't engage.

The Chief Executive of DHU Healthcare thanked officers for their report. DHU are a community interest company providing services across the broader midlands area. The company run the NHS 111 Service and Out of Hours Urgent Care services and are currently seeing an increased number of people attending services with dental problems and hygiene issues. The services offered by DCCT could be integrated into a Directory of Services for use by staff, or self care advice could be given to clients face to face.

The CEX also asked how much did it take to provide this service. He extended an offer to meet with the service providers to discuss how DHU Healthcare can support with resources around staffing by providing voluntary support. There are similar services available in other parts of the country that could be learnt from, perhaps the current service offer could be enhanced. The officer explained that all services were externally funded. Derby City Public Health provide funding for children and young people. The offer of a meeting to discuss support in more detail was welcomed. The Chair suggested that a further report on dentistry be brought to the next meeting with a stronger focus on how the different organisations can

help each other.

A Board member asked how the substance misuse service operated. It was expalained that it was funded by Public Health and referrals came through Rehabilitation; if in treatment they could be referred on to the 12 month programme. A councillor asked for an explanation of referrals to other programmes on offer. It was explained that self referrals were not available for the substance misuse programme but were suitable for most of the other programmes, except for Long COVID where referrals would come from the hospital/clinic or University of Derby. A Board member asked if there were referrals from consultatants or should the relationship between the organisations be strengthened. It was agreed it should be strengthened.

A Board member asked how the service was providing evidence of the impact of their programmes. It was explained that several programmes had been evaluated already. Data was also collected for every new programme, if a new programme did not provide results then it would be re-worked.

The HWB Board:

- **Noted the report and recognised the breadth of work delivered by DCCT and for the Board.**

- **Considered DCCT as a key delivery partner who are integral in health and wellbeing plans moving forward.**

15/22b Update on the Livewell Service

The Board received a report of the Director of Public Health. The report provided the HWB with an update on the Livewell Service including outcomes, current activities, and future plans.

The officer reported that Livewell was Derby City Council's (DCCs) free integrated lifestyle service funding mostly by Public Health. It played a significant role in the HWB outcome indicators of:

- Reducing smoking prevalence
- Improving the number of adults who are a healthy weight
- Improving participation in physical activity
- Improving mental health and wellbeing

The service supports:

- Adult weight management for people aged 18 plus with a BMI greater than 30 or 27.5 for people of Black African, African-Caribbean and Asian ethnicity.
- Stop smoking – tobacco smokers aged 12 plus.
- NHS Health Checks for people aged 40 to74 without existing CVD diagnosis.
- Specialist Programmes.
- Liveability - Weight management for people with learning disabilities.
- Healthy pregnancy (pre and post) Service.

The service offers:

- Up to 12 months support with an adviser.
- Direct Nicotine Replacement Therapy (NRT) supply with no vouchers.
- Free prescribed physical activity across the city and in DCC leisure centres (gym and swim).
- Weight management education course accredited by RSPH.
- Face to face, digital and telephone support available Monday to Thursday 8am to 8pm and Saturday am.
    - Wellbeing workshops – designed with people accessing the service
    - Sleep well
    - Long term conditions
    - Mindfulness and eating habits
    - Resilience
- Escape – pain courses for people suffering with back, hip and knee pain.
- Cook and Eat workshops.

The Headline outcomes for 2022-23 were indicated:
716 people joined to lose weight 54% achieved at least 5% weight loss
613 people achieved a 4 week smoking quit (62% quit rate)
961 Community NHS Health Checks completed
91% would recommend to a friend or family member.

The Board were informed that the prevalence of smoking for the adult population in Derby has decreased to 13.2% in recent years, the national average was 13%. The service endeavours to work in different ways to help people who would not normally engage with smoking cessation services. An example was working with communities and organisations where the prevalence of smoking was high, like social housing providers and routine or manual workforces. The Board heard that 44% of Livewell's weight management clients and 55% of smoking cessation clients live in the 7 most deprived wards in the city.

The Board were reassured by the report. A councillor highlighted the danger to health of some ultra processed foods, and asked if a video of the workshop undertaken by Livewell could be made available on the Livewell Website for people to access. The officer confirmed there was a Livewell Channel available to stream live workouts and that Workshops could be recorded and made available to access if the resources were available.

The Board were concerned about vaping and asked what could be done. The DoPH explained it was a complicated issue. Vaping was less harmful than smoking but if a person did not smoke then vaping should not be encouraged as there was uncertainty about the potential risks. There are groups who see switching to vaping being of value to those who are trying to quit smoking but finding it hard. Children vaping was an issue, the challenge being the number of vaping products being marketed to children and young people. Headteachers had concerns about children vaping in schools. Public Health are working with schools looking at their programmes of work and also with Trading Standards considering their enforcement around illegal vapes. There was uncertainty about the contents of illegal vapes. Public Health were working with University of Derby around analysing the content of vapes and what was coming through the vaper.

A Committee member asked where Community Health Checks are carried out. The officer explained they mainly take place at two locations, the Council House and Florence Nightingale Hospital, to limit moving of testing equipment between sites. However, at various

times of the year Community Checks were at several different workplaces around the City. Church Halls and Derby Homes Buildings had been used.

One councillor asked if people could access the weight loss management course through self referral more than once. It was confirmed that for weight management loss courses it was only possible to access on one occasion, because only a very small number of people can be supported on the programme. A lot of work was done prior to people beginning the weight management course to ensure it was the right time for them to start.

The Chair suggested there was a case for having a report around food, which was underepresented on some of the current health strategies, and it was an important and complex issue in terms of the food industry and the individual choices of people.

A Board member stated it was reassuring to see Normanton as a point of focus. A Derby Health Inequalities Partnership (DHIP) consultation around services commissioned by Public Health had shown that this was an area where work needed to be done. He asked if demographics recorded ethnicity data around the community and core 20plus group ? He stated that access was a major issue and not enough work was being done to engage communities in the best way. He asked where do you see gaps in provision and what is you plan to overcome them ?

The officer explained that specific work was targeted. Demographic information was recorded, 73% services accessed last year were of White British origin, the rest was made up of vast array of different ethnicities. The annual report of age, gender ethnicity and breakdown would be shared once completed. There were gaps in knowledge and provision around “smoking cessation”. There was a need to engage with Eastern European communities to understand why smoking was not seen as an issue. There were gaps around the diversity of messaging around healthy eating, for example “South Asian Eat Well Plate” The service had worked with people to buy the typical food eaten by them and put it on an Eat Well plate. The work had taken time and resources, but now there are colleagues from other organisations who are willing to work together to provide their support differently. It was hoped that next year the annual report will show a positive improvement.

Some comments from a Board Member highlighted the issues of access to services. Organisations within health and social care, the public sector and anchor organisations should commit to the Livewell initiative, employees in these organisations should also be encouraged to support the programme. There was support for these programmes in other parts of the country where programmes are sited in locations like leisure centres and football stadiums It was known that people already go to those locations, so services located there can be prescribed for them. It was about putting services in the right locations to enable easy access.

The HWB Board noted the report.

16/23 Derby Poverty Commission

The Board received a report and presentation from the Vice Chair of Derby Poverty Commission which gave an update on the progress and achievements of the Derby Poverty Commission to the HWB.

The officer provided data about the national and local position. The Board learnt that nationally an estimated 14.5 million people are living in poverty. 1 in 7 households had experienced food insecurity during the last 12 months. 7.3 million low-income households reported going without essentials like showers, essential transport journeys and warm homes.

Locally in Derby City there was an increase of 4,789 on the previous year, and a 9% rise since 2015. 38.3% of children were living in Poverty in 2021/2022, this equalled 23,099 children.

Of the 374 local authority (district/unitary) areas in the UK, Derby falls into the top 5% of those LA's with the highest rates of both variants (absolute & relative) of child poverty. In the case of children living in households in absolute poverty it was ranked 10th of 374.

Between 2021 and 2022 children aged 0-15 in relative low-income families:

- in Derby South 47.6% children were living in poverty (this puts Derby South in the top 3% of worst constituencies for child poverty).
- In Derby North 35.4% children were living in poverty

Some of the impacts were highlighted:

People are going without the basics - Derby Food 4 Thought Alliance is providing an average of 2,300 food parcels per month.

Families are increasingly struggling with Adverse Childhood Experiences (ACE's):

- Mental illness was present in 70% of the households
- Domestic violence in 64% of the households
- Neglect in 55% of the households

The officer reported that the Derby Poverty Commission was an independently-led commission launched in April 2021. The Commission's purpose was to:

- Understand the nature of poverty and inequality in the city of Derby
- Scrutinise the scope, range and impact of poverty
- Communicate to stakeholders about the nature of poverty
- Examine the causes of poverty
- Make recommendations and proposals for alleviating poverty.

Phase 1 was launched in Autumn 2022, with 7 individuals from across the city who had a range of experiences; the asylum process, care leavers, disability, living in a high deprivation area, social housing tenants, personal carers, mental health sufferers, and those impacted by bereavement. The Derby Poverty Truth Commission held a launch event in May, where the 7 individuals shared their personal stories to an audience of leaders across the city, with an invitation to those in attendance to join the Commission going forwards.

The issues raised were:

- Poor response from Housing Providers in resolving disrepair claims causing knock-on issues
- Difficulties with using on-line services

- Being made homeless through poor management of housing succession
- Insensitive/unhelpful responses from organisations that should have helped
- Asylum seeker's 10 year wait for resolution of her case.
- Being made to feel like a number not a person.
- Bereavement and the impacts the system causes or exacerbates to those who remain.

The Board felt the presentation was succinct and gave an update on the overall picture. They understood that Child Poverty was a real concern that needed to be addressed.

Children in poverty are often seen in homelessness service. People are placed in Bed & Breakfast arrangements where there was no access to cooking facilities, people should have access to cooking facilities. There was a gap between local housing allowance and local rental cost. There was a huge impact by the cost of living which stopped people from affording a property, top up rent was available but this was not a long term solution as it was too expensive. How can the accommodation need be provided for in Derby.

A councillor suggested using Churches, Faith Groups and community buildings. Councillors could contact Localities Teams to see if cooking facilities were available in their area. It was understood that the cost of electricity would be an issue. The Vice Chair of Derby Poverty Commission and the Head of Housing and Homelessness agreed to meet to discuss possible options and then meet with the Head of Community Safety and Localities.

A councillor asked that poverty was a national issue were there any links or learning that could be obtained from other cities and towns. The contacts already in place were described for the Boards information. They included the Poverty Truth Network, the Joseph Rowntree Foundation, Greater Manchester Poverty Action. The Child Poverty Action Group had visited Derby, where a cost of the school day session had been run with partners to share learning. Community and Faith Groups could be involved, but they would need training, a Councillor suggested that she and other councillors could support, but they would need training. The DoPH suggested this idea could be considered. It was asked if a "Buddy/ Champions" Scheme could be established for people to contact, it was important to listen to people.

A Board member suggested that local public sector organisations with restaurants could be asked to recycle food into their local communities. Approaching "FareShare" Charity was suggested using the OLIO app for sharing, giving away, or getting, items in communities for free to reduce household and food waste.

The Board were thanked for all their comments. There was a poverty crisis at the moment and there should be further discussion on this issue. Social economic factors are a key determinant on ill health.

The Board:

1. **Noted the report and the highlighted focus areas of the Derby Poverty Commisssion's work.**

2. **Considered the opportunities for the HWB to engage with and support the Derby Poverty Commission and vice versa.**

3. **Understood the work of the Poverty Truth Commission and considered**

opportunities for engagement with it.

4. **Considered the research into the impact of children relying on food-parcels long-term and its effect on their nutritional intake and development.**

5. **Considered the wider impacts of deprivation and poverty on the wellbeing and mental health of those facing the challenges long-term.**

Items for Information

17/23 Joint Local Health and Wellbeing Strategy Update

The Board received a report of the Director of Public Health which provided an update of plans and progress to update the Joint Local Health and Wellbeing Strategy (JLHWS).

The officer reported that the HWB, Place Partnership and Derby Health Inequalities Partnership (DHIP) have a shared place-based ambition to improve population health and reduce health inequalities for the people of Derby. This provided an opportunity to develop a shared strategy to meet the ambition.

An initial discovery workshop was held on 25 July 2023 with community representatives from DHIP. The workshop explored the understanding of the HWB and its purpose and to created an opportunity to work collaboratively with members of HWB and Place Partnership.

It was recommended that a joint workshop be held in partnership with the HWB and Place Partnership to explore next steps. The workshop should take place before the end of October 2023. The Board heard that it was key that HWB members wre engaged in the process and that invitations to the HWB Board members for the October Workshop would be sent out in the near future.

The HWB Board

1. **Noted and supported the progress made to refresh the JLHWS in collaboration with Derby Health Inequalities Partnership (DHIP) and the Derby Place Partnership, as agreed in March 2023.**

2. **Noted the outputs and learning from the initial discovery workshop held in July 2023, with members of DHIP.**

3. **Noted that further workshops are planned between September 2023 and March 2024, and HWB members should actively participate in a joint planning workshop, in partnership with other stakeholders, by the end of October 2023.**

Private Items

None were submitted.

MINUTES END

PUBLIC

MINUTES of a meeting of **HEALTH AND WELLBEING BOARD** held on Thursday, 5 October 2023 at Council Chamber, County Hall, Matlock, DE4 3AG.

PRESENT

Councillor C Hart (in the Chair)

Councillors J Patten, J Davies, M Dooley, A McKeown, E Sherman, and A Archer.

Also in attendance was A Appleton, T Braund, J Creaghan, H Gleeson, J Gracey, K Hanson, E Houlston, E Langton, S Lee, H McDougall, S Millar, K Monk, C Stanbrook, and R Wright.

Attended Virtually – C Clayton.

Apologies for absence were submitted for Councillors M Burfoot, N Hoy, C Poole, K Rouse, and C Cammiss, J Corner, H Henderson, S Scott, S Stevens, G Smith, B Webster.

In quorate meeting

There were not a sufficient number of board members present to transact business and cast votes, therefore the meeting took place to note the information shared.

36/23 MINUTES

The following amendment had been suggested;

Minute number 34/23 to include in the resolution the addition of the review of the statutory action on the next ICP agenda.

37/23 DRAFT LOCAL HEALTH AND WELLBEING STRATEGY

The Health and Wellbeing Board were provided with a report and presentation, providing an update on the proposed priorities / areas of focus of the new Joint Local Health and Wellbeing Strategy.

Officers had clarified that the restrictions on non-essential spending at Derbyshire County Council would not impact any areas of work discussed.

RESOLVED;

1) That Board Members note the report.

38/23 ANNUAL SECTION 75 UPDATE FOR 0-19 COMMISSIONED SERVICES

The Health and Wellbeing Board were provided with a report, providing detail on the progress made within the Section 75 agreement for commissioned 0-19 Public Health Services over the period September 2021 to March 2023.

It had been outlined that regular reporting for the Section 75 agreement would transfer to the County Place Partnership Board, with the Health and Wellbeing Board retaining strategic oversight.

RESOLVED;

1) That Board Members note the report.

39/23 WINTER PREPAREDNESS AND COST OF LIVING UPDATE - OVERVIEW OF SUPPORT TO DERBYSHIRE RESIDENTS

The Health and Wellbeing Board were provided with a report and presentation, sharing the overview of support being offered to Derbyshire residents in the most vulnerable communities.

The Board were asked to review the current position and consider any further opportunities that could encourage and strengthen the broad partnership response on this key issue to help mitigate the adverse effects of the cost-of-living and winter pressures.

RESOLVED;

1) That Board Members note the report.

40/23 TOBACCO CONTROL IN DERBYSHIRE

The Health and Wellbeing Board were provided with a report and presentation, informing that Derbyshire Public Health were completing a Tobacco Control Health Needs Assessment and would implement a comprehensive tobacco control framework for Derbyshire.

It had been suggested that tobacco control should be a key priority in the new Joint Health and Wellbeing Strategy.

There had been a government announcement that the age of sale was to be raised and that funding for stopping smoking provision would be made available.

RESOLVED;

1) That Board Members note the report.

41/23 BETTER CARE FUND OUTTURN REPORT AND BETTER CARE FUND PLANNING SUBMISSION

The Health and Wellbeing Board were provided with a report, outlining the 2023-25 Better Care Fund Plan for Derbyshire as well as the proposal to review local BCF processes and arrangements to ensure match with local health, social care, and housing system priorities.

RESOLVED;

1) That Board Members note the report.

42/23 MENTAL HEALTH AND SUICIDE PREVENTION

The Health and Wellbeing Board were provided with a report and presentation, outlining the high need and the broad range of influencing factors around mental health in Derbyshire to inform the Joint Health and Wellbeing strategy development.

RESOLVED;

1) That Board Members note the report.

43/23 HEALTH PROTECTION BOARD UPDATE

The Health and Wellbeing Board were provided with a report, noting the key messages arising at the Derbyshire Health Protection Board from its meetings on 23 June and 8 September.

RESOLVED;

1) That Board Members note the report.

44/23 HEALTH AND WELLBEING ROUND UP

The Health and Wellbeing Board were provided with a report, providing a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda.

RESOLVED;

1) That Board Members note the report.

45/23 ANY OTHER BUSINESS

Board Members shared thanks to colleagues for the work done collating the agenda and balancing the wider deterrents of health.

NHS
Derby and Derbyshire
Integrated Care Board

MINUTES OF THE AUDIT AND GOVERNANCE COMMITTEE

HELD ON 10 AUGUST 2023 VIA MS TEAMS AT 2.00PM

Present:		
Sue Sunderland	SS	Non-Executive Director/Audit Chair
Jill Dentith	JD	Non-Executive Director
Margaret Gildea	MG	Non-Executive Director
In Attendance:		
Lisa Butler	LB	Complaints and PALs Manager (part)
Helen Dillistone	HD	Chief of Staff
Debbie Donaldson	DD	EA to Chief Finance Officer (note taker)
Richard Heaton	RH	Business Resilience Manager
Donna Johnson	DJ	Acting Assistant Chief Finance Officer
Chris Leach	CL	Head of EPRR (part)
James Lunn	JL	Head of Human Resources and Organisational Development
Usman Niazi	UN	Client Manager, 360 Assurance
Glynis Onley	GO	Assistant Director, 360 Assurance
Fran Palmer	FP	Corporate Governance Manager (part)
Chrissy Tucker	CT	Director of Corporate Delivery
Richard Ward	RW	Head of Procurement (ICB) Arden and GEM CSU (part)
Apologies:		
Andrew Cardoza	AC	Audit Director, KPMG
Ged Connolly-Thompson	GCT	Head of Digital Development & Digital Health Skills Development Network Lead
Darran Green	DG	Acting Operational Director of Finance
Keith Griffiths	KG	Chief Finance Officer
Martin Ndoro	MN	Audit Manager, KPMG
Suzanne Pickering	SP	Head of Governance

Item No.	Item	Action
AG/2324/214	**Welcome, introductions and apologies.** Sue Sunderland as Chair welcomed all members to the meeting. Apologies were received from Andrew Cardoza, Martin Ndoro, Darran Green, Suzanne Pickering, Ged Connolly-Thompson and Keith Griffiths	
AG/2324/215	**Confirmation of Quoracy** The Chair declared the meeting quorate.	
AG/2324/216	**Declarations of Interest** The Chair reminded Committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the Integrated Care Board (ICB). Declarations declared by members of the Audit and Governance Committee are listed in the ICB's Register of Interests and included	

	with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: www.derbyandderbyshire.icb.nhs.uk No declarations of interest were made at today's meeting.	
	AUDIT	
AG/2324/217	**Internal Audit** **Progress Report:** Since the last Audit and Governance Committee 360 Assurance had: • Issued the final report resulting from the 2023/24 Data Security and Protection Toolkit review – Substantial Assurance (based on NHS England Assurance Levels) • Issued the final report resulting from the 2023/24 Safeguarding review – Significant Assurance. It was noted that this had one medium and three low risk actions. • Issued Terms of Reference for the 2023/24 Head of Internal Audit Work Programme (included as Appendix B). There were no significant changes to that work programme. • Issued the draft report resulting from the 2022/23 Committee Effectiveness review. This was currently being finalised with ICB Officers. The draft report would then be circulated to Committee Chairs for review before the final report was issued. • Issued draft Terms of Reference for System Wide Discharge Management – management comment was awaited from System partners. A summary of the status of all follow-up activity had been attached at Appendix C of the progress report. However, Glynis Onley drew the committee's attention to the following: • The ICB's follow up rate was based on the first follow up; these were actions which were implemented by the original due date. The first follow up rate in 2023/24 was currently 50% and the overall implementation rate was 75%. • Eight actions had fallen due since 1 April 2023 and four of these had been implemented within the original due date and two had been implemented outside the original due date. • An additional nine actions related to the Transformation and Efficiency review which was the subject of a separate follow up and hence these actions had been excluded from the calculation of the implementation rate. A meeting was to be arranged with Keith Griffiths and Tamsin Hooton to agree more formalised implementation dates. 360 Assurance proposed to revisit that follow up towards Q4 as part of their programme. • The two overdue actions related to Committee Terms of Reference. A revised implementation date of 30 September 2023 had been agreed for these two actions. • A request to amend an item in the plan had been received from Mick Burrows to cancel S117 process out of the current years	

	plan. The request to the change had been made on the basis that it was not appropriate or gives value for money at the current time. A proposal had been put forward to replace this review with Mental Health Act Assessment Claims. • It was noted that Audit Committee was supportive of deferring the S117 review from the plan to Q4 rather than cancelling it. It was agreed that the Mental Health Act Assessment Claims would be covered through the PPV focus work. • The Chair encouraged members of staff to implement the follow up actions within the agreed timescales. **Audit and Governance Committee NOTED the progress report from 360 Assurance.**	
FOR DECISION		
AG/2223/218	**Terms of Reference** Helen Dillistone reported that the Audit and Governance Committee Terms of Reference was formally adopted by the ICB Board on the 1st July 2022. The Terms of Reference (TOR) had been reviewed as part of the annual review and following the formal delegated responsibility of the Primary Medical Services, Pharmaceutical Services and Local Pharmaceutical Services, Primary Ophthalmic Services and Primary Dental Services delegation from NHSE. The Terms of Reference, were published on the ICB website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the ICB Board. Recommended changes to the Terms of Reference were highlighted in red tracked changes. Helen Dillistone reported that the Committee was required to review and agree the Terms of Reference for recommendation to the ICB Board for approval. It was noted that the Terms of Reference would be reviewed every 6 months. Jill Dentith highlighted the use of acronyms in the TOR and asked that these be put in full initially. She went on to add that the TOR had been amended due in part to the ICBs delegated responsibility, but they seemed to have excluded GP services; these she felt needed to be added. Helen Dillistone thanked Jill Dentith for highlighting these issues and agreed to make the necessary amendments to the TOR. Jill Dentith requested some clarity regarding Estates in the TOR. She reported that she was currently Chair of System Finance and Estates Committee and asked whether there was an overlap with what Audit Committee were doing, or whether this was more about the general strategic and assurance process that was being dealt with, as the TOR just referenced estates – there was nothing that linked it in the scheme of delegation.	

	It was noted that Margaret Gildea was the Freedom to Speak up Guardian. The TOR referred to the Freedom to Speak up Guardian being invited to this Committee by invitation, this now needed to be amended to state that Margaret Gildea was now a full member of this Committee. Donna Johnson reported that the TOR in some areas referenced Director of Finance/Executive Director of Finance, the TOR needed to be amended to the title of Chief Finance Officer to be consistent with the Scheme of Delegation and Constitution. Donna Johnson referred to paragraph 2.4 which referred to the Prime Financial Policies, she reported that we did not have these anymore, we just had Standing Financial Instructions. The Chair referred to the membership of this Committee, she reported that we had three Non-Executive Members, not four as stated in the TOR. Helen Dillistone agreed to make all the necessary amendments detailed above to the TOR. **The Audit and Governance Committee APPROVED the Committee's Terms of Reference, incorporating the above amendments, for recommendation to the ICB Board for approval in September 2023.**	HD/SP
AG/2324/219	**Audit and Governance Policies** **Complaints Handling Policy:** Lisa Butler explained that the ICB Complaints Policy provided a framework and guidance on the procedure for the handling of complaints and the resulting actions in line with the Local Authority Social Services and NHS Complaints (England) Regulations 2009, the NHS Constitution and the principles of remedy set by the Parliamentary and Health Service Ombudsman (PHSO). Following delegation from NHSE on the 1st July 2023, the policy had been updated to reflect the ICB's statutory responsibility for complaint handling for Primary Care services, which included General Practices, Dentists, Pharmacists, and Opticians. All amendments were detailed in red within the policy. Jill Dentith highlighted Helen Dillistone's title contained within this policy (Executive Director of Corporate Affairs), this now needed to be updated to read Chief of Staff. It was noted that this was an internal facing policy, and not for the use by the general public. Lisa Butler explained that complaints would be managed by the East Midlands Complaints Hub, which would be hosted by NHS Nottingham and Nottinghamshire ICB. The DDICB had a data sharing agreement in place with NHS Nottingham and Nottinghamshire Integrated Care Board for the handling of Primary Care related complaints.	LB

	The Hub would handle the complaint and carry out a complaint investigation review on behalf of the ICB where this was required. The ICB would hold overall responsibility for the complaint with sign off by the Chief Executive Officer. **The Audit and Governance Committee APPROVED the Complaints Handling Policy with the above amendment.** **Lone Worker Policy**: Richard Heaton explained as a Public Sector organisation, the ICB had a duty to ensure the safety, health, and welfare of our workforce whilst at work. That duty extended to employees who travelled during their work and those who worked away from our core premises. The Lone Worker Policy was drafted for the ICB as a 'lift and shift' from the CCG to NHS Derby and Derbyshire ICB, with a further review then taking place by colleagues in the Medicines Management Team, due to the high number of staff classed as 'lone workers' within this directorate. The policy had also been reviewed by a Health and Safety Consultant at Peninsula. The Chair referred to Item 6 of the policy, the opening sentence stated, *'In the vast majority of work activities lone working is not illegal',* she asked for clarification as to why this had been stated and was it relevant; she hoped the ICB was not doing anything illegal? Helen Dillistone wondered whether this sentence was linked to clinical policy and clinical known workers, she suggested that Richard Heaton take advice on this. The Chair reported that if we needed to state this in the policy, then it needed more context around it. Jill Dentith referred to paragraph 1.1, *'This policy applies to NHS Derby and Derbyshire Integrated Care Board, subsequently referred to in this document as the ICB'*, she asked whether in fact that it should link back to ICB staff and not the ICB Board? Richard Heaton agreed to review the wording for 1.1 and take advice for Item 6 of this policy. Jill Dentith highlighted Appendix 2, paragraph 3.6.2 which referred to an annual review, and asked whether this was frequent enough? Richard Heaton reported that various things could prompt a review of this policy, and therefore could be more frequent if things changed. **The Audit and Governance Committee APPROVED the Lone Worker Policy.**	RH RH
CORPORATE ASSURANCE		
GOVERNANCE		
AG/2324/220	**Board Assurance Framework - Quarter 1 2023/24** Chrissy Tucker presented the Board Assurance Framework for Quarter 1 2023/24 and explained that nine Strategic Risks had been identified in the Derbyshire system in the delivery of our aims.	

	It was noted that since the last presentation of the BAF to Committee, further development had taken place to strengthen our response to those risks and the mitigating actions. Chrissy Tucker reported that we had now put in place a cross referencing and action monitoring system to ensure that all the gaps in control had an agreed action to close that gap, and any progress on those actions would be monitored. There had been no movement in scores on those Risks for this Quarter. Jill Dentith referred to Risk SR8 Digital and Data Risk, she thought that this Risk had been agreed to be split; the Digital to Finance and Estates Committee and Data to Quality and Performance Committee, but on the document, it still stated that it was owned wholly by Finance and Estates Committee. Chrissy Tucker reported that we were in the process of doing this update and the Risk would be split in time for the next Committee meeting in October. **The Audit and Governance Committee NOTED the Quarter 1 BAF Strategic Risks 1 to 9 approved by the ICB Board on 15th June 2023.**	
AG/2324/221	**ICB Corporate Risk Register Report July 2023** Chrissy Tucker presented the ICB Corporate Risk Register Report for July 2023. Committee was asked to note the position of the five risks it had responsibility for, two of those risks were scored in the high category, namely the risks around climate change and staff wellbeing. Updates on those mitigating actions were given in appendix 1 to the cover sheet. The three remaining risks had been scored low and all five risks were detailed in appendix 2. Committee were asked to note the virtual approval received for the decrease in score for Risk 15 relating to the ICB not having sufficient resource and capacity to service the functions to be delegated by NHSE. Jill Dentith referred to Risk 16 '*Risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being',* and asked for further clarification regarding the 'uncertainty' of what? Chrissy Tucker reported that this Risk needed rewording as it referred to Running Cost Allowance/Structure Changes. Chrissy Tucker agreed to update the wording of this risk. **The Audit and Governance Committee:** • **RECEIVED the Risks responsible to the Committee as detailed in Appendix 1.** • **NOTED the virtual approval received for the decrease in score for Risk 15 relating to the ICB not having sufficient**	CT

	resource and capacity to service the functions to be delegated by NHSE. • **NOTED Appendix 2 which detailed the full ICB Corporate Risk Register.**	
AG/2324/222	**Staff Survey 2022 - Action Plan** Helen Dillistone reported that the staff survey 2022 action plan had come to Committee for assurance. The following was highlighted: • The ICB had participated in a national NHS staff survey in 2022. • A full report was taken to June 2023 ICB Board and there had been a full discussion with members. • We needed to develop an action plan to support some of the themes that had emerged from the staff survey. • We had scores/results from last year as well as this year and comparative scores from other like for like organisations. • The results had been tested with our staff network groups eg Diversity Inclusion Network and Organisational Effectiveness and Improvement Group (OEIG). • There were areas that we would like to focus on. • Timescales would be worked up as to when we could bring back the action plan to share with Committee. Margaret Gildea highlighted the area regarding inconsistency of treatment; she could not see where in the actions we were going to address inconsistency of treatment between employees in different teams. James Lunn reported that the consistent approach comes in three or four areas of the staff action plan and highlighted the following: • Staff would be able to feedback on the managers. • We would be implementing appraisal training for all line managers to ensure consistent approach to performance development, wellbeing conversations and support for colleagues. • There would be a leadership induction for new and existing leaders around the values and behaviours of the organisation. • There would be an HR induction for line managers/or a refresher for line managers in terms of our policies and procedures. • Senior leadership team would reflect on aspects of consistency with a view to implementing a consistent way of recognising and rewarding colleagues whether that was through a formal award scheme or a more informal but structured kind of feedback process. • OEIG would be taking some suggestions through to SLT regarding this. • These actions would probably develop into some more detailed work, which would be made clear in the action plan.	

	• Case studies would be drawn up so that managers could refer to. Jill Dentith referred to the next phase of this and timescales that were required to develop the action plan. Helen Dillistone reported that monitoring would be taken on a regular basis and quarterly reports would be produced. Audit and Governance Committee would have oversight and regular reports brought back. The new national staff survey would be launched in early October 2023. It was noted that we needed to do more work to embed values and behaviours across the organisation. The Chair requested sight of the action plan with timescales and measures at the next Committee meeting in October 2023. **The Audit and Governance Committee:** • **NOTED the outcome of the joint Organisational Effectiveness and Improvement Group (OEIG) and Diversity and Inclusion Network workshop.** • **APPROVED the recommended staff survey action plan.**	HD
AG/2324/223	**EPRR and Business Continuity Report** The Chair reported that EPRR was a very technical area, the policies put before Committee today appeared to be comprehensive; she was pleased to see that there had been testing. The Chair reported that it would be helpful to understand whether there was any national guidance regarding what should be contained within these policies to ensure we had covered everything. The Chair thought it would be helpful to understand the role of the EPRR Assurance Group. She felt this group should be acting as a mid-way point and that they should be reporting to Audit and Governance Committee that they had reviewed all these policies with their expertise and found them to be robust. The policies could then be put to Audit and Governance Committee for sign off. The Chair asked whether it would be appropriate for the EPRR Assurance Group to take on this role, in order to provide the level of assurance for this Committee as part of the signing off process. Richard Heaton responded that the policies were technical, but this year we had done a great deal more consultation with colleagues and NHSE on the content of them, which had been recorded and we had made sure that we used that information in support of our EPRR submission. It was hoped that this year we were better placed to satisfy the core standards as an ICB and CAT 1 Responder. It was noted that approval was required from Committee to key policies before the end of August 2023, and recorded, in order to meet the standards.	

	Richard Heaton reported there were only three new policies being put forward to Committee today, New and Emerging Pandemics, the Communications Plan, and an On Call Policy. Richard Heaton confirmed that the learning from the testing of these policies were enacted upon and incorporated into the on-call processes. The Chair highlighted the section of the report that summarised the progress against the EPRR core standards for each organisation, quite a few organisations were showing positive progress. However, Derbyshire Healthcare FT seemed to be still indicating non-compliance and EMAS appeared to be deteriorating; the Chair asked whether there was anything that needed to be flagged to members regarding this? Richard Heaton reported that regarding EMAS there were issues with the Manchester Report, and this was influencing some of the progress they could make or otherwise. Derbyshire Healthcare FT had been slow, but were making progress, and the ICB was working with all providers, and this would continue into the next year. Richard Heaton provided an update to Committee on the progress of the Integrated Care Board (ICB) in relation to Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity processes internally and for the system, this update included detail on: • Update on Industrial Action 2023 – NOTED. • DDICB EPRR Policy – Jill Dentith referred to P220, section 5.4.2 which indicated that the 'ICB Executive Team and Board were assured and committed to ensuring suitable and effective resources', and asked whether we were assured or did we get the assurance following the implementation? Chrissy Tucker reported that this related to our internal team resource which had to be increased in order to meet the CAT 1 responsibilities; we felt we had this resource in place now – APPROVED. • DDICB New and Emerging Infectious Diseases and Pandemics Plan – APPROVED. • DDICB Communications Emergency Plan – APPROVED. The Chair reported that the Plan referred to Brigid Stacey being the Chief Nursing Officer on P194; this needed amending to name her replacement. • DDICB Updated Adverse Weather Plan – APPROVED. • DDICB On Call Policy – Section 5 on call payments had been costed into the financial plan – APPROVED. • DDICB Evacuation and Shelter Guidance (incorporating Fire and Bomb Evacuation) – APPROVED. • DDICB Fire and Emergency Evacuation Procedure – APPROVED. • EPRR Core Standards 2023/24 – NOTED. • Training update – NOTED. **The Audit and Governance Committee:** • **NOTED the EPRR and Business Continuity Report.**	

	• **APPROVED the New and Emerging Infectious Diseases and Pandemics Plan, the Communications Emergency Plan, Evacuation and Shelter Guidance (incorporating Fire and Bomb Evacuation) and the Fire and Emergency Evacuation Procedure.**	
AG/2324/224	**Health, Safety and Fire Report** Richard Heaton presented the Health, Safety and Fire Report. The report provided assurance to the Audit and Governance Committee that NHS Derby and Derbyshire ICB was: • Coordinating work to meet its health and safety obligations to remain compliant with health and safety legislation; and • Responding effectively and appropriately to changes in working practices because of moving to a hybrid model. • Providing a biannual health, safety, and fire update. • Training Statistics – there was a high level of compliance to give a level of assurance to Committee. • Two inspections had already been carried out with a third planned for 11 August. Jill Dentith highlighted Action 4 regarding the air conditioning units and asked whether we had a problem with the units, or was it that we had not just received a report due to a timing issue? Richard Heaton confirmed that it was just that we had not received a report yet. Chrissy Tucker reported that engineers had been in to service the air conditioning units at Cardinal Square and a clean report had been received last year. The Chair highlighted the issue regarding first aiders and fire wardens and asked whether hybrid working had affected sufficient coverage in the offices. Richard Heaton reported that sufficient coverage was provided most days. **The Audit and Governance Committee NOTED the Health, Safety and Fire Report.**	
AG/2324/225	**Derbyshire ICS Green Plan** Helen Dillistone presented the Derbyshire ICS Green Plan, which had been brought to Committee for assurance. Helen Dillistone highlighted the following: • Each member organisation had its own individual Trust Green Plan. • The joint ICS Green Plan identified elements which were better undertaken together, where co-ordination was required across organisations or where additional value could be brought to the system by working together.	

	• JUCD established a Greener Delivery Group in June 2021, who initially met bi-monthly and now meets quarterly. The ICB's Chief of Staff is the Chair of the Group. The Derbyshire Provider Trust Sustainability Leads are members, together with specialist Lead Pharmacists within the ICS. • We were performance managed regularly from region regarding our Green Plan. • The workstream areas focused on governance, medicines, Primary Care, travel and transport, estates and facilities, supply chain and procurement and data and digital. • The Derbyshire ICS Green Plan had been approved by the Derbyshire ICS Trust Boards. • The ICS was also a member of the NHS Midlands Regional Greener NHS Delivery Board, established in June 2021. The Board meets bi-monthly and monitors performance on the NHSE Net Zero priorities for carbon reduction. System Review Meetings with NHSE and the ICB take place quarterly. • Main priorities for this year across all our acute settings had been a target to reduce some of the carbon intensive anaesthetic gases used. In community, primary care, medicines management and pharmacy we had done a lot of work with colleagues on the use of inhalers and drug switches from gases to powder for respiratory conditions. • Feedback from the Regulator had indicated that they felt that some of our work on the Green Plan had been exemplary. • It was noted that if Committee would like to see data of the real differences, we could see a year in, this could be brought to a future meeting. • It was noted that there was an important link to the work that we were doing on the green agenda with Estate and Facilities work streams; membership of the green group also included the Estates Leads. Matt Scarborough was the System Estate Lead and he worked very closely with Simon Crowther, so there was a direct line of sight. There were very specific targets around estates which we were working towards. • It was noted that we were not asking for any more resources in terms of 'people' to work on this, and over the last year the green plan had been embedded as part of our existing portfolios. • In terms of investments, the largest part related to this plan would be around the estates and this would be costed as part of the work that Simon Crowther was doing. • The Chair highlighted that there was no comment about the ICB and its own position and footprint within the plan. She felt that there should be a quantified plan for reducing to net zero. • Helen Dillistone reported that the ICBs footprint was marginal in terms of a contributor overall in the system. We had opportunities around staff travel and transport, and we were very much working to a hybrid model and the green agenda played into that operating model. We had two headquarter sites, which we were hoping to significantly reduce to both help drive down the running cost reduction as well as supporting the green agenda. • The ICB saw its role as supporter/coordinator and providing leadership for the System around the Green agenda.	

	• It was noted that in terms of any new procurement by the ICB, all new contracts, and standard NHS contracts would follow the new guidelines. **The Audit and Governance Committee RECEIVED assurance on the Joined-Up Care Derbyshire (JUCD) Integrated Care System (ICS) Green Plan.**	
AG/2324/226	**Internal Audit Recommendations Report** The Chair requested that this item be moved up the agenda to be taken after the Internal Audit Progress Report for future meetings. The tracker was reviewed by members and no questions or comments were raised. **The Audit and Governance Committee NOTED the Internal Audit Recommendations Tracker.**	SP
AG/2324/227	**Mandatory Training Compliance Report** Chrissy Tucker presented the Mandatory Training Compliance Report which indicated compliance figures up to 31 July 2023. It was noted that most compliance figures did not give cause for concern, however, we were investigating low compliance rates for Adult and Children Safeguarding training. It appeared that some teams had been doing the training, but results had not appeared on ESR; there had been one or two technical glitches with ESR previously and sometimes it took a while for those problems to come to our attention. We were checking with ESR currently, and talking to the Safeguarding Team, who had agreed to put out some comms to staff in the next couple of days, to remind everyone to do their training and if staff experienced a problem with ESR to then report it. Chrissy Tucker reported that she was going to work with HR colleagues regarding monitoring arrangements for training going forwards. Margaret Gildea found a lot of the mandatory training was too generic and that it had to be done as a tick box exercise for this Committee; she asked whether it could be tailored to a role without great expense then she felt it would have more value. Chrissy Tucker reported that a lot of these courses were national and where some of these things were a key part of someone's role, then they would then have supplementary training. **The Audit and Governance Committee RECEIVED the Mandatory Training Compliance Report.**	
AG/2324/228	**Estates Update**	

	Chrissy Tucker reported that the ICB was required to make a 30% saving on our running costs, and as part of that we had been reviewing our estate, and how we might consolidate space again at Cardinal Square given hybrid working. A number of options were being worked on and costed out and when a conclusion had been met, a report would be presented to this Committee, hopefully at its next meeting. It was noted that we were also looking at reducing costs at Scarsdale in the next few months, and a couple of providers had enquired about space there. Chrissy Tucker reported that System partners had enquired about space at Cardinal Square, it was hoped that this would help us with income and with our efficiency targets. The Chair was pleased that our estate was under active consideration. **Audit and Governance Committee NOTED this verbal update.**	
AG/2324/229	**National Oversight Framework – Role of Committee** Chrissy Tucker reported that the National Oversight Framework was a monitoring framework, it described how NHSE would work with ICBs and providers in reviewing performance in order to spot early signs of deterioration and to put in any remedial plans and support to help with that. The ICB was required to consider a set of metrics and complete a quarterly template for each of its main providers, which would be used to indicate potential issues and prompt further investigation of support needs and align with the five national themes of the NHS oversight framework namely quality of care, access, and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability. Performance against the metrics was organised into four segments, where segments 3 and 4 attracted mandated support from NHSE as described in Appendix 1. It was noted that up until now, these templates had been reviewed by the Quality and Performance Committee, ICB Executive Team, and NHS Executive Team. However, it was felt that Finance and Estates Committee should have oversight of the financial element of the template and that Audit and Governance Committee should have overall oversight of the templates before we submitted them to NHSE. The proposed governance process would be: • Data released by NHSE. • Draft templates prepared by the corporate team in conjunction with performance, quality, and finance colleagues. • Drafts reviewed by Executive Team • Drafts reviewed by Quality and Performance Committee	

	• Drafts reviewed by Finance and Estates Committee • Templates approved for submission by Audit & Governance Committee • Submission to NHSE • Following submission, templates provided for information to the NHS Executive group. Due to the short time window between the release of data and the formal submission date to NHSE, it may be that drafts would need to be circulated to the Committee by email. The next quarterly submission would be late September and a sample template was attached at Appendix 2 for information. Helen Dillistone clarified that the role proposed for Audit and Governance Committee was not to comment on the content related to nature of performance, quality, and financial metrics, what would be required from this Committee would be to take assurance from the process that we were undertaking. **The Audit and Governance Committee NOTED the process set out in this report.**	
AG/2324/230	**Procurement Highlight Report** Richard Ward explained that this report illustrated the ICB's status of projects in terms of services being in progress, future projects or completed. The status of the project was indicated via a RAG rating identifying the level of risk exposure based on the ICB decisions in terms of Process (timeline), Contracting and Compliance with the regulations. Projects with Medium/High risk at present for the ICB were as follows: **In-progress:** **Triage Service (Clinical)** – there was a red compliance risk against this; however, following a meeting yesterday with commissioners this had been adjusted to amber. There was current uncertainty around the actual value of the contract, but there was some belief now that it was below the financial legislative threshold. Once confirmed, this would be reviewed again, procurement advice would be given, and an updated rag rating would be applied. **Wheelchair Services Project** – within the circulated report this had been rag rated as green, as the intention at the time was to undertake a compliant procurement process to renew the contract, although the timeline was tight and challenging. The ICB intention was now to extend the current contract for a period of 12-18 months to review the model and reprocure. It was noted that the decision to extend the contract was not strictly compliant and the ICB would need to proceed at risk and therefore this rag rating would be amended to red. The level of risk was unknown at this time and	

	there may be a low level of challenge; the level of spend was £3.4m per annum. The Chair requested, on behalf of Audit Committee, that members be given assurance that this contract was going to be properly managed. **Future Projects (Contracts coming up for expiry in the next 18-months):** **Impact+ Respiratory Services (Clinical)** – the ICB had confirmed that a paper would be going to PHSCC and the ICB Board after the summer period. From 1 April it was expected that the service would be varied into the UHDB FT core contract. Procurement had confirmed Regulation 72 which was a variation of contract as a potential option. This was confirmed as compliant by lawyers. This was still rag rated an amber risk from a compliance point of view. The Chair reported that this Committee had queried this contract in the past and was currently on the action log AG2223/145. A separate briefing on the action and learning had been prepared and circulated outside of the Committee schedule summarising what the findings were, why it had been delayed and what improvements had been agreed. Chrissy Tucker reported that Committee had been informed previously that the contract had expired but the procurement routes and legal advice had not been fully explored. It was not known what the current position was. It was noted that discussions were being undertaken with Arden and GEM CSU/Corporate /Commissioning to try and get a more streamlined approach to monitoring contract expiry dates. The Chair agreed to close action AG2223/145 on the action log but requested that a new action be raised to ensure that there was support to the Committee with contract queries going forwards by inviting a Commissioning representative to attend for the Procurement Highlight Report; Chrissy Tucker agreed to take this action. Chrissy Tucker also agreed to forward the email briefing to Jill Dentith as she had not received it. **Community Action Derby (Clinical)** – this was a direct award of contract for 12 months. The spend was below public contract regulations. Compliance with the procurement, patient choice and competition regulations were still required. Although the risk of challenge was likely to be low, there was still possible risk of challenge of criteria stipulated under that set of regulations could not be met. **MSK & Triage Service (Clinical)** – These contracts expired on 31 March 24. It was understood that the intention was to extend these contracts. There was a risk to extending services further as they were non-compliant with PCR15. Commissioners had been advised and accepted the risk. There were potential conflicts of	CT

	interest with System leads and potential challenge from the market as competition was present for these services. **Community Physio for Non-Complex Service (Clinical) and Occupational Therapies (Clinical) –** These two contracts were to be extended from 31 March 24. Richard Ward was not aware of any procurement for these services being undertaken. However, he understood that a review of the model was being undertaken. Chrissy Tucker reported that Craig Cook was working with the Provider Collaborative on a new commissioning and contracting approach for these services. Richard Ward reported that procurement legislation was likely to be changed later this year. It was expected that there would be a lead in period for it to become law. Chrissy Tucker suggested that a joint cover sheet from CSU/Corporate/Commissioning be compiled which pulled out any exceptions and described them to accompany the Procurement Highlight Report going forwards. The Chair agreed that this would be helpful. **The Audit and Governance Committee:** • **REVIEWED the Highlight report for Derby and Derbyshire ICB.** • **NOTED status of projects – future project, in-progress and completed.** • **REVIEWED key issues and activities over the current period.**	CT
FINANCE		
AG/2324/231	**Month 3 ICB Financial Position Review** Donna Johnson reported that as of 30th June 2023, the ICB's financial position was breakeven both year-to-date and forecast outturn. However, the efficiencies had been phased based on an increasing rate of delivery as the year progresses. The ICB efficiency delivery at the end of June 2023 was £0.5m over the year-to-date plan and was forecasting to deliver the efficiencies required to meet the plan. Given that the majority of each line was breakeven, it raised questions to the reality of the outcome or if it was at this point commitment to achieving the target. There was also £27.5m (62%) of red and amber Rag rated schemes, that came with high to medium risk to delivery. Of this, £19.9m related to recurrent delivery which would create a big problem in 2024/25 unless this was achieved. As a result, this cannot be considered a confidence-assured position, and further work must be done to achieve assurance. Within the forecast outturn breakeven position was collective pressures from Primary Care Co-Commissioning funding pressure of £1.0m and Mental Health £0.8m, currently being managed with	

	offsetting benefits. The likely case prediction was a deficit of £6.6m driven by excess inflation. The worst-case scenario of £25.8m deficit included a known pressure on the BCF of £5.0m which would need additional efficiencies identified and put onto ePMO for M4. There were other operational risks, which required Executive Directors to work with their teams, supported by finance colleagues, to manage. On top of this there was risk in delivery of efficiencies of £8.1m, in order to increase assurance on delivery of this, teams had been asked to ensure opportunities go through the relevant gateways, to move them from red and amber to green. Donna Johnson reported at M4 we were still forecasting a breakeven position, but we were seeing new pressures particularly on prescribing. A lot of the pricing we were seeing was much higher than expected, and on speaking to other ICBs they too had been seeing this over the last couple of months. Donna Johnson reported that this would be flagged as an overspend and part of our excess inflation in our likely position to NHSE. It was noted that the BCF risk had been reported as having materialised and was in the position. To mitigate this, we had put in the additional £5m of efficiencies. Donna Johnson reported that we were mitigating the prescribing risk with dental allocations. It was noted that we could see that dental was underspending, but this was a ring-fenced allocation. It was noted that across the region and nationally we were seeing other ICBs reporting that underspend in order to flag it to NHSE. As we could not spend that money, we were using it to mitigate the prescribing risk. Although we were forecasting breakeven, it was noted that NHSE were fully aware of the pressures we were facing and what scenarios we were looking at; we had been totally transparent about where the risks were and what we were doing about it. Jill Dentith asked whether we were going to get any national support for the prescribing inflation issues? Donna Johnson reported that this was still to be determined and was out of our control. Regarding the dental allocation, there were no NHS dentists to deliver this work and that was why patients were unable to get an NHS dentist. As previously stated, the dental underspend was being flagged to NHSE. **The Audit and Governance Committee NOTED the M3 ICB Financial Position.**	
AG/2324/232	**Aged Debt/Write Offs/ Losses and Special Payments Report** Donna Johnson presented the Aged Debt/Wright Offs/Losses and Special Payments Report. It was noted that there was minimal aged debt, and there had been a couple of small risks identified in the report.	

	No comments or questions were raised. **The Audit and Governance Committee NOTED the report contents regarding the level of aged debt at 30 June 2023.**	
AG/2324/233	**Single Tender Waiver Report** Donna Johnson explained that this paper included a report of the Single Tender Waivers (STWs) received and approved following those reported at the ICB's February 2023 Audit & Governance Committee and 31st July 2023, along with trend analysis to show the change in number of STWs approved year on year. It was noted that the level of STWs had been comparable over the past two years as the organisation engaged with the procurement process and where STWs were required. No comments or questions were raised. **The Audit and Governance Committee NOTED the report of Single Tender Waivers approved by the Chief Finance Officer.**	
	FOR INFORMATION	
AG/2324/234	**Non-Clinical Adverse Incidents** Chrissy Tucker reported that there had been no non-clinical adverse incidents. The Junior Doctor and Consultant industrial action continued during August. The Junior Doctors had planned industrial action from tomorrow until 15 August with Consultants action from 24-28 August. It was noted that plans were in place to help mitigate these actions. **Audit and Governance Committee NOTED this verbal update.**	
AG/2324/235	**Primary Care Pharmacy Optometry and Dental Delegated Services Update** Chrissy Tucker reported that this item had been placed on the agenda to give assurance on the transfer of those services from NHSE to ICBs from 1 July 2023. Chrissy Tucker reported that the paper described governance arrangements that had been established and the documentation agreed and signed off in support. Notts ICB were hosting this on behalf of the East Midlands ICBs. Chrissy Tucker reported that we were starting to see a little bit of an impact on our Complaints Teams which would be monitored going forwards. It was noted that we were now planning for the transfer of the specialised commissioning functions from April 2024 and updates on this would be brought to future Committees.	

	No comments or questions were raised. **The Audit and Governance Committee RECEIVED the update for information and GAINED ASSURANCE in relation to the final governance documents being signed by the ICB.**	
AG/2324/236	**Annual Assessment of Derby and Derbyshire ICB's performance in 2022/23 letter** Helen Dillistone reported that this letter was on the agenda for information; the ICB Board would also have sight of this letter. It was noted that the letter would be taken through the Executive Team and System NHS Executive Team to be worked through. It was felt that it was a balanced and accurate record of where the organisation and more broadly where the System was now. The Chair concurred with this. No comments or questions were raised. **Audit and Governance Committee NOTED this letter.**	
	MINUTES AND MATTERS ARISING	
AG/2324/237	**Minutes from the Audit and Governance Committee Meeting held on 8 June 2023** The minutes from the meeting held on 8 June 2023 were agreed as a true and accurate record.	
AG/2324/238	**Action Log from the Audit Committee meeting held on 8 June 2023** The action log was reviewed and updated during the meeting.	
	CLOSING ITEMS	
AG/2324/239	**Forward Planner** **The Audit and Governance Committee NOTED the Forward Planner.**	
AG/2324/240	**Assurance Questions:** Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **YES**	
	Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? **YES**	
	Has the committee discussed everything identified under the BAF and/or Risk Register, and are there any changes to be made to these documents as a result of these discussions? **YES**	
	Were papers that have already been reported on at another committee presented to you in a summary form? **NO**	
	Was the content of the papers suitable and appropriate for the public domain? **YES**	
	Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? **YES**	

	Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? **NO**	
	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? **NONE**	
AG/2324/241	**Any Other Business** **Fit and Proper Person Test for Board Members:** Helen Dillistone explained that we had received new guidance entitled 'Fit and Proper Person Test for Board Members', which related to both existing and new Board members. The ICB Chair would be writing to existing Board Members regarding what needed to be done as an existing Board, as well as then highlighting to colleagues what needed to be in place for any new appointments that we made. James Lunn reported that for existing Board Members there would be a requirement for completion of an annual Fit and Proper Person Self Attestation Form, to confirm that they were in adherence with the FPPT requirements, with the outcome being entered onto the Electronic Staff Record (ESR). The Chair would be required to submit outcomes of the test for each Board member to the NHSE Regional Director. The annual attestation by Board Members was expected to be undertaken at the same time as the annual appraisal process and assessment of competence against the six competency domains of the LCF, would also be used to guide the Board member's development plan for the coming year. The line manager would also capture stakeholder feedback as part of the appraisal process and summarise competence against each of the six competency domains. The annual appraisals of the past three years would then be used to guide the Board member's reference. New data points were being added to ESR to record the testing of relevant information about Board members' qualifications and career history. The FPPT information within ESR was only accessible within the Board member's own organisation and there was no public register. **The Audit and Governance Committee NOTED the requirements of the new Fit and Proper Person Test Framework for Board Members.** There was no further business.	

DATE AND TIME OF NEXT MEETING
Date: Thursday 12 October 2023
Time: 2.00PM
Venue: MS Teams

Signed: …… Dated: ……..
(Chair)

Derby and Derbyshire
Integrated Care Board

MINUTES OF THE PUBLIC PARTNERSHIP COMMITTEE

HELD ON: 29 August 2023, 10:00 – 12:00

VIA MS TEAMS

Present:		
Julian Corner	JC	Non-Executive Member DDICB **(Chair)**
Steven Bramley	SB	Lay Representative
Val Haylett	VH	Governor, University Hospitals of Derby and Burton NHS Foundation Trust
Karen Lloyd	KL	Head of Engagement, DDICB
Tim Peacock	TP	Lay Representative
Amy Salt	AS	Engagement and Involvement Manager, Healthwatch Derbyshire
Jocelyn Street	JS	Lay Representative
Sue Sunderland	SS	Non-Executive Member, DDICB
Sean Thornton	ST	Deputy Director Communications and Engagement, DDICB
Lynn Walshaw	LW	Deputy Lead Governor, Derbyshire Community Health Services NHS Foundation Trust
Carol Warren	CW	Lead Governor, Chesterfield Royal Hospital
In Attendance:		
Angela Deakin	AD	Asst Director Condition Specific Pathway & Commissioning, DDICB
Lucinda Frearson	LF	Executive Assistant, DDICB (Admin)
Sam Hardy-Ainger	SHA	Commissioning Manager Condition Specific Pathway, DDICB
James Lewis	JL	Head of Joint Strategic Commissioning, Learning Disabilities & Autism, DDICB
Apologies:		
Helen Dillistone	HD	Executive Director of Corporate Affairs, DDICB
Hazel Parkyn	HP	Governor, Derbyshire Healthcare NHS Foundation Trust
Maura Teager	MT	Lead Governor, University Hospitals of Derby and Burton NHS Foundation Trust

Item No.	Item	Action
PPC/2324/030	**Welcome, Introductions and Apologies** Julian Corner (JC) as Chair welcomed all to the meeting with apologies being noted as above.	
PPC/2324/031	**Confirmation of Quoracy** The meeting was confirmed as quorate.	
PPC/2324/032	**Declarations of Interest** JC reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the Integrated Care Board (ICB).	

	Declarations declared by members of the Public Partnerships Committee (PPC) are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: www.derbyandderbyshire.icb.nhs.uk Declarations of interest from today's meeting: No declarations of interest were made during today's meeting.	
	ITEMS FOR DECISION	
PPC/2324/033	**Learning Disability Short Breaks** The paper was presented by James Lewis (JL) the purpose of which was to provide understanding around how best to utilise short breaks provision across Derbyshire and to ensure the right services were being offered to the right people at the right time, making best use of the resources available. The paper was taken as read. JL added that this was a long-standing piece of work for a small number of families who have been unsure for many years around these services, and he was looking for guidance and advice on the engagement process from members of the committee. The paper summarised the approach taken to look at and understand the need of families. Now that understanding had been gained the next step was to go out to families and staff and discuss how they see things moving forward, noting the importance of bringing to the committee's attention as this will become an ever-increasing topic. The Committee offered the following comments and questions: - • JC highlighted in the paper that there was just one individual that was receiving nursing care therefore it looked as though the NHS were providing a short break provision to a number of people who did not actually qualify for NHS support. • Jocelyn Street (JS) was pleased to hear of the sensitive approach due to the capacity for bad headlines and publicity. • Sue Sunderland (SS) added that even if they were providing value for money, it did not look like the aims were being fulfilled so if anything was to continue the learning and educational opportunities would require review along with timescales due to the amount of time it had been going on. • Steven Bramley (SB) understood the difficulties dealing with this emotive subject but questioned provision of the service and whether we had to provide through the NHS. JL highlighted the service users were not getting anything out of the service, but the families and carers were getting the respite. • Val Haylett (VH) asked if Derby City Council had a similar scheme, and if not part of the scheme, will they be reviewed too. JL advised there was no further provision in the City. JC pointed out the inequality if just in the north of Derbyshire.	

	• Lynn Walshaw (LW) added that she was fully aware this was such an emotive subject the families need consistency and clarity, and we need to be clear around services and timelines. Derbyshire is seen nationally an area that manages LD and Autism well, so eyes will be on us around this change. The paper has also produced information around people making that transition from short stay into the community and using alternative provision, do we have the appropriate workforce out there. • Amy Salt (AM) advised Healthwatch had been receiving a lot of feedback from the public in terms of this area since the review of day centres, the data gathered may help with short breaks as there could be overlap. • SS clarified the need to be very clear given the financial position across the system, it is vital that on all services if we can save money, we do save money, and we would be misleading if something was identified as not an effect service. • Sean Thornton (ST) felt the ICB message to the Local Authority would be different to that relayed to other key partners due to the significant ties into the Local Authority services and understanding our legal duties. **The Public Partnerships Committee DISCUSSED the current progress in relation to the Short Breaks project.**	
PPC/2324/034	**Glossop Services Engagement Approach** ST provided committee with a verbal update reminding members that there had been a transition of citizens into Derbyshire last July from Glossop (circa 33,340 population) and since then there had been relatively slow progress, but some was being made by the internal ICB group looking at variations between service provision. A paper was to be presented to the September Population Health and Strategic Commissioning Committee (PHSCC) outlining what some of the variations look like. Just 3 or 4 areas have been found with variation in terms of specification of the services. Overall, the variations are not as great as originally thought and were there are variations the schemes have small patient numbers or are specialist areas and apart from fertility there is unlikely to be any confrontational engagement. There will need to be engagement work with residents in Glossop but not as great as thought last year. The Committee offered the following comments and questions: - • JS asked if the wider population of Derby and Derbyshire would also get a say due to interest from Derby and Derbyshire too. **The Public Partnerships Committee NOTED the verbal update.**	

PPC/2324/035	**Terms of Reference (TORs)** ST presented the TORs for review and agreement prior to presentation to the ICB Board in September 2023 for approval. **The Public Partnerships Committee REVIEWED and AGREED the TORs presented.**	
COMFORT BREAK		
ITEMS FOR DISCUSSION		
PPC/2324/036	**Long Covid Services** Sam Hardy-Ainger (SHA) presented this paper for assurance providing evidence that the ICB and lead provider had sought to engage on the development of a future service model advising since 2021 there had been non-recurrent funding to implement the long covid services. The service was launched in 2020 then expanded in April 2022 to include recess hubs. Referrals have decreased since December 2022 from around 20 per week to 12 per week. The ICB have been informed by NHSE that the funding will be significantly reduced for 2024/25 which was expected due to the reduction in referrals. SHA highlighted the risk staff may start to look for employment elsewhere which may destabilise the workload. Options proposal and business case had been completed for 2024/25 to mitigate the key challenges identified and SHA was wishing to gain approval on the recommended service model by November 2023 allowing 5 months to implement by March 2024. The 4 possible options were: • Decommission the post Covid service. • Enhance existing services to accommodate long covid patients. • Provide nominal service based on current model and review how this would look with reduced staffing and funding. • Development maintaining the integrated and holistic approach that has been embedded within the service and additionally consider the opportunity to reduce service health inequity. The formal options appraisal process will not commence until the pre-engagement exercise is complete. Karen Lloyd (KL) added the decision had been made to withdraw the funding then to reduce the funding with a short period of notice for what is a huge service with a large amount of funding. Engagement have been liaising with various different clinics available to people with long covid and 4 workshops have been set up face to face and digitally to talk to existing patients, plus a survey has been created that will go out to areas of deprivation as there is a wish to target those particular areas. There is a keenness to get the pre-engagement completed to gain an idea of what is most important to people, and this needs to be done as soon as possible as staff and patients need to be informed as early as possible.	

	The Committee offered the following comments and questions: - • LW believed this to be almost premature as we still do not know the impact of covid and felt uncomfortable at the moment as a lot of those patients are staff so feels too early to be using language around totally decommissioning. • SB felt hands were tied as NHSE were reducing funding which would make it difficult to keep a service running in its entirety. • SS supported a consultation as a helpful way of informing around what decisions we may need to take. • VH noted the good outcomes from those patients that had used the service. • JC asked within the consultation process what people were being consulted on, are they asked about experiences or what options they would prefer. KL explained that this was not a consultation as the service was not being decommissioned, the status was pre-engagement to find out what matters most to the patient, if the decision was to decommission then there would be further consultation. **The Public Partnership Committee NOTED the Derbyshire Post (Long) Covid Syndrome Service review paper.**	
PPC/2324/037	**Citizen's Panel** KL reported to committee the decision to stand down resourcing a Citizen's Panel initiative within Joined Up Care Derbyshire and recommended committee to agree with the decision adding that funding had only been provided for the first year and during the pandemic a lot of the membership had unsubscribed and subsequent recruitment to the Panel was unsuccessful. There were now also many other ways to gauge people's thoughts and opinions. **The Public Partnership Committee AGREED with the recommendation to stand down the Citizen's Panel.**	
	CORPORATE ASSURANCE	
PPC/2324/038	**Patient and Public Involvement (PPI) Assessment Log** The PPC are recommended to note the PPI Forms and take assurance that forms are being completed and actioned appropriately. Included in the report were 21 PPIs received since the last report. KL highlighted the increase in PPI Forms partly due to the success of raising awareness within the ICB around the PPI process, along with the increase in PPI Forms for Clinical Policies due to work with the Clinical Policies Advisory Group (CPAG) but also due to the transition of Glossop into Derby and Derbyshire and the assessment of a lot of service lines that impact on Glossop residents.	

	The 2 key services highlighted were the LD short breaks which was discussed earlier on the agenda and IVF due to a disparity between DDICB's policy and the policy that covers Glossop residents currently. The Committee offered the following comments and questions: - • SS pointed out active recovery cancer and its temporary closure whilst carrying out the review, and asked if any assessment of the impact was done prior to any sort of closure, highlighting the need for some kind of transition for those people who are actively going through a service that at a point in time will cease. KL advised that this had been an inherited issue around funding not being aware the funding was going to end when it did, but they had been advised that equality and quality assessments were required along with patient assessments. • ST noted the need to communicate at the beginning if the scheme is a pilot highlighting the possibility of review and potential change. **The Public Partnerships Committee NOTED and RECEIVED ASSURANCE that the forms were being completed and actioned appropriately.**	
PPC/2324/039	**Board Assurance Framework (BAF) Strategic Risk** The Public Partnerships Committee are recommended to discuss and agree the Board Assurance Framework Strategic Risk 3 which is the responsibility of the Public Partnerships Committee. **Strategic Risk 3**: *There is a risk that the population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.* The risk score remains high at level 12 but would like by the end of the year to be at a target score of 9. The Committee offered the following comments and questions: - • JC felt the team were doing a significant amount of work, yet the risk remained high, and asked at what point do we say we are doing lots of things to say that the public are being engaged. • SS agreed and proposed flagging as part of the highlight report to the ICB Board. ***The Public Partnerships Committee DISCUSSED and AGREED the Strategic Risk 3.*** ***The Public Partnerships Committee AGREED risk score level 12 for Strategic Risk 3.***	
PPC/2324/040	**Risk Report - August 2023** The purpose of the paper was to present the operational risk owned by the committee held on the ICB's Corporate Risk Register for review and	

	to provide assurance that robust management actions were being taken to mitigate them. As at August 2023 the PPC are responsible for 2 ICB corporate risks. **RISK 13**: *Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.* Additional information had been added around the restructuring taking place in the ICB. The Risk score has not been changed but if the restructuring is delayed longer then it may have to be changed. **It is recommended that the overall risk score remains at a level 9.** **RISK 17**: *Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.* **It is recommended that the overall risk score remains at level 12.** The Committee offered the following comments and questions: - • SB asked if there could be a baseline of staff for the engagement team rather than relying on secondments, with a minimum level to enable the team to achieve. ST replied that there was a substantive allocation in the engagement team so there was permanent funding, but a couple of engagement managers were seconded out as part of their development but did wish to have confirmation long term. **The Public Partnerships Committee RECEIVED Risk 13 and 17 assigned to them.** **The Public Partnerships Committee AGREED a risk score of 9 for Risk 13.** **The Public Partnerships Committee AGREED a risk score of 12 for Risk 17.**	
PPC/2324/041	**Confidential Risk Report – August 2023** **The Public Partnerships Committee AGREED the risk score.**	
	FOR INFORMATION	
PPC/2324/042	**System Insight Group – Update** This item was deferred to a future agenda.	

MINUTES AND MATTERS ARISING		
PPC/2324/043	**Minutes from the meeting held on: 27 June 2023** The Public Partnerships Committee **ACCEPTED** the Minutes as a true and accurate record of the meeting.	
PPC/2324/044	**Action Log from the meeting held on: 27 June 2023** The action log was reviewed and will be updated for the next meeting.	
CLOSING ITEMS		
PPC/2324/045	**Forward Planner 2023/24** The Forward Planner was **ACCEPTED** by the Committee.	
	Assurance Questions: 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **Yes** 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? **Yes** 3. Has the committee discussed everything identified under the BAF and/or Risk Register, and are there any changes to be made to these documents as a result of these discussions? **Yes/No** 4. Were papers that have already been reported on at another committee presented to you in a summary form? **n/a** 5. Was the content of the papers suitable and appropriate for the public domain? **Yes** 6. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? **Yes** 7. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? **No** 8. What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? **None at this time.**	
PPC/2324/046	**Any Other Business** No further items of business were raised.	

DATE AND TIME OF NEXT MEETING
Date: Tuesday 26 September 2023 – **Development Session**
Time: 10:00 – 12:00
Venue: MS Teams

Derby and Derbyshire
Integrated Care Board

MINUTES OF THE PUBLIC PARTNERSHIP COMMITTEE

DEVELOPMENT SESSION

HELD ON: 26 September 2023, 10:00 – 12:00

VIA MS TEAMS

Present:		
Julian Corner	JC	Non-Executive Member DDICB **(Chair)**
Steven Bramley	SB	Lay Representative
Helen Dillistone	HD	Executive Director of Corporate Affairs, DDICB
Val Haylett	VH	Governor, University Hospitals of Derby and Burton NHS Foundation Trust - Deputising for MT
Karen Lloyd	KL	Head of Engagement, DDICB
Hazel Parkyn	HP	Governor, Derbyshire Healthcare NHS Foundation Trust
Tim Peacock	TP	Lay Representative
Amy Salt	AS	Engagement and Involvement Manager, Healthwatch Derbyshire
Sue Sunderland	SS	Non-Executive Member, DDICB
Sean Thornton	ST	Deputy Director Communications and Engagement, DDICB
Carol Warren	CW	Lead Governor, Chesterfield Royal Hospital
In Attendance:		
Jim Austin	JA	Chief Digital Information officer, JUCD, ICB
Dawn Atkinson	DA	Head of ICS Digital Programme, ICB
Lucinda Frearson	LF	Executive Assistant, DDICB (**Admin)**
Hannah Morton	HM	Public Involvement Manager, ICB
Andrea Kemp	AK	Engagement Specialist, ICB - Observing
Apologies:		
Jocelyn Street	JS	Lay Representative
Maura Teager	MT	Lead Governor, University Hospitals of Derby and Burton NHS Foundation Trust
Lynn Walshaw	LW	Deputy Lead Governor, Derbyshire Community Health Services NHS Foundation Trust

Item No.	Item	Action
PPC/2324/047	**Welcome, Introductions and Apologies** Julian Corner (JC) as Chair welcomed all to the meeting. Apologies were received from: Jocelyn Street, Maura Teager and Lynn Walshaw	
PPC/2324/048	**Confirmation of Quoracy** The meeting was confirmed as quorate.	

PPC/2324/049	**Declarations of Interest** JC reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the Integrated Care Board (ICB). Declarations declared by members of the Public Partnerships Committee (PPC) are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: www.derbyandderbyshire.icb.nhs.uk Declarations of interest from today's meeting: No declarations of interest were made during today's meeting.	
	ITEMS FOR DISCUSSION	
PPC/2324/050	**Digital Engagement** Jim Austin (JA), Chief Digital Information Officer for the ICB and who undertakes an equivalent role for Derbyshire Community Health Services NHS Foundation Trust (DCHS) presented the report for discussion, highlighting the Digital and Data Strategy update and the ambition to establish formal links to the Public Partnership Committee due to strategic risk 08 which highlights a risk around digital improvements implemented across Derbyshire not being delivered due to lack of citizen engagement or clinical engagement. Three questions were posed to the Committee: - • How can the digital programmes of work demonstrate to the PPC / ICB that they are engaging citizens? • What management methods would the committee encourage use of? • How would the PPC like to see future updates? Dawn Atkinson (DA), Head of ICS Digital Programme, informed members of current digital inclusion and collaborative working alongside Derbyshire County Council (DCC) and the completion of a piece of work agreeing a number of key priorities: • Residents are empowered to develop and improve digital skills. • Everyone is connected. • Digital inclusion is embedded into organisations and provision is sustainable. Headline findings for adults in Derbyshire showed: - • 7.6% - Did not have internet access at home. • 21% - Did not have all essential digital skills for life. • 39% - Did not have all essential digital skills for work. • 14.1% - Did not have a smartphone. • 8.5% - Were offline. • 18.7% - Did not have a laptop or PC.	

	The NHS App was launched in 2019 and used through Covid as a way to book covid vaccinations etc but the NHS App is now being pushed quite considerably nationally as a safe way to access certain health information and repeat prescriptions. There is a wish to ensure Derbyshire citizens are effectively using the NHS App and have the ability to use the app. With the assistance from Rural Action Derbyshire hopefully any issues will hopefully be addressed along with a wider use of the voluntary sector. The Committee offered the following comments and questions: - • Steven Bramley (SB) outlined the financial issues creating barriers and the fact that DCC would make these issues worse with their financial position, creating a bigger challenge. • Tim Peacock (TP) asked if during the engagement a user group was consistently engaged. DA advised that the wider Derbyshire Patient Participation Groups (PPGs) were used but found it tricky to draw together a group of people as it had been during covid, so another way was being sought and this was one of the questions asked of the committee. JA felt cautious to have a digital group which may encourage those already with digital knowledge, therefore, work is being done with Rural Action Derbyshire through the DCC. • Val Haylett (VH) asked around facilitation of people and equipment and the kinds of numbers. JA advised that the numbers would be in the thousands and that DCHS gave out iPad devices to patients to assist them, 200 were not particularly used, that is why it was felt the voluntary sector were better equipped to deal with this. • Helen Dillistone (HD) wondered how this committee and the wider engagement team could help through connections and assist with the theme of codesign. Also, principles of stopping the old to implement the new. Thinking about the covid app, people were expected to use to book their vaccinations and whilst we have parallel systems being run there will always be people that stick with the old and will take longer to transition. JA agreed and there will always be some type of safety net with a need to ensure we support everyone and have a legal duty to do so. • SB emphasised that the technology had only be around for the last 5 years in a practical form with incredible in roads made around how many people use it and there will be natural move whilst the population matures and becomes embedded, the challenge is those that do not use it so how do you get to the correct cohort and as a committee how do we know you are engaging with the correct cohort to move forward. • Sue Sunderland (SS) noted the research had contacted a lot of people with identifying needs and asked if it was possible to explore with those people further and alternatively are their organisations such as Healthwatch that could tap into people and identify people that have issues and explore further.	

	• Amy Salt (AS) advised Healthwatch had gone into the community and spoken to those not heard from and were receiving a lot of comments around digital inclusion some quite detailed, so Healthwatch could provide some information sharing as they visit community groups such as food banks. **The Public Partnerships Committee DISCUSSED the report.**	
PPC/2324/051	**JUCD Patient Participation Groups (PPGs) Derby & Derbyshire** Hannah Morton (HM) presented the report to PPC for discussion reporting on the development of a JUCD PPG Network and wished to keep the committee informed and sighted on the approach providing an opportunity to influence. The Derby and Derbyshire PPG Network was established in 2019 facilitated by the ICB Engagement Team. It was originally set up to bring together PPG Chairs and their members to understand how best to support them in engaging and communicating with their practice population, however, over the course of the pandemic, although meetings continued, the network became more of a way for PPGs to learn and keep updated on the developments within the system. In 2022 the network started to look at developing its approach and it was clear members wanted it to become a place for them to share learning and help one another whilst also retaining the updates and involvement in system developments and changes. A small working group was set up to take forward and undertook a PPG survey. The survey was live between 30 January and 06 March 2023 and was mainly shared online via survey monkey, paper copies were available on request, with 70 responses received from 41 different PPGs/practices. Next steps include trying to understand why there was no response from the other PPGs and practices, whilst acknowledging pressure on primary care. The Committee offered the following comments and questions: - • JC asked for clarity on the actual number of practices/PPGs as the report was showing different figures to those on the presentation slides produced. **Action: HM to clarify actual practice/PPG figures.** • TP advised that he had been involved in the survey and believed that HM and Karen Lloyd (KL) had turned the forum into a very important helpful forum which provided 3 perspectives from patients, customers and providers and commissioners. • Sean Thornton (ST) pointed out the contractual elements if certain routes were taken with a view of trying to facilitate a network of interest of PPGs. • JC believed the PPGs needed to be a useful group and needed to sit with the primary care commissioning group, noting that they are	**HM**

	paid and we as the commissioner require the work to be done. As we are now also the commissioner for primary care services there was some leverage. • SB congratulated HM on the work and had attended some of the network PPGs pointing out one downside of the network although a good network those that are not using or pushing PPGs are not benefiting. There are a lot of practices saying they have a PPG when challenged by the system but that is not always the case. **The Public Partnerships Committee NOTED the report.** **Post Meeting Note received from HM**: *For clarification on the statistics for the PPG Network report, the figures within the slide deck delivered to the PPC around the number of Practices and active PPGs were from the latest eDEC results which were collected in November 2022 eDEC, so we believe this to be the latest position from Practice Managers with regards to active PPGs. Within the coversheet, I referenced an earlier piece of work led by the ICB Primary Care Team, which was presented to the JUCD PPG Network in June 2022, at the time this survey was conducted there were 114 Practices across Derby and Derbyshire (early 2022) and this survey identified 87% of Practices had a PPG however around ¼ of these were not 'active' and were being contacted by the ICB Primary Care Contracting Team. Since, the survey led by the Primary Care Team, two Practices have merged and we, therefore, now have 113 Practices across the Derby/Derbyshire footprint.*	
COMFORT BREAK		
PPC/2324/052	**Engagement Plan Assurance Questions** TP presented a guidance paper to the PPC proposed and drafted by lay members within the PPC to assist presenters in preparing for the PPC meetings, and for the PPC to introduce some structure to the evaluation of engagement and consultation. The Committee offered the following comments and questions: - • SS felt this was a great piece of work, TP had focused on the key areas that the PPC should be interested in such as the engagement plans and in terms of closing the loop and taking that feedback back to them. SS felt it may be helpful to include under the scope for change a reference to how this change will help in the delivery of the 5-year plan. • HD thanked TP for the great piece of work and bringing to PPC. HD liked the lessons learned, with continued learning and reflection being good in situations like this. • ST liked the paper which provided a lot of content within questions if commissioners follow engagement model this is not an extra burden on them it should be there when putting papers together for committee.	

	• SB highlighted the need to streamline the process with information being received to be discussed and then the presenters give a presentation which repeats the same information. • JC welcomed the process which should assist the PPC in learning and developing and by streamlining the presentations the committee should work through the agenda quicker. **The Public Partnerships Committee SUPPORTED the report.**	
PPC/2324/053	**Assuring PPI Involvement within the ICS** KL presented this paper to discuss the role of the ICB in assuring patient and public involvement taking place in NHS Trusts/Foundation Trusts in Derby and Derbyshire as NHS Trusts, Integrated Care Boards, and NHS England have a legal duty to 'make arrangements' to ensure that individuals to whom services are being or may be provided and their carers/representatives are involved when planning and delivering services for NHS patients. The ICB is achieving and mitigating against not meeting that duty with PPI guidance and PPI forms. Question is what to do about the provider NHS Trusts. The Trusts would be taken to court for judicial challenge but as commissioner for that service do we have a duty to put in appropriate process to meet those duties. It had been found that there are no processes in place and work is underway to assist Trusts to put these in place as the guidance raised around the PPI process was written with providers in mind. The concern is if the engagement team were to receive their PPI forms it would be a big resource and the ICB would not necessarily be involved in the process if the provider trust was leading. The Committee offered the following comments and questions: - • HD commented on the helpful and important paper but should be cautious how far as an ICB we go and where our responsibilities start and end. HD would be concerned about capacity in terms of the engagement team noting it was not our responsibility to police but hoped the Trusts were using good process and if there were significant changes then we would be involved. • SS agreed and was concerned to see the report on the agenda as the remit was not for this committee to decide and would have concerns around capacity to pick up additional work in light of running costs. • ST acknowledged the concern around capacity but highlighted the issue that whilst making steps to share guidance from a ICB perspective there is a risk that providers do not have a process and it would be interesting to see what happens if the Trust was taken to court for not providing. • TP pointed out the critical issue around what areas the PPC does cover a question which is central to this committee. Are we beginning to confuse the legal duty for the more general, are we just engaging across Derbyshire when it comes to a service change.	

	• JC emphasised that the remit was clear and set out in the TORs it was not for the PPC to take on responsibilities for Trusts who have their own responsibilities and governances in place. **The Public Partnerships Committee DISCUSSED the report.**	
	FOR INFORMATION	
PPC/2324/054	**Insight Group Report & Insight Framework** Due to time this item was deferred to the next agenda.	
PPC/2324/055	**Glossop Transition** ST provided a report on the Glossop Transition which was taken as information. The PPC was recommended to note the Glossop transition in relation to the proposed process being undertaken in order to align Glossop and Derbyshire contracts, following a boundary change, Tameside & Glossop CCG transitioned specific functions to Derby and Derbyshire ICS from Greater Manchester ICB on 1st July 2022. Following a presentation at the Population Health & Strategic Commissioning Committee meeting in July, it was agreed that a quarterly report would be provided to assure the committee of the process being undertaken to align Glossop and Derbyshire contracts. **The Public Partnerships Committee RECEIVED the report.**	
PPC/2324/056	**Committee Annual Report for 22/23** The purpose of the report is for the Committee to formally review, discuss and agree the Public Partnership Committee Annual Report for the 1st July 2022 to 31st March 2023. It is a requirement for Committees of the ICB to produce an Annual Report each financial year, as set out in the terms of reference and provides a review of the work that the PPC has completed during the period which will be presented to the ICB Board for assurance. **The Public Partnerships Committee NOTED the Annual Report.**	
	MINUTES AND MATTERS ARISING	
PPC/2324/057	**Minutes from the meeting held on: 29 August 2023** The Public Partnerships Committee **ACCEPTED** the Minutes as a true and accurate record of the meeting.	
PPC/2324/058	**Action Log from the meeting held on: 29 August 2023** The action log was reviewed and will be updated for the next meeting.	
	CLOSING ITEMS	
PPC/2324/059	**Forward Planner 2023/24** The Forward Planner was **ACCEPTED** by the Committee.	

	Assurance Questions: 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **Yes** 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? **Yes** 3. Has the committee discussed everything identified under the BAF and/or Risk Register, and are there any changes to be made to these documents as a result of these discussions? **No** 4. Were papers that have already been reported on at another committee presented to you in a summary form? **n/a** 5. Was the content of the papers suitable and appropriate for the public domain? **Yes** 6. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? **Yes** 7. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? **No** 8. What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? **None at this time.**	
PPC/2324/060	**Any Other Business** No further items of business were raised.	
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 31 October 2023		
Time: 10:00 – 12:00		
Venue: MS Teams		

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON 31st August 2023, 09:00 – 10:30 FLORENCE NIGHTINGALE BOARDROOM, CARDINAL SQUARE & MS TEAMS

Present:		
Adedeji Okubadejo (Chair)	AO	Non-Exec Director, DDICB
Paul Lumsdon	PL	Interim Chief Nurse, DDICB
Jill Dentith	JD	Non-Exec Director, DDICB
Lynn Andrews	LA	Non-Exec Director, DHCFT
Kay Fawcett	KF	Non-Exec Director, DCHS
Chris Weiner	CW	Medical Director, DDICB
In Attendance		
Joanne Pearce (Minutes)	JP	Executive Assistant to Paul Lumsdon - DDICB
Jo Hunter	JH	Director of Quality, DDICB
Andy Harrison (item 058)	AH	SRO, Making Room for Dignity Programme
Samuel Kabiswa	SK	Assistant Director Planning and Performance
Apologies:		
Gemma Poulter	GP	Assistant Director, Safeguarding, Performance and Quality- Derbyshire County Council
Zara Jones	ZJ	Executive Director of Strategy and Planning, DDICB
Craig Cook	CC	Chief Data Analyst, DDICB
Robyn Dewis	RD	Director of Public Health, Derby City Council

Ref:	Item	Action
Q&P/2324 /052	**Welcome, introductions and apologies.** AO welcomed all to the meeting, introductions were made, and apologies noted as above.	
Q&P/2324 /053	**Confirmation of Quoracy** The meeting was confirmed as **not being quorate** as it did not meet the quoracy requirements of two Non-Executive Members, one ICB Executive or Deputy, one Provider Representative and one Local Authority Representative. There was no representative from the Local Authority.	
Q&P/2324 /054	**Declarations of Interest** AO reminded Committee members of their obligation to declare any interest they may have on any issues arising at Committee meetings which might conflict with the business of the ICB. Declarations declared by members of the ICB Quality and Performance Committee are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/?cn-reloaded=1	

	Declarations of interest from sub-Committees No declarations of interest were made. Declarations of interest from today's meeting No declarations of interest were made. There were no declarations of interest noted.	
Q&P/2324 /055	**Integrated performance report** JH presented the quality aspect of the report and noted two areas. • Work taking place around right care right person. Progress reports will be brought back to this committee and a deep dive is schedules for March 2024. • Emergency response around the Manchester Arena enquiry. 149 recommendations in total, 63 of which have direct implications for EMAS. SK presented the performance aspect of the report. There is ongoing pressure around diagnostics, SK gave assurance that these issues are being dealt with. Winter Planning – the first submission to NHSE is being reviewed and more detail will be brought to the meeting in September. A deep dive around virtual wards is planned and will come to a future meeting. AO asked for more detail around maternity. PL acknowledged CRH recent CQC well led and safe assessment achieved a good rating. Momentum needs to continue, and services developed. CQC are currently assessing both UHDBFT and QHB. Formal feed back is awaited. Issues have arisen from the assessment and UHDBFT Board are working on implementing improvements. AO noted that UHDBFT have been in Tier 3 oversight for some time, work is ongoing however concerns remain around the numbers of stillbirths and neonatal deaths. A deep dive in this area will come to Q and P Committee in November. KF asked the following: Does the system know how patients are feeling about maternity services. PL will confirm about the voice of the mother is being heard. What is the system doing to support staff who will be under significant pressure to deliver. PL responded to say that the 38 vacancies are due to be filled but this will pose preceptorship and training challenges. Leadership and looking after staff are key and this can be seen at CRH. CW added data has been drawn to go via the business intelligence team, feeding through to the LMNS around and quality metrics and some aspects of performance. There is a national data set which is being reviewed with the hope of being utilised to provide local metrics that can be followed as a system.	

	AO noted the perinatal thematic review which is in progress and LMNS assessing trusts for compliance against the six elements. JED noted the 2023/24 operational plan and asked how it links to the 5 years forward plan. SK replied to say that work is taking place to align the two. JED noted the ongoing issue around delayed discharges and asked if there are any short-term solutions to speed up progress. SK replied to say that pathway 0 which is the main blocker and due to in hospital processes. The ICB are working with providers around this. CW added, in terms of trying to optimize performance for this winter, it is important to recognise the last year in the 2022/23. A letter from NHSE national team identified 10 evidence-based approaches which could improve performance in relatively short time frame. The NHSE national team and regional team have reemphasized in recent weeks the same 10 interventions. AO summarised and noted the good work taking place, and the areas of concern that have been discussed around maternity, virtual wards, and delayed discharges. There is some level of assurance that there is significant work taking place in these areas and as formal reports are presented to this committee it will gain proper assurance. AO also noted the importance about patients, population, and patient experience.	
Q&P/2324 /056	**Board Assurance Framework (BAF)** JH presented the paper on behalf of the Corporate Directorate. JH noted risks one and two for which the Quality and Performance Committee are responsible. The report is an intermediate report, and the next task and finish group will meet on Monday. JH noted that there is no change to the information in the BAF report. JED queried risk SR08 around which was going to be split between digital and data and q and p committee and Finance and estates. CW confirmed that it is likely that this will be shown in the next set of reports. The Committee received the Board Assurance Framework and were assured by its contents.	
Q&P/2324 /057	**System Quality Group Assurance Report** JH presented the paper to the Committee noting there were no areas of concern to highlight or escalate following the System Quality Group meeting on 1st August 2023. The Committee received the System Quality Group Assurance Report and were assured by its contents.	

Q&P/2324 /058	**Deep Dive Making Room for Dignity Programme (Dormitory Eradication)** AH shared a presentation on the ongoing work that DHCFT are doing to eradicate dormitory accommodation. PL asked if staffing and pathways were being looked at to ensure skill sets will be compatible with the new facilities. AH confirmed that early recruitment is taking place which gives the opportunity to factor in intense training ready for the go live dates. JED noted the possible VAT reclamation issue which is on the region of 12.5m. AH confirmed that the trust has lodged an appeal with HMRC on VAT abatement. The central capital team are aware of the risk and are following the appeal process closely. LA highlighted that the legal requirements to meet the correct privacy and dignity will not be met until 2025. The Committee noted the programme and felt assured that funding is in hand pending the VAT issue and there is clear workforce plan.	
Q&P/2324 /059	**Schedule of Deep Dives** JH presented the paper that went to SQG on 1st August 2023. JH noted that IPC, CDiff and Virtual wards will be presented as deep dives at the next System Quality Group meeting on 5th September 2023. The Committee noted the schedule of deep dives.	
Q&P/2324 /060	**Terms of Reference** JH explained that the ToR are part of a piece of work following the 360 Audit report to look at strengthening governance across all the sub committees of the Board. There have been some amendments to the ToR to fit with the audit advice. membership has been considered in light of the challenges around quoracy and further work to look at the scheme of delegation. The System Quality group is no longer a statutory requirement, and the statutory function has been transferred to the Quality and Performance Committee. Comments raised by Committee members were noted. **Action - AO will speak to Local Authority colleagues around their input and engagement.** The Committee approved the ToR with the minor amendments suggested.	**JP / AO**
Q&P/2324 /061	**Quality Framework** JH asked committee members to note the progress to year end 2022/23 and agree the proposed improvement and quality actions for 2023/24. The quality framework did not start until November last year due to the ICB being constituted. There are some actions that have been carried	

	over into this year and initially there was no formal framework to report against actions. This has now been agreed and will report into System Quality Group on a quarterly basis. Escalations will be brought to quality and performance committee as and when needed. The committee agreed to sign off the action plan and agree the amended quality improvement actions.	
Minutes and Matters Arising		
Q&P/2324 /062	**Minutes From the Meeting Held On 31st July 2023.** The minutes from the meetings on 31st July 2023 were approved as a true and accurate record.	
Q&P/2324 /063	**Action Log and Future Papers - From the Meeting Held On 31st July 2023.** The action log was reviewed and updated.	
Closing Items		
Q&P/2324 /064	**Forward Planner** It was agreed that the following papers will be added to the forward planner. Delayed Discharges – November 23 Maternity – November 23	
Q&P/2324 /065	**AOB** LA asked a question around Quality Impact assessments and asked if the committee are sighted on any of the issues that arise. JH confirmed that she would take the question away and feedback to LA. **ACTION.**	**JH**

Assurance Questions		
1	Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes?	Yes
2	Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations?	Yes
3	Has the Committee discussed everything identified under the BAF and/or Risk Register, and are there any changes to be made to these documents as a result of these discussions?	Yes
4	Were papers that have already been reported on at another Committee presented to you in a summary form?	Yes
5	Was the content of the papers suitable and appropriate for the public domain?	Yes
6	Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes?	Yes
7	Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting?	Schedule of deep dive shared
8	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting?	AO will discuss further with PL and JH.
DATE AND TIME OF NEXT MEETING		
Date: Thursday 28th September 2023		
Time: 9.00am to 10.30am		
Venue: Florence Nightingale Room, Cardinal Square, DE1 3QT		

Derby and Derbyshire
Integrated Care Board

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON

28th SEPTEMBER 2023 AT 09:00AM

MS TEAMS

Present:		
Adedeji Okubadejo	AO	Chair
Robyn Dewis	RD	Director of Public Health – Derby City Council
Jill Dentith	JED	Non-Exec Director – DDICB
Lynn Andrews	LA	Non-Exec Director – DHCFT
In Attendance:		
Jo Hunter	JH	Director of Quality - DDICB
Phil Sugden	PS	Assistant Director of Quality & Patient Safety Specialist - DDICB
Jo Pearce (minutes)	JP	EA to Dean Howells - DDICB
Shekeela Bouya	SB	360 Assurance
Usman Naizi	UN	360 Assurance
Samuel Kabiswa	SK	Assistant Director of Planning & Performance
Letitia Harris	LH	Assistant Director of Quality
Apologies:		
Chris Weiner	CW	Chief Medical Officer – DDICB
Gemma Poulter	KF	Assistant Director, Safeguarding, Performance and Quality- Derbyshire County Council
Kay Fawcett	KF	Non-Exec Director - DCHS
Paul Lumsdon	PL	Interim Director of Strategy and Planning- DDICB
Dean Howells	DH	Chief Nursing Officer - DDICB

Item No.	Item	Action
Q&P/2223 /067	**Welcome, Introductions and Apologies**	
Q&P/2223 /068	**Confirmation Of Quoracy** The quorum shall be one ICB Non-Executive Member, to include the Chair or Vice Chair, plus at least the Chief Nursing Officer, or Chief Medical Officer from the ICB (or deputy), and two provider representatives (to include one provider Non-Executive Director, with responsibility for Quality). Nominated deputies are invited to attend in place of the regular member as required. It was noted that the meeting was not quorate as there was only one provider representative in attendance.	
Q&P/2223 /069	**Declarations Of Interest** AO reminded Committee members of their obligation to declare any interest they may have on any issues arising at Committee meetings which might conflict with the business of the ICB.	

	Declarations declared by members of the ICB Quality and Performance Committee are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/?cn-reloaded=1 Declarations of interest from sub-Committees No declarations of interest were made. Declarations of interest from today's meeting No declarations of interest were made.	
QP/2223/070	**Integrated Performance Report – for discussion and assurance** JH presented the quality aspect of the integrated performance report. The national Safeguarding meeting has recently taken place, this is part of the annual schedule of work for both Safeguarding Adults and Children's teams. The ICB Safeguarding assurance submission was reviewed and the meeting was considered very positive. JH referred to the unannounced CQC inspection to Osmaston Surgery. The inspection report was published on 16th of August and showed a rating of inadequate. There is a remedial action plan in place, and the practise will be revisited in October. The Primary Care Quality Team are supporting the practice during this time. JH noted the high number of out of area mental health patients, there is a significant amount of work being undertaken from a quality perspective with all interested parties to look at how the patients can be repatriated in a sensible and proportionate manner. SK talked through the performance aspect of the report and highlighted the key messages. Ambulance and A&E - performance is stable, bed occupancy is on plan. The number of patients in hospital with no criteria to reside has improved and there is sustained improvement particularly at Chesterfield Royal Hospital (CRHFT). Planned Care - there has been a small improvement in those on the waiting lists and work is being done around a national programme called PIDMAS which looks to address the waiting list numbers. Mental Health - The out of area placements continue to prove challenging, this is not a local issue but one that is seen nationally. The following questions and comments were raised by Committee members:	

Safeguarding
JED noted the positive feedback from the national Safeguarding meeting.

Osmaston Surgery
JED referred to Osmaston Surgery and asked for an update on communications to the patient population. JH confirmed there has been a huge amount of work around communications with the practice population, work has been done with the ICB communications team to ensure messages have been appropriate.

Virtual Wards
JED noted the progress being made in terms of performance however, referred to the issue around virtual wards being fully utilised. JH responded to say it is hoped that a deep dive into virtual wards will come to Quality and Performance Committee in the next few months. SK explained that figures have improved, moving from 20% at implementation to the current 52%. This is due to the virtual wards team putting in a concerted effort to make improvements. The team are confident that the figure will increase 80% by November.

AO referred to the virtual wards and asked if the virtual wards model allows for escalation particularly into the winter period all if capacity is fixed. SK agreed to bring back an answer within the report for the October meeting.

LA asked if there is evidence that the virtual wards all making a difference and making an impact in terms of the quality the patients are receiving. SK responded to say this will be part of the work being done to unpick the five-year plan, part of the work will be to evaluate the impact of interventions that have been put into place against the key objectives.

Cancer Referrals
JED referred to cancer referral figures and noted the national campaign which is currently in train and queried whether there could be a link to the increase in cancer referrals. SK responded saying he has not had sight of any data to suggest there is a link and he will ask his team to investigate further.

Mental Health Out of Area Placements
JED acknowledged the issues with mental health out of area placements and asked if there were any time scales as to when this might be resolved. JH explained there is huge amount of work which is being led by the Chief Executive of the Mental Health Trust, supported by the ICB to ensure there is as much movement as possible within the Transforming Care Partnership team in terms of repatriation, however identifying suitable placements for this challenging and complex cohort of patients remains difficult. JH added that until the PICU facility is available it is inevitable that there will be Derbyshire residents with mental health issues having to be placed out of area.

Maternity

	RD referred to maternity and noted the extended perinatal mortality thematic review is in progress and a date for the final report is awaited. RD queried weather the Committee is sufficiently cited on how this programme of work is progressing. AO asked where the report will be shared and if it would be part of the deep dive into maternity and neonatal services along with assurance around CRHFT compliance against the six elements. JH requested for the remainder of this conversation to be moved to the confidential session of the meeting. JH gave assurance that there is significant work taking place, with scrutiny from the ICB and regional colleagues into the Trusts. SK made reference to a recent meeting he had attended to look at early warning systems and confirmed that at an appropriate time the ICB and trusts will agree measures and indicators that can be used to provide an early warning system. **Winter Plan** LA asked about risks to the system around the winter plan in the event that there is a lack of funding or if priorities have to be placed in different areas. SK explained that the ICB 2023/24 operational plan has assumed for winter and has been testing its preparedness. AO summarised noting the positive feedback around Safeguarding. There are concerns around Osmaston Surgery however there is reassurance that the patient population is not being disadvantaged. Improvements are being seen in terms of virtual wards and a deep dive will come to Quality and Performance Committee and will include objectives and measures used to assess outcomes. There are improvements to the flow of patients in and out of hospital and it is hoped this will be sustained. There are concerns around maternity and deep dive will come to Quality and Performance Committee. A summary was provided around the winter plan and feedback on the assessment of the plan will come to the Committee in October. **The Committee noted and approved the Integrated Performance Report.**	
Q&P/2223 /071	**Deep Dive – Infection Prevention and Control and Cdiff.** JH explained the national concerns around CDiff, and that Derby and Derbyshire ICB are one of the top five areas that have increasing infection rates. LH noted the key highlights from the presentation. • The target for healthcare acquired infections is zero tolerance for the coming year. • The ICB have been identified as one of the geographical areas that are experiencing increased healthcare acquired infections. • Both trusts have been put on enhanced surveillance with input from the regional team • Significant work has been undertaken by both providers to make the required improvements.	

	• Further visits to the Trusts from NHSE are due at the beginning of October. RD acknowledged the pressures on the IPC system. RD referred to a review of IPC specification and IPC input from a community perspective, RD asked if there was an update that could be shared. LH replied to say that the IPC specification has been drafted, there has been several ongoing conversations between providers, local authority and UKHSA and costings are being reviewed. LA referred to workforce, estate and cleaning teams, and noted CRHFT are unable to carry out deep cleans due to lack of decant facilities. LA asked for further assurance in this area. LH acknowledged that they have been challenges and CRHFT are exploring alternative approaches to deep cleaning. AO spoke about compliance with basic IPC measures, something which is not excusable and asked if there was a problem with staff knowledge, staff attitude or a culture of acceptance. AO summarised that the Committee noted the amount of work taking place and noting work that still needs to be implemented. The Committee discussed the impact of poor practice on patients and also the impact on finance. There are difficulties around workforce, estates and cleaning and alternative processes are being explored. **The Committee noted the deep dive and were assured by its contents.**	
Q&P/2223 /072	**Board Assurance Framework – for discussion** JH presented the Board Assurance Framework to the Committee. The Quality and Performance Committee are responsible for risks SR01 and SR02. Work has been carried out in relation to risk SR08 regarding data and digital and an update to for that risk will come to the Quality and Performance Committee in October. A comprehensive Q2 update will be presented at the Committee meeting in October. **PAPER** AO referred to the sentence" *intelligence and evidence are required to understand health inequalities and make decision to review ICS progress*" and asked if there was any update concerning this work. RD confirmed work has taken place with the Delivery Boards and Provider Collaboratives around how health inequalities are woven into all of the plans. RD agreed to bring a paper to the next Quality and Performance Committee. **PAPER.** JED commented that there seems to be little progress in terms of how the ICB are managing the risks and queried whether the ICB has a realistic risk appetite and realistic target score and suggested that conversations could picked up at the ICB Board meetings. JH	**JH** **RD**

	explained that this is an interim paper and the Q2 report will ask questions around risk appetite and risk scores. **The Committee noted and discussed the Board Assurance Framework.**	
Q&P/2223/073	**System Quality Group Assurance Report** JH presented the assurance report from the System Quality Group meeting on 5th September 2023. Appendix 1 shows the items that were presented. JH highlighted the matters of concern around postpartum haemorrhage which is an area of focus for both providers. There is a piece of work being carried out around chronic leg wounds. **The Committee noted the System Quality Group Assurance Report and were assured by its contents.**	
Q&P/2223/074	**Quality & Performance Committee Annual Report 1st July 2022 to 31st March 2023** AO presented the Quality and Performance Committee Annual Report. AO invited comments and questions from Committee members. LA questioned how the ICB gain the view from others on how the ICB is making a difference in carrying out their accountable responsibilities. JH explained there is a piece of work being undertaken to compare the terms of reference against the forward plan to ensure that all areas are covered in terms of reporting. JH suggested getting feedback on the annual report from the ICB providers and partners. LA suggested carrying out a self-assessment exercise prior to sharing the annual report with providers and partners for comment. JH will discuss the practicalities with colleagues from the Corporate Directorate. **ACTION.** **The Committee noted and approved the Quality & Performance Committee Annual Report 1st July 2022 to 31st March 2023.** **Due to the meeting not meeting quoracy requirements the Annual Report will be shared with Committee members for virtual approval. ACTION.**	**JH** **JP**
MINUTES AND MATTERS ARISING		
Q&P/2223/075	**Minutes from the meeting held on 31st August 2023** JED noted that her name should be abbreviated as JED. LA asked about provider NED representation for CRHFT.	

	JP confirmed that this is Nora Senior who has been invited to all the Quality and Performance Committee meetings. AO asked about a provider representative for University Hospital Derby & Burton FT (UHDBFT). JP will pick up with DH. **ACTION** The minutes from the meeting held on 31st August 2023 were agreed as a true and accurate record pending the amendments listed above.	**JP**
Q&P/2223/076	**Action Log from the meeting held on 31st August 2023** The action log was reviewed and updated, as necessary. JH asked for an action around how this Committee are cited on issues that arise from Quality Impact Assessments. **ACTION – JP to add to the action log.**	**JP**
CLOSING ITEMS		
Q&P/2223/077	**Forward Planner** Virtual Wards to be added to the agenda for October meeting**. PAPER** Schedule of Deep Dives to be updated on the forward planner. **PAPER**	**JP**

1.	Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **Discussed getting appropriate representation from Provider organisations. Conversations are taking place in terms of Primary Care representation.**	**N**
2.	Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations?	**Y**
3.	Has the Committee discussed everything identified under the BAF and/or Risk Register, and are there any changes to be made to these documents as a result of these discussions?	**Y**
4.	Were papers that have already been reported on at another Committee presented to you in a summary form?	**Y**
5.	Was the content of the papers suitable and appropriate for the public domain?	**Y**
6.	Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes?	**Y**
7.	Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting?	**N**
8.	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting?	**Y**

DATE AND TIME OF NEXT MEETING
Date: 2nd November 2023
Time: 1.30pm to 3pm
Venue: Florence Nightingale Room, Cardinal Square, DE1 3QT

NHS
Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board

Meeting in Public

Forward Planner 2023/24

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

ICB Key Areas	20 Apr	15 Jun	20 Jul	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Welcome / Apologies and Quoracy	X	X	X	X		X		X		X
Declarations of Interests • Register of Interest • Summary register of interest declared during the meeting • Glossary	X	X	X	X		X		X		X
Minutes and Matters Arising										
Minutes of the previous meeting	X	X	X	X		X		X		X
Action Log	X	X	X	X		X		X		X
Strategy and Leadership										
Chair's Report	X	X	X	X		X		X		X
Chief Executive Officer's Report	X	X	X	X		X		X		X
Annual Report and Accounts				X						
Risk Management										
Risk Register	X		X	X		X		X		X

ICB Key Areas	20 Apr	15 Jun	20 Jul	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Board Assurance Framework		X				X		X		X
Strategic Planning & Commissioning										
NHS Joint Forward Plan	X	X	X					X		
NHS Long Term Workforce Plan			X					X		
Operational Plan 2023/24		X						X		
Organisational Development and People – ICB staff survey		X						X		
Organisation Development and People - ICB Strategic Framework		X								
Medium Term Financial Planning								X		
Financial Plan	X	X								X
Winter Plan					X					
Primary Care Strategy						X				
Innovation & Information • Digital Development Update • Research	X									X
Green NHS Plan and Progress										X
One Public Estate Strategy										X
Memorandum of Understanding - Voluntary, Community and Social Enterprise Sector and the ICB		X								

ICB Key Areas	20 Apr	15 Jun	20 Jul	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Partnership Consultation for DCHSFT Organisational Strategy 2023-2028			X							
System Focus										
System level Primary Care Access Improvement Plan						X				
Integrated Care Strategy								X		
Population Health & Inequalities										X
Place Alliance and Provider Collaborative Update								X		
Derbyshire County Council Director of Public Health Annual Report 2023						X				
Derby City Council Director of Public Health Annual Report 2023										X
Integrated Assurance & Performance										
Integrated Assurance and Performance Report • Quality • Performance • Workforce • Finance	X		X	X		X		X		X
Corporate Assurance										
Constitution				X						
Audit and Governance Committee Assurance Report	X		X	X		X		X		X
Finance and Estates Committee Assurance Report	X	X	X	X		X		X		X
People and Culture Committee Assurance Committee			X	X		X		X		X

ICB Key Areas	20 Apr	15 Jun	20 Jul	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Population Health and Strategic Commissioning Committee Assurance Report			X	X		X		X		X
Public Partnership Committee Assurance Committee	X		X	X		X		X		X
Quality and Performance Committee Assurance Report	X		X	X		X		X		X
Corporate Committees' Annual Reports						X				
Update and review of Committee TORs				X						
Delegation of Pharmacy, Optometry and Dental Services Update	X									
Hewitt Review – Government response			X							
For Information										
Domestic abuse, sexual violence and serious violence duty briefing	X									
Delegation of Pharmacy, Optometry and Dental Services Update				X						
Ratified Minutes of ICB Corporate Committees	X		X	X		X		X		X
Ratified Minutes of Health & Wellbeing Boards		X		X		X		X		X
Closing Items										
Forward Planner	X	X	X	X		X		X		X
Risk Assurance Questions			X	X		X		X		X
Any Other Business	X	X	X	X		X		X		X

ICB Key Areas	20 Apr	15 Jun	20 Jul	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Questions received from members of the public	X	X	X	X		X		X		X