NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC AGENDA – ICB BUSINESS FOCUS

Thursday 20th July 2023 at 9am to 10.45am

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 /040	Welcome, introductions and apologies: Helen Dillistone	Richard Wright	Verbal
	ICBP/2324 /041	Confirmation of quoracy	Richard Wright	Verbal
	ICBP/2324 /042	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 /043	Minutes from the meeting held on 15.6.2023	Richard Wright	Paper
	ICBP/2324 /044	Action Log – June 2023	Richard Wright	Paper
09:10	**Strategy and Leadership**			
	ICBP/2324 /045	Chair's Report – June 2023	Richard Wright	Paper
	ICBP/2324 /046	Chief Executive Officer's Report – June 2023	Dr Chris Clayton	Paper
09.20	**Risk Management**			
	ICBP/2324 /047	ICB Risk Register Report - June 2023	Chrissy Tucker	Paper
09:30	**Strategic Planning & Commissioning**			
	ICBP/2324 /048	Partnership consultation for DCHSFT Organisational Strategy 2023-2028	Tracy Allen Jayne Needham	Paper

Time	Reference	Item	Presenter	Delivery
	ICBP/2324 /049	Joint Forward Plan – Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28	Zara Jones	Paper
	ICBP/2324 /050	NHS Long Term Workforce Plan	Linda Garnett	Paper
10:00	**Integrated Assurance & Performance**			
	ICBP/2324 /051	Integrated Assurance and Performance Report • Quality • Performance • Workforce • Finance	Dr Chris Clayton Dr Deji Okubadejo / Paul Lumsdon Julian Corner/ Zara Jones Margaret Gildea / Linda Garnett Jill Dentith / Keith Griffiths	Paper
10:20	**Corporate Assurance**			
	ICBP/2324 /052	Hewitt Review – Government response	Chrissy Tucker	Paper
	ICBP/2324 /053	People and Culture Committee Assurance Report – June 2023	Margaret Gildea	Paper
	ICBP/2324 /054	Audit and Governance Assurance Report – May / June 2023	Sue Sunderland	Paper
	ICBP/2324 /055	Derbyshire Public Partnership Assurance Report – June 2023	Julian Corner	Paper
	ICBP/2324 /056	Quality and Performance Committee Assurance Report – April/May/June 2023	Dr Deji Okubadejo	Paper
	ICBP/2324 /057	Population Health and Strategic Commissioning Committee Assurance Report – May/June/July 2023	Julian Corner	Paper
	ICBP/2324 /058	Finance and Estates Committee Update – June 2023	Jill Dentith	Verbal
10:35	**Items for information**			
	The following items are for information and will not be individually presented			
	ICBP/2324 /059	Ratified minutes of ICB Committee Meetings: • Audit & Governance Committee – 23.3.2023 / 4.5.2023 • People & Culture Committee – 8.3.2023 • Public Partnership Committee – 28.2.2023 / 28.3.2023 / 25.4.2023 / 30.5.2023 • Quality & Performance Committee – 30.3.2023 / 27.4.2023 / 25.5.2023	Richard Wright	Papers

Time	Reference	Item	Presenter	Delivery
10:40	**Closing Items**			
	ICBP/2324 /060	Forward Planner	Richard Wright	Paper
	ICBP/2324 /061	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?	Richard Wright	Verbal
		2. Did any of the discussions prompt us to want to change any of the risk ratings up or down?		
	ICBP/2324 /062	Any Other Business	Richard Wright	Verbal
	ICBP/2324 /063	Questions received from members of the public	Richard Wright	Verbal
Date and time of next meeting in public NHS System focus meeting: **Date:** Thursday, 21st September 2023 **Time:** 9am to 10.45am **Venue:** via MS Teams **Date and time of next meeting in public ICB Business focus meeting:** **Date:** Thursday, 19th October 2023 **Time:** 9am to 10.45am **Venue:** via MS Teams			Richard Wright	Verbal

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	Partner Member - DCHS	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	Ongoing	
				Sister-in-law is Business Development Director of Race Cottam Associates (who bid for, and undertake projects for the Derbyshire system estates teams)				✓	01/07/22	Ongoing	
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	Partner Member - Clinical and 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	N/A	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	Non-Executive Member	Public Partnership Committee Population Health & Strategic Commissioning Committee Remuneration Committee	As the CEO of Lankelly Chase Foundation, I may have an interest in organisations being commissioned by the JUCD if that would support a grant funding relationship that Lankelly Chase has with them.		✓			01/03/22	30/06/25	Not aware of any grant relationships between Lankelly Chase and Derbyshire based organisations, or organisations that might stand to benefit from JUCD commissioning decisions. If that were to happen I would alert the JUCD chair and excuse myself from decisions both at Lankelly Chase and JUCD.
Dentith	Jill	Non-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	
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	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	People and Culture Committee Population Health & Strategic Commissioning Committee Quality and Performance Committee Remuneration Committee	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	
Green*	Carolyn	Interim Chief Executive, DHcFT	People & Culture Committee Population Health & Strategic Commissioning Committee	Board Member - National Mental Health Nurse Directors Forum		✓			06/12/22	31/03/23	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Griffiths	Keith	Executive Director of Finance	Finance & Estates Committee Population Health & Strategic Commissioning Committee	Nil							No action required
Houlston	Ellie	Partner Member - Derbyshire Local Authority	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	
Jones	Zara	Executive Director of Strategy & Planning	Finance & Estates Committee Population Health & Strategic Commissioning Committee Quality & Performance Committee	Nil							No action required
Lumsdon	Paul	Interim Chief Nurse Officer	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee	Nil							No action required

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
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	Partner Member – Primary Medical Services	Joint Area Prescribing Committee System Quality Group	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
				Clinical Director, ARCH Primary Care Network	✓				01/07/22	31/03/22	
				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 (Other) Member	Audit & Goverance Committee 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	
Powell	Mark	Partner Member - DHcFT	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	Partner Member - Derby City Local Authority	N/A	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	
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 Population Health & Strategic Commissioning Committee IFR Panels CFI Panels	Audit Chair NED, Nottinghamshire Healthcare Trust		✓			01/07/22	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
				Audit Chair of Joint Audit Risk & Assurance Committee for the Office of the Police & Crime Commissioner and Chief Constable of Derbyshire		✓			01/07/22	Ongoing	
				Husband is an independent person sitting on Derby City Audit Committee				✓	01/07/22	Ongoing	Unlikely for there to be any conflicts to manage
Weiner	Chris	Executive Medical Director	Population Health & Strategic Commissioning Committee Quality & Performance Committee System Quality Group EMAS 999 Clinical Quality Review Group Local Maternity & Neonatal System Board	Nil							No action required
Wright	Richard	Chair	Remuneration Committee	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, 15th June 2023

via Microsoft Teams

Unconfirmed Minutes

Present:		
John MacDonald	JM	ICB Chair (Meeting Chair)
Tracy Allen	TA	Chief Executive DCHSFT and Place Partnerships (NHS Trust & FT Partner Member)
Jim Austin	JA	ICB Chief Digital and Information Officer
Dr Chris Clayton	CC	ICB Chief Executive Officer
Julian Corner	JC	ICB Non-Executive Member
Helen Dillistone	HD	ICB Executive Director of Corporate Affairs
Linda Garnett	LG	ICB Interim Chief People Officer
Margaret Gildea	MG	ICB Non-Executive Member / Senior Independent Director
Keith Griffiths	KG	ICB Executive Director of Finance
Ellie Houlston	EH	Director of Public Health – Derbyshire County Council (Partner Member for Local Authorities)
Zara Jones	ZJ	ICB Executive Director of Strategy and Planning
Dr Andrew Mott	AM	GP Amber Valley (Partner Member for Primary Care Services)
Dr Deji Okubadejo	DO	ICB Non-Executive Clinical Other Member
Brigid Stacey	BS	ICB Chief Nursing Officer and Deputy Chief Executive Officer
Sue Sunderland	SS	ICB Non-Executive Member
Dr Chris Weiner	CW	ICB Chief Medical Officer
Richard Wright	RW	ICB Non-Executive Member
In Attendance:		
Helen Blunden	HB	Interpreter
Kate Brown	KB	Director of Joint Commissioning and Community Development (part meeting)
Dr Robyn Dewis	RD	Director of Public Health, Derby City Council (part meeting)
Wynne Garnett	WG	Programme Lead, Engaging the VCSE sector in the ICS (part meeting)
Fraser Holmes	SW	Interpreter
Dawn Litchfield	DL	ICB Board Secretary
Suzanne Pickering	SP	ICB Head of Governance
Sean Thornton	ST	ICB Deputy Director of Communications and Engagement
Apologies:		
Dr Avi Bhatia	AB	Clinical & Professional Leadership Group participant to the Board
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)

Item No.	Item	Action
ICBP/2324/022	**Welcome and apologies** John MacDonald (JM) welcomed everyone to the meeting. Apologies for absence were noted as above.	

Item No.	Item	Action
ICBP/2324/023	**Confirmation of quoracy** It was confirmed that the meeting was quorate.	
ICBP/2324/024	**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/2324/025	**Minutes of the meeting held on 20th April 2023** **The Board APPROVED the minutes of the above meeting as a true and accurate record of the discussions held**	
ICBP/2324/026	**Action Log from the meeting held on 20th April 2023** There were no outstanding items on the action log. **The Board NOTED the Action Log**	
ICBP/2324/027	**Chair's Report** JM 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: • Today was JM's last meeting as the ICB Chair. After a year in the role, he looked back with pride, satisfaction and recognition of the achievements made and the great steps taken in improving System collaboration and partnership working, which has facilitated navigation through some of the most challenging times that the NHS has ever seen. Good foundations have been built to face the challenges ahead, however, it is now time for the Derbyshire System to work together to increase the effectiveness of service delivery; the Integrated Care Strategy and NHS Joint Forward Plan will help set this direction of travel. • Positive work is being undertaken with the voluntary sector. The Memorandum of Understanding (MoU) between the ICB and the Voluntary, Community and Social Enterprise Sector (VCSE) has the potential to harness the innovations they could bring to the System. These relationships need to be strategically developed. • Key areas for consideration include improving the health of the population, the digital and technological aids to help deliver this in the Derbyshire area, and the benefits that social care and the System have on the wider determinants of health; many of the items on today's agenda fall within these themes. • JM thanked Board members for the work they, and their teams, have done over the last year, both in terms of the recovery and immediate	

Item No.	Item	Action
	challenges but also the steps taken to develop the System. This has not been an easy time to launch the ICB, with Covid-19 and the constraints on resources and workforce; however, it is now known where the System wants to go and how it wants to work. • JM considered it an honour to have been part of the ICB journey; he has learnt a huge amount about System working and looks forward to hearing about the successes in Derbyshire over the coming years. On behalf of the ICB Board, Dr Chris Clayton (CC) gave sincere formal thanks for the work that JM has undertaken since the ICB's inception, and for the JUCD Board prior to that; he has brought wisdom, guidance and patience to the developments made. There is no doubt that the next 12 months will be very busy for JM, with his skills being fully utilised in Northamptonshire; Derbyshire looks forward to seeing what developments are made across those hospital groups. A considered thank you was given to JM, and he was wished all best for the future. **The Board NOTED the Chair's report**	
ICBP/2324/028	**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: • Today is Brigid Stacey's last Board meeting as the ICB's CNO and Deputy CEO. CC formally thanked Brigid for all the important work she has done over the last few years and wished her the best of luck for the future. • The focus of today's agenda is principally around the operational position across the NHS for Month 1, going into Month 2. The importance of connectivity was highlighted. Going forward consideration will be given to the role of the ICB in the integrated partnership, and the role of the NHS in the broader development of communities within the anchor approach. • On 5th July, coinciding with the 75th birthday of the NHS, an ICB staff event is scheduled to consider the priorities of the organisation over the coming years and its role going forward. It has been through a transition period and is now in a more stable position; it is now time for a re-set and re-think of the ICB's purpose over the next few years. • Of importance are the developments that have happened in April. The ICB has taken on significant delegations related to Primary Care, for which the Board will be required to hold discussions on; the recovery access plan for General Practice is currently receiving a great deal of media interest nationally. <u>Questions / Comments</u> RW queried what the Government response to the Hewitt Report has been and whether there is anything of significance for ICBs to be aware of. CC responded that the Government's response to the report was only received yesterday; it will take time to review and consider it. The NHS Confederation is putting forward a review of the Government's response, which will be considered alongside the ICB's own thoughts. The Report was presented at the Board Development Session in May and its thoughts were noted. JM added that the report echoed the direction of travel for the	

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	ICB. It will be the ICB's role to try to move it forward, however it should not change its approach. **The Board NOTED the Chief Executive's report**	
ICBP/2324/030	**2023/24 Financial Plan and Delegated Budgets** Keith Griffiths (KG) requested formal approval of the 2023/24 Financial Plan and Budgets. The following points of note were made: • The Financial Plan has previously been considered by the Finance and Estates Committee and at an Extraordinary Confidential Board Session, as part of the wider System 2023/24 plans, given the impact of the challenges faced this financial year. • The total allocation for the ICB, based on its resident population, is £2.2bn, for which the ICB must demonstrate financial stewardship. • The total spend on care by partner organisations across Derbyshire is £3.1bn; the University Hospitals of Derby and Burton Foundation Trust (UHDBFT) provide care into Staffordshire, and East Midlands Ambulance Trust (EMAS) provides care beyond the Derbyshire boundary for which it receives income directly from other ICBs. Of the £3.1bn spend, only £2.2bn comes directly into DDICB. • The £2.2bn includes the money committed with provider organisations, all of which have their own Financial Plans demonstrating how they intend to breakeven for 2023/4; the ICB's Financial Plan confirms how much it will be paying these organisations. • Other spend includes that on primary care, prescribing and the Better Care Fund. The ICB depends on strong relations and the collective actions taken with its System partners to achieve breakeven. There are operational and financial challenges within all organisations, therefore conversations are being on delivery within the financial envelope. • The ICB must save £44.2m in year to deliver the breakeven plan; this saving will need to be found from the ICB's running costs and from efficiencies, productivities, and transformation work with its System partners. The Acute, mental health and community hospitals all have their own Cost Improvement Plans (CIPs) to achieve; the total CIP for the System in 2023/24 is £136m, of which the ICB's proportion, excluding NHS provider organisations, is £44.2m. This is just one component of the bigger CIP challenge, which equates to just over 4% of total turnover. • This Plan is part of a breakeven strategy for the whole System which was submitted to NHSE on 4th May and is now in action. • Richard Wright (RW), as Chair of the Finance and Estates Committee, added that the biggest lesson learnt this year is how far things have moved on as a System. This was a tough plan to pull together and relied on all partners taking a collective view. People have had to make difficult decisions and choices; although there is still a long way to go to deliver the plan, this demonstrates how far it has come. The only answer to achieve the Plan is to continue to work together as a symbiotic organisation. <u>Questions / Comments</u> Because of the dependencies on the co-working within the System to deliver the efficiencies and productivity, it was enquired whether there is confidence in the robustness of the delivery plans, because everyone	

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	needs to work together (DO). KG responded that this varies; there are some difficult challenges to deliver, with some plans being further advanced than others. There is work taking place in one place whilst the benefits occur elsewhere. Working for collective benefit, as opposed to purely an organisation one, is a new philosophy and requires effort and collegiate focus. There is a positivity around the direction of travel achieved, however there will be challenges due to the complexity of it all. **The Board DISCUSSED and APPROVED the ICB 2023/24 Financial Plan and resultant Delegated Budgets and efficiencies**	
ICBP/2324/030	**Memorandum of Understanding (MoU) between the ICB and Voluntary, Community and Social Enterprise Sector (VCSE)** *Kate Brown (KB) and Wynne Garnett (WG) attended for this item only* CC introduced the MoU between the ICB and the VCSE which sets a framework for the principles, culture and activities needed to underpin the VCSE sector's contribution as a partner in the Integrated Care System. CC's role is to implement a framework to deliver against a complex agenda; making health improvements is not straightforward and the influences of the partnership are required to make a difference to overall health outcomes. This MoU is about the VCSE sector's partnership with the NHS, which needs to be reviewed from the lens of the ICB; however, an MoU is required between the VCSE and the Integrated Care Partnership (ICP). WG gave a presentation to the Board, a copy of which was circulated with the meeting papers. The MoU will be launched on 26th June where the potential of the VCSE to contribute more to the agenda will be highlighted. <u>Questions / Comments</u> • It was pleasing to see the outcomes and opportunities to ensure VCSE involvement is increased, as they have a real contribution to make. The impact of this MoU, as it starts to embed in, are very much looked forward to (SS). • WG was thanked for taking on the important task of pulling the VCSE sector together, a role which should not be underestimated. It would be wrong to look at this solely as a formal relationship, as a lot of informal things are also happening; it is about having a common understanding of where the System wants to get to. It was asked what difference the MoU would make to the health of the Derbyshire population and how it could be improved. The NHS family is currently compiling the Five-Year Joint Forward Plan, which will become part of a wider ICP Plan; the benefits that the VCSE can add to this need to be included (RW). • This is a challenging area to pull together, and it has been done thoroughly and sensitively. It is good to have cohesive ways of describing the VCSE as part of the System, however it will not solve the power dynamics but could mask them; there is a need to ensure that the feedback loops are in the right places. The ICB must be sure that it is doing the right things, with the right organisations doing them; one starting point is to focus on the different types of organisations.	

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	The VCSE has different cultures, values, financial models, and regulatory Systems; it is critical that the ICB is sensitive to this. The ICB needs to be as clear as possible what it is trying to achieve through models like Place-based working and population health management to achieve the fullest understanding of what it needs to do. Looking at what the populations and citizens need will provide a more creative understanding as to what contributions are required from different organisations; organisations need to be supported to play their role and be provided with clarity as to what is needed (JC). WG responded that, in terms of the power imbalance, feedback from organisations that receive funding from statutory partners demonstrated that they felt compromised around being open and honest about their feelings; ways of de-personalising feedback through third parties have been explored to prevent this issue occurring in future. It is critical to involve the VCSE sector at the earliest possible opportunity when developing pathways of action; the danger of not including them is that creative contributions may be designed out due to thought not being given to challenges faced. Engaging the sector is constantly challenging. There is an open membership of the alliance; infrastructure colleagues work at a local level and have their own memberships and constituencies; other networks and forums for specific conditions are being closely worked with to cascade information. A virtual platform has been established for on-line engagement. The points of interest to the VCSE organisations, whether that be at a local Place level or with organisations dealing with particular conditions, need to be linked to ensure effectiveness. • Co-production is a word that has been used for many years in the NHS; an example of true co-production with the population was requested (BS). WG felt that there is some way to go before co-design and co-production becomes endemic in the System. The work done around the autism pathway is a good example of building on the positives to take forward. • An effort has been made to get these groups together in such a diverse and fragmented sector. Given that the VCSE is a collection of different people doing different things, it was enquired how the volunteers are represented by the VCSE Alliance and how it is ensured that the different activities are pulled together to support the NHS, and the volunteers get the support they need (MG). • One of the opportunities presented when working with local government is to consider how to build capacity and strength to support the VCSE sector, many of whom have short term contracts. It may be worth talking to the local government about the approach to building up robust VCSE capacity, as the NHS may need to rely on this sector more and more in future (JM). KB added that the relationship between the organisations is telling in that WG was given the opportunity to attend today's meeting to present the MoU. This is where this piece of work starts to be built upon; it will not be done in isolation but embedded into networks to ensure that it is working well. The MoU will be channelled into the System via the ICP, if adopted at the next meeting, using that forum to collectively highlight where things are working well and whether changes need to be made. **The Board APPROVED and ADOPTED the Memorandum of Understanding between the ICB and the VCSE**	

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ICBP/2324/031	**Operational Plan 2023/24** CC introduced the Operational Plan for 2023/24, which helps to demonstrate that there is a significant grip on the challenges faced in achieving key outcomes for Derbyshire patients, through the proposed direction of travel. Performance – Zara Jones (ZJ) outlined the key messages of the Operational Plan from a performance perspective, as described in the meeting papers. This was the first opportunity to present the Plan at a Board meeting in public, for completeness and assurance. It will be important to continuously monitor how the ICB is performing against each of the identified measures within the Plan in order to ascertain what is working well and where the challenges are; to this effect, the Integrated Performance Report will be presented to the Board on a regular basis to provide updates against the key measures. Workforce – Linda Garnett (LG) outlined the key messages of the Operational Plan from a workforce perspective, as described in the meeting papers. LG thanked everyone involved in compiling this data, confirming that there have been minimal changes to the workforce numbers, with clarity provided where any staffing increases have been necessary. The intention is to increase the substantive workforce in an aim to reduce bank and agency costs. Month 1 is slightly off plan in terms of pay costs and overall numbers due to the junior doctor and nursing staff industrial action; it is hoped that this will recover as the industrial action abates. Going forward the System HR Directors have agreed two key priorities upon which to collaboratively work over the next year: increasing workforce supply and managing pay costs to plan. This will mean improving the accuracy of workforce data, and its triangulation with finance. Close working will be undertaken with finance colleagues to proactively monitor delivery against plan. Finance – Keith Griffiths (KG) stated that the work done in last few months has provided confidence in the triangulation of data between activity, finance, and workforce; a lot of operational patient-centred work is being undertaken to provide a greater level of intelligence in these areas. KG outlined the key messages from the Month 1 System financial (April 2023) position, as described in the meeting papers. DDICB submitted a breakeven Financial Plan to NHSE on 4th May. The System has a Month 1 deficit of £3.5m, predominantly due to the additional costs associated with the ongoing industrial action; this is one of the biggest financial risks on the System, as it sits outside the Plan. Other risks include the not receiving full funding for the NHS national pay awards and the cost-of-living inflation that is putting added pressure on the non-pay expenditure incurred by the System. There is a real commitment by all partner organisations to achieve breakeven by the year end. CC summarised that the Operational Plan is now being closely monitored against plan. This plan will be collectively managed through Provider Collaboratives; managing it through this mechanism of joint working will be key. Thought will be required on the skills, development and partnership working needed beyond operational delivery. The System has high expectations of the community-based Team Up approach for urgent	

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	and emergency care. Strategic finance is not just about managing efficiency but also strategic allocation. <u>Questions / Comments</u> • It is excellent that System's HR Directors (HRDs) have endorsed the priorities set. There are still risks in increasing workforce supply; it will take a huge effort by all System partners to make a reduction in vacancies and staff absence and increase recruitment and retention. The People and Culture Committee agreed that, whilst concentrating on the here and now, thought be given going forward to build the future workforce. In addition to improving financial collaboration, a forum will be established for the System's HRDs, Finance Directors and Chief Operating Officers to triangulate finance and activity to mitigate risk (MG). • An update was requested on the how virtual wards are performing on preventing admissions and facilitating discharges; it was requested that this be picked up in future reports (SS). ZJ responded that virtual wards are a key part of operational delivery, which are monitored and managed through the Urgent and Emergency Care Board (U&ECB); virtual wards are one of U&ECB's key priorities for the year ahead. There is a good view on how they are performing from a System perspective. A Clinical Lead and Programme Manager provide resilience from a programme and management perspective to drive this forward. There is more to do to maximise the potential of this initiative. Although there were initial delays around mobilisation, these have now been resolved, however, there is some catching up to do in year. Monthly targets have been set to monitor against; this information will be incorporated into the Integrated Performance Report for assurance purposes as will feedback received from the U&ECB. Dr Chris Weiner (CW) added that the System is one bed short of where it should be in terms of virtual ward bed numbers. Nationally there is a push for bed occupancy to be circa 80% in the virtual ward space; DDICB is a long way off this. A significant part of bed occupancy levels relates to clinicians' confidence in their ability to maintain oversight; the Digital Enabler System was commissioned and rolled out across the System to facilitate increased oversight. It is expected that in the coming months, virtual ward beds and bed occupancy will increase. • It is good to see that the prevention agenda is included in the Plan, however, it is not known what the proposed improvements will look like for 2023/24 for pre-diabetes, tobacco dependency and weight management at the end of Quarter 1; the importance of having targets for these areas was highlighted, particularly the delivery expectations and achievements (EH). ZJ agreed with the importance of these areas, and whilst there are no targets set for these priorities, they are important, and will be measured against to ensure progress is being made. The Joint Forward Plan will start to draw out where the impacts need to be made; there is more work to do on the measurables to demonstrate the impact which the Operational Plan does not specify. CC added that there is a need to push further on many prevention areas. The ICB Board needs to understand the NHS position regarding the Operational Plan but also take the conversation into the Integrated Care Partnership (ICP) to achieve a partnership approach to the prevention agenda. ZJ agreed to raise this to assist the creation of agreed priorities and metrics around the ICP Plan.	**ZJ**

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	CW valued EH's challenge around tobacco dependency, which remains one of the most important drivers of poor health outcomes and inequalities, despite all the work delivered by partner organisations and changes in the legislation. **The Board APPROVED the 2023/24 Operational Plan and NOTED the Month 1 Performance Plan progress update against the planned commitments and targets**	
ICBP/2324/032	**Organisational Development and People** Staff Survey – Helen Dillistone (HD) confirmed that this survey related to the staff directly employed by Derby and Derbyshire Integrated Care Board in September / October 2022. The survey's results are compared with those of the previous year, when the majority of staff were employed by the Clinical Commissioning Group (CCG) The following key points of note were made: • The 88% response rate demonstrates that the staff are engaged and want to share their thoughts and views on the previous year. • The survey provides valuable information which allows the data to be presented in many ways which helps the organisation fully understand any requirements for development and improvement. • Nationally there are seven People Promise themes against which the ICB measures progress and demonstrate how 2022 benchmarks against the 2021 measures. • The staff survey results have been shared with the ICB's senior leaders, internal engagement forums, and staff to encourage discussion and help formulate an Action Plan. • A breakdown of the responses was provided by the protected characteristics; the report highlights how these experiences compare to staff who do not identify with any of these characteristics. • A joint Organisational Effectiveness and Improvement Group (OEIG) and Diversity and Inclusion Network (DIN) workshop was held on 6th June 2022 to discuss improvement strategies, suggest actions and set targets. This feedback will form part of an agreed Action Plan and feed into the overall Organisational Development Plan, oversight of which will sit with the ICB's Audit and Governance Committee. Questions / Comments • It is positive that the teams are being engaged in agreeing what needs to happen; it is hoped that a clear outcome-based Action Plan, defining the targets and required responses will be produced. There is a need for the ICB to rank better against itself year on year, as opposed to rating better against other organisations (MG). **The Board NOTED the results of the 2022 staff survey for NHS Derby and Derbyshire ICB** Strategic Framework – LG advised that this is a good example of co-production within the People and Culture arena. Two sessions were held with Clever Together to initially design the process, and subsequently to review the framework. A final version of the framework was included in the meeting papers. One of its key benefits is that it provides clarity on the role of the ICB and its objectives, thus providing useful information for	

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	the ICB's teams and individuals' objectives; it could be used as a foundation for appraisals, internal planning, and to guide the thoughts of the ICB's Senior Leadership Team. It is a good starting point to develop the ICB Organisational Development Plan' giving thought to what kind of organisation it wants to become and what kind of System partner it wants to be. Questions / Comments Richard Wright (RW) added that, when looking at the Five Year Joint Forward Plan currently being compiled, it needs to be asked whether, in year 5, the health and wellbeing across all communities in Derbyshire has improved; this is one of the ICB's visions. There is a need to align against this, by building it into appraisals and objectives. **The Board DISCUSSED and APPROVED the ICB's Strategic Framework as a basis for development and use across the organisation as a way of working**	
ICBP/2324/033	**NHS Joint Forward Plan (JFP)** Zara Jones (ZJ) highlighted the key messages from the NHS Joint Forward Plan, a copy of which was circulated with the meeting papers. The following key points of note were made: • The JFP sets out the key challenges currently being faced by the System and what actions will be taken to mitigate them. • The 30th June is being worked towards for the publication of the Five Year NHS Joint Forward Plan. • Engagement is currently being undertaken with System partners, including Health and Wellbeing Boards, System Delivery Boards, Provider Collaboratives, the Integrated Place Executive, and the General Practice Provider Board. This feedback is being collated with the discussion held at the Board Development Session recently held. • The published version of the JFP will be presented at the July Board Meeting in Public for a fuller review. Questions / Comments • Given that a public friendly version of the JFP will be published, it was enquired what it will be called; this is a vital public document which it is hoped will help to engage the population and aid them to understand the challenges and opportunities within the System. 'Joint Forward Plan' is not a very inviting title for the document. ZJ requested further thoughts on the naming of the public version of the JFP. **The Board NOTED the update provided on the development of the Joint Forward Plan**	**ZJ** **All**
ICBP/2324/034	**Digital Development** Jim Austin (JA) provided an update on the progress being made to implement the ICS Digital and Data Strategy and the support being given to the Delivery Boards. A presentation was given to highlight the work being undertaken, a copy of which was included in the meeting papers. A	

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	Board Development Session is scheduled for August to further discuss digital, cyber and data development. Questions / Comments • From a user perspective, it is good to see that the NHS App will remain the front door; it was enquired whether it is known how much this is being used and how much it can integrate with the System architecture (DO). JA confirmed that there is a national plan around the NHS App will plug it into different things. There is available data from Primary Care, and part of the patient experience portal work is to ensure that Secondary Care Systems can also be accessed through this App. The NHS App has been a phenomenal success, largely due to necessity around the Covid-19 pandemic. It is a huge opportunity for those people who are happy to engage with it, however, work needs to be done to improve access for those people not currently using it; the voluntary sector is well placed to assist with this agenda. • In order to get all of this to work, there needs to be a single patient record for everyone. It is likely that the prevention work will also be added to this in future. It was enquired how far away things are from having a whole NHS Shared Care Record (RW). JA responded that in an unconstrained environment, a single record of everything would be good; however, the wider it goes the less specific it becomes to any development. There is a Shared Care Record in Derbyshire which is well connected for direct care purposes; Emergency Department clinicians can see Acute, GP, community, and mental health records. The System is on the verge of sharing data with Nottinghamshire, South Yorkshire, and Staffordshire to facilitate patient flows. The best use of available assets needs to be made through data sharing agreements. Using data to inform strategic commissioning and make better use of resources requires different agreements, principles, and System engagement. **The Board DISCUSSED and NOTED the update on the Digital Programme**	
ICBP/2324/035	**System Board Assurance Framework** Helen Dillistone (HD) presented the 2023/24 System Board Assurance Framework (BAF) for Quarter 1. The BAF sets out the Strategic risks against the Strategic Objectives of the ICB Board. The ICB's Corporate Committees maintain oversight of the risks, which are reviewed at each meeting. HD confirmed that no material changes have been made to the BAF since it was last considered by the Board. **The Board APPROVED the Quarter 1 Board Assurance Framework**	
ICBP/2324/036	**Ratified Minutes of Health and Wellbeing Board Meetings** • Derby City Council – 10.1.2023 • Derbyshire County Council – 25.1.2023 **The Board RECEIVED and NOTED the above minutes for information**	

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ICBP/2324/037	**Forward Planner** **The Board NOTED the forward planner for information**	
ICBP/2324/038	**Any Other Business** No items of any other business were raised	
ICBP/2324/039	**Questions received from members of the public** No questions were received from members of the public	

Date and Time of Next Meetings

ICB Business Focused Meeting		**ICB System Focused Meeting:**	
Date:	Thursday, 20th July 2023	**Date**:	Thursday, 21st September 2023
Time:	9am to 10.45am	**Time**:	9am to 10.45am
Venue:	via MS Teams	**Venue**:	via MS Teams

ICB BOARD MEETING IN PUBLIC

ACTION LOG – JUNE 2023

Item No.	Item Title	Lead	Action Required	Action Implemented	Due Date
ICBP/2324/031 15.6.2023	Operational Plan 2023/24	Zara Jones	The ICB Board needs to understand the NHS position regarding the Operational Plan but also take the conversation into the Integrated Care Partnership (ICP) to achieve a partnership approach to the prevention agenda. ZJ agreed to raise this to assist the creation of agreed priorities and metrics around the ICP Plan.	This is being progressed via the ICS Executive Team with an item scheduled at its July meeting to agree a way forward. It is suggested this action be closed on the Board action log and further updates will be provided as applicable in the future.	**Complete**
ICBP/2324/033 15.6.2023	NHS Joint Forward Plan (JFP)	Zara Jones	The published version of the JFP will be presented at the July Board Meeting in Public for a fuller review. Given that a public friendly version of the JFP will be published, it was enquired what it will be called; ZJ requested further thoughts on the naming of the public version of the JFP.	Agenda item – July meeting Following discussion with Board members the naming of the plan was finalised and included in the published document.	**Complete** **Complete**

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

20th July 2023

Item: 045

Report Title	Chair's Report – June 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 Chair's Report.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
This is my first report as Acting Chair of Derby and Derbyshire Integrated Care Board. I take on the role at a time of important publications for the NHS; alongside the NHS Workforce Plan published on 30th June, we also published our own 5-Year Plan the same day. The plan pulls together so many of the things we have talked about wanting to achieve within the NHS family and forms a really great foundation on which we can move forward. Operationalising this and building our culture and ways of working necessary for the system to deliver it will be no mean task but an exciting challenge that we know will be to the benefit of the people of Derbyshire. We will be thinking carefully about how we communicate and engage going forward because in many ways we want the people of Derbyshire to understand, buy in and engage as much as we want the people in the NHS and some of our partners to engage for this vision to be successful. **NHS Joint Forward Plan** NHS partners have been working on the first version of the NHS Joint Forward Plan and this was published on Friday 30th June. Set out in legislation as a statutory requirement of ICBs, the Joint Forward Plan – to be known as the 'Derby and Derbyshire NHS' Five Year Plan' describes a medium term plan for the delivery of Joined Up Care Derbyshire (JUCD) strategic aims and

priorities. Legislation requires that the Joint Forward Plan responds directly to the Integrated Care Strategy.

The plan will continue to develop, with clear actions to be set against each of five guiding policy headings:

1. 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.
2. Give people more control over their care.
3. Identify and remove activities from the provision of care which result in time and cost being expended but do not materially improve patient outcomes.
4. Prioritise the improvement of the System's Intelligence Function and the capacity and capability of its research programme.

The full plan is being discussed on today's agenda. The ICB has also recently published its 2023/24 Operational Plan, which provides a summary of the work to be delivered in year one of the five year plan. We will be producing summary versions of these plans shortly to meet the requirements of NHS England's Joint Forward Plan guidance.

NHS Workforce Plan

The NHS Long Term Workforce plan was published on Friday 30th June by NHS England. It is a once in a generation opportunity to put the NHS on a sustainable footing to deliver high quality patient care now and over the long term.

The Plan sets out an expansion in training, changes to ways of working, and improvements to culture that will increase the NHS permanent workforce over 15 years, this could mean at least an extra:

- 60,000 doctors
- 170,000 nurses
- 71,000 allied health professional (AHPs)

The plan also sets out that there will be an expansion in the number of new roles such as physician associates and nursing associates. We will also increase the number and proportion of apprenticeships, creating opportunities for people to join the NHS from a range of different backgrounds and with a wealth of different experiences. This plan sets out supply and demand scenarios and a range of projections for key workforce groups and professions over the short, medium and long term which will be repeated regularly as part of the NHS planning round.

ICB Board Appointments

Richard Wright MBE became acting chair of the ICB with effect from 1st July 2023, following the departure of current chair John MacDonald. Richard is ICB Vice-Chair and previously chair of the System Finance and Estates Committee. Jill Dentith has been appointed to the Board as Non-Executive Member to replace Richard in this role.

ICB Chief Nurse Brigid Stacey retired earlier in July, and Paul Lumsdon joined the ICB as Interim Chief Nursing Officer from the 1st July 2023. As an experienced leader at executive level, Paul will bring a wealth of senior nursing and operations experience as we transition to substantive arrangements and allow the system to maintain its momentum on developing integrated care during this time. The interim appointment has been made to complement the skills and experience of our Deputy Chief Nurses and retain stability in key areas at this time.

Professor Dean Howells has been appointed to the substantive post of Chief Nursing Officer, with effect from 1st September 2023. Dean will join the ICB from Black Country Healthcare NHS Foundation Trust and has significant healthcare experience in the NHS, independent and charity

healthcare sectors, both as an Executive Director of Nursing and Chief Operating Officer. Prior to working in the Black Country, Dean's most recent NHS role was as Executive Director of Nursing, Camden and Islington NHS Foundation Trust and previously as Executive Director of Nursing and Quality at Nottinghamshire Healthcare NHS Foundation Trust.

The ICB is also in the process of recruitment to the post of Chief Strategy and Delivery Officer to replace Zara Jones, who will be joining Doncaster and Bassetlaw NHS Foundation Trust in the autumn.

Industrial Action
The British Medical Association has announced a five-day period of industrial action by junior doctors, commencing on 13th July 2023. This will be followed by 48-hour period of industrial action for senior hospital doctors from 7am on 20th July 2023.

Many other unions have now accepted pay offers from the Government. Pay negotiations continue to be a matter for Government, and the NHS system has continued to make fully collaborative preparations for the periods of industrial action, including with colleagues from local authorities to ensure the continued flow of patients through the urgent and emergency care system.

NHS 75th Birthday
The NHS celebrated its 75th Birthday on 5th July 2023. A range of celebration events took place across the country and county during the week of the birthday, including a national tour for the George Cross awarded to the NHS by Her Majesty Queen Elizabeth II during the Covid-19 pandemic, and a range of buildings lighting up blue across the country to show support for the work of the NHS.

Locally, NHS organisations held a 'baton' relay across Derby and Derbyshire, with a wooden carved '75' that had been commissioned from a community group in Derby being passed among organisations through the course of the week. There will be a wide range of other activities taking place to mark the special anniversary, including prominent buildings lighting up blue, the launch of new facilities and special events to thank staff. There was also a special service held at Westminster Abbey, to which many local NHS staff were invited.

NHS@75
To coincide with the NHS's 75th birthday, and under the banner of 'NHS@75', the NHS Assembly, which brings together a range of individuals from across the health and care sectors to provide independent advice to the Board of NHS England, collated the views of those who work in the NHS alongside patients, the public, and the wider healthcare community.

NHS@75 aims to help shape the future NHS and during a tight window of engagement, a survey has been circulated widely across the NHS and partners asking for views on the past successes of the NHS, on what is working well today and what needs to be the focus for the future. The NHS Assembly has now published its report based on all of the feedback and this has been presented to NHS England.

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.	☐			

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?

Not applicable to this report

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Not applicable to this report.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

20th July 2023

Item: 046

Report Title	Chief Executive Officer's Report – June 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 NHS celebrated its 75th Birthday on 5th July 2023. It was a chance for ICB colleagues to meet for the first time since the start of Covid-19, reflect on all that has been achieved and set the purpose and direction for our organisation for the next 5 years. It was a significant milestone to firstly be able to gather in person, and to then be able to share with our staff the output of the Derby and Derbyshire Together engagement programme to set the ICB's strategic framework, and to be able to discuss the headlines contained within the Derby and Derbyshire NHS' Five Year Plan. The full plan – our version of the statutorily-required ICB Joint Forward Plan – sets out five guiding policies which we will need to tackle in the next five years, along with a set of transformative targets to ensure we are improving important indicators of health and service access. Our Operational Plan for 2023/24 provides further detail of delivery, and I am pleased to recommend to our Board a significant assurance on the stated direction of travel as part of today's Board agenda. The 5 Year Plan, along with the broader Integrated Care Strategy, have been many months in development and is the product of strong and mature relationships between NHS, local authority, VCSE sector and other partners. The plan is truly a system plan and reflects coherence across

system partners, so that the NHS - not just the ICB - has contributed to that development. The documents represent a solid foundation on which to make progress towards a healthier population, with equity of access to care and health outcomes. I signalled to ICB staff at our event last week that the task now is to prove that there is value in what we believe, that we are clear what we need to do going forward and get this done in Derbyshire.

To support this, the ICB is taking stock of its functions and structures, with a signal of reset both internally and externally, and we now enter a period of delivery to follow the thinking and planning. The reset is a positive thing, we need to grasp it and be excited by it. I also signalled to colleagues the role the ICB must play within the NHS family as part of the reset; the ICB is here to play its role in supporting our place and scale collaboratives to find solutions, with data and strategic commissioning intelligence – as well as our population – guiding and advising our system colleagues. The plan represents once and for all the movement from the tasks of the former CCG into the ICB landscape, where the ICB has a clearly different job. I empowered everyone in the ICB to discuss their roles in delivery, to act this year in taking necessary steps, and to not wait for further guidance.

This work is not without its challenges, which are documented within our combined performance report at Board today, and we must work collaboratively to overcome them. The national workforce plan was published on 30th June and sets out a direction of increased training places and steps towards improved retention. We are working through the detail and await further information on the direct impact for Derby and Derbyshire. Understanding our workforce requirements to deliver the care required, alongside the financial affordability of delivery, is now at the heart of our approach. The underlying financial challenge is long-standing and we have to solve it and protect as much investment as possible to fund the prevention and health improvement agenda set out in our plans.

In the short to medium term, we must solve our challenges on waiting times for operations, for access to cancer care and for receiving care through our emergency services; there is significant work underway to do this, and we are seeing positive change occurring in all areas. Our NHS system must work on both fronts, to manage the care demands of today at the same time as putting in place the infrastructure to support our population's health for the future.

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

NHS publishes first ever Long Term Workforce Plan

The NHS Long Term Workforce Plan sets out how the NHS will address existing vacancies and meet the challenges of a growing and ageing population by recruiting and retaining hundreds of thousands more staff over 15 years and working in new ways.

NHS steps up battle against life-threatening infections following successful world-first pilot

The NHS has launched plans to expand pioneering subscription-style drug contracts to develop lifesaving antibiotics of the future. It comes as data shows more people are contracting drug-resistant superbugs than ever before, with antimicrobial resistance (AMR) predicted to cause 10

million global deaths each year by 2050 if no action is taken. With the subscription-style contracts breaking the link between the payments companies receive and the number of their antibiotics prescribed, the NHS is removing any incentive to overuse antibiotics, decreasing the risk of life-threatening infections, such as sepsis and pneumonia, becoming resistant to treatment.

First national picture of mental health service provision and workforce mapped
A new mental health mapping tool has been developed for commissioners, service providers, and strategy makers, which maps mental health services within Integrated Care System/Board regions and Local Authority footprints. A high-level resource, developed to support commissioning and collaborations locally, the map provides the first national picture of mental health service provision. Developed by the Association of Mental Health Providers, the tool integrates data from NHS, Care Quality Commission, and the VCSE Sectors and details demographic data including age, race, faith, and carers based on the recent Census.

Parliamentary awards held to celebrate incredible work of NHS staff on 75th anniversary
On the 75th birthday of the NHS, Members of Parliament from across the political spectrum came together to celebrate the work of NHS staff who have gone above and beyond in their field, for the NHS Parliamentary Awards.

Special service at Westminster Abbey to celebrate NHS 75th birthday
Their Royal Highnesses The Duke and Duchess of Edinburgh were joined by NHS staff, senior government and political leaders, health leaders and celebrities at a service at Westminster Abbey to celebrate the NHS 75th birthday.

NHS shingles vaccine will be offered to almost one million more people
Almost a million more people (900,000) will become eligible for a shingles vaccination from September. Anyone who is severely immunosuppressed and over 50 will be able to get two doses of the Shingrix vaccine – currently the vaccine is only available to those over 70.

NHS England appoints Chief Information Officer
NHS England has appointed John Quinn as their new Chief Information Officer to oversee digital technology across the health service. His key responsibilities will include running and evolving the NHS's critical technical infrastructure and managing cyber security for national services.

Premier League supports NHS Charities 'More Than Football' campaign
To mark the 75th birthday of the NHS, the Premier League is supporting NHS Charities Together, including the 'More Than Football' campaign which uses the power of football to prevent mental health crises among men. In a video, Liverpool and England footballer Jordan Henderson speaks about how the campaign is helping men open up more about their mental health and get support when they need it.

Local developments

The NHS in Derby and Derbyshire celebrates the 75th anniversary of the NHS
Staff working in hospitals, community services and commissioning organisations joined with civic leaders in marking the occasion, taking part in various activities throughout the week. From staff events, to baton relays, art contests, park runs and bake-offs – the NHS in Derby and Derbyshire celebrated the 75th anniversary of the creation of the NHS in many ways.

- Derby and Derbyshire represented at Westminster Abbey 75th NHS anniversary service
- The very first day of the NHS - Angela's story
- Celebrating 75 Years of the Windrush Generation

Strategy agreed for improved health in Derby and Derbyshire

Derby and Derbyshire Integrated Care Strategy is a far-reaching strategy to improve the health of people in Derby and Derbyshire. The strategy was developed by Derby and Derbyshire Integrated Care Partnership (ICP) and was approved by their board in April. It has now received its final approvals from Derbyshire County Council's cabinet and on Derby City Council's cabinet. The strategy sets out three "key areas of focus" for health, council and community organisations - start well, stay well and age well and die well – and aims to tackle health inequalities, which are avoidable, unfair differences in health between different groups of people.

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

NHS Derby and Derbyshire has now been published its five-year plan. It sets out a guiding policy for changing the way the NHS operates and the actions it needs to take to improve population and healthcare outcomes, reduce inequalities, enhance productivity, and support broader social and economic development. In producing this five-year plan for the NHS across Derby and Derbyshire, we have engaged with our Integrated Care Board and Integrated Care System partners to best reflect the views, experiences, and recommendations for how we significantly reset our approach to delivery. The five year plan is in part the NHS response to the Derby and Derbyshire Integrated Care Strategy.

New Emergency Department opens at Chesterfield Royal Hospital

The new development offers a state-of-the-art approach to patient flow, embracing ultra-modern technology. The Emergency Department is also grounded in the local through the locally sourced artwork on display.

Chesterfield Royal Hospital opens new Health and Wellbeing Hub

The new Health and Wellbeing Hub will provide respite, support and relief to colleagues.

New NHS gambling service launched across East Midlands

The East Midlands Gambling Service, a Derbyshire Healthcare NHS Foundation Trust-led service, has been launched to offer specialist treatment and support to people struggling with a gambling problem. The service, which is based in Derby, provides specialist therapies, treatment and recovery to those affected by gambling addiction and gambling problems in Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire and Rutland.

EMAS introduces brand new ambulances into service

The first of 110 new replacement ambulances have been introduced to stations across the East Midlands as part of the regional fleet programme. Each brand new vehicle rolled out will replace an older ambulance which will be retired from service.

£29.9m Investment in 'One-Stop-Shop' Community Diagnostic Centres in Derby and Derbyshire

More than one million people living in Derby and Derbyshire will have access to five Community Diagnostic Centres (CDCs) by 2025, as part of a national £2.3 billion investment to reduce waiting times and provide care in communities. CDCs are 'one-stop shops' designed to provide an easier and altogether better patient experience by having a host of diagnostic facilities and services in one place.

Process changes for Derby and Derbyshire patient complaints about primary care services

As part of the delegation of NHS England's direct commissioning functions to integrated care boards (ICBs), the complaints process for all NHS Primary Care Services (GP, Pharmacy,

Optician and Dental) functions changed on 1 July 2023. The updated arrangements for patients wishing to share feedback, or to make a complaint about the primary care services they receive is described on our ICB website which also includes the complaints process for other services too.

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.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

20th July 2023

Item: 047

Report Title	Integrated Care Board Risk Register Report – as at 30th June 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 – June 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 *(virtual approval)*							

Recommendations

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

- the Risk Register Report
- Appendix 1, as a reflection of the risks facing the organisation as at 30th June 2023
- Appendix 2, which summarises the movement of all risks in June 2023

Purpose

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

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 £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.	☒			☐

The report covers each strategic risk.

Financial impact on the ICB or wider Integrated Care System		
Yes ☒	No☐	N/A☐
Details/Findings Strategic risk SR4 describe the system's financial risk. *There is a risk that the NHS in Derby and Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move to a sustainable financial position and achieve best value from the £3.1billion available funding.*		**Has this been signed off by a finance team member?** 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

1. INTRODUCTION

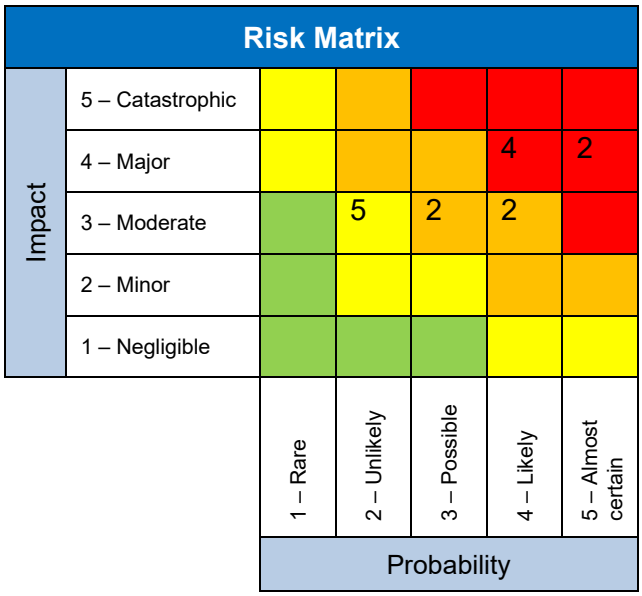
The purpose of this report is to present the ICB Board with the very high (red) operational risks from the ICB's Corporate Risk Register in order to provide assurance that robust management actions are being taken to mitigate them.

2. VERY HIGH OPERATIONAL RISKS

The ICB currently has 6 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 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.* **Update:** • Both acutes have been asked to provide an improvement trajectory for type 1 performance to increase up to 76% as per the Urgent and Emergency Care (UEC) recovery plan which was released in January 2023. • Improvement groups have been set up at both Acute trusts and an update was to be shared with the Urgent and Emergency Care Delivery Board (UECDB) during June 2023. • The Emergency Care Improvement Support Team (ECIST) have visited the Queen's Hospital Burton site and shared their observations, they are	Overall score 20 **Very High** (5 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	expected to visit the Royal Derby Hospital site within the next 4 to 6 weeks. • NHS England 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. <u>May performance:</u> • CRH reported 77.2% (YTD 78.1%) and UHDB reported 73.2% (YTD 72.5%). • CRH: The combined Type 1 and streamed attendances remain high, with an average of 178 Type 1 and 94 streamed attendances per day. • UHDB: The volume of attendances remains high, with Derby seeing an average of 211 Type 1 adult attendances per day, 110 children's Type 1s and 131 co-located UTC. At Burton there was an average of 195 Type 1 attendances per day and 29 per day through Primary Care Streaming. • The acuity of the attendances was high, with Derby seeing an average of 11 Resuscitation patients and 199 Major patients per day and Burton seeing 76 Major/Resus patients per day.		
Risk 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.* **Update:** • Review of practice Quality Outcomes Framework (QOF) and individual meetings scheduled with practices who have achieved less income in 2022/23 compared to 2021/22. These will be carried out during July 2023 as set out in the winter pressures letters to practices (23rd December and 23rd January). • Continuation of weekly OPEL reporting. • The risk score is to remain the same due to ongoing pressures and the continued risk of practices returning their contract.	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:** • At Month 2, the year to date (YTD) system performance was £11.6m deficit against £7.5m planned, driven by industrial action, a pay award shortfall, and excess inflation. There is a shortfall in efficiencies delivered of £1.4m YTD.	Overall score 16 **Very High** (4 x 4)	Finance and Estates Committee

Risk Reference	Risk Description	Current Risk Score	Responsible Committee

	• The risks to delivering the 2023/24 financial plan are:
	  ○ The planned rate of delivery of efficiencies increases substantially in the coming months. If the YTD shortfall continues and equally increases, the financial position will be difficult to recover;
	  ○ The Enterprise Project Management Office (e-PMO) is not fully populated for efficiencies, however there is now intensive support to complete Project Initiation Documents (PIDs) and ePMO reporting;
	  ○ Further work is required to ensure ownership of financial plans at every level, particularly with quality, safety and risk;
	  ○ A capital programme is in place with risks and is being overseen by a strategy group;
	  ○ There is a liquidity risk should cash releasing efficiency schemes not be delivered. NHS England are due to announce the circular movement of cash around Systems, which will provide some mitigation against this.		

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***:* <u>Quarter 3 data presented to Quality & Performance Committee:</u> • 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 quarter 4, month 12 2022/23. • In terms of completing all processes by quarter 4, DCHS have undertaken the implementation of the risk stratification and harm review process as an iterative process whereby the Standard Operating Procedures (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 completed by quarter 1 2023/24.	Overall score 16 **Very High** (4 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
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.* **Update:** • The Emergency Care Improvement Support Team (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 is ongoing to develop a Memorandum of Understanding (MOU) which sets out the commitment between the ICB, Acute Providers, NHS England and Ambulance Trusts to support ambulance crews ending their shift on time, when in attendance at busy emergency departments with ambulance handover delays. • One Hospital Ambulance Liaison Officer (HALO) has been recruited, the commencement date is to be agreed.	Overall score 20 **Very High** (5 x 4)	System Quality Group
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 ongoing pressures relating to the contingency hotels. The Home office and Serco have informed the system that two hotels in the county will have their bed capacity increased in order to meet the demands of asylum seekers needing to be accommodated. • Partners have expressed concerns to the Home office and Serco about this decision.	Overall score 16 **Very High** (4 x 4)	System Quality Group

3. RISK MOVEMENT

Appendix 2 details the movement of risk scores during June 2023 and the graphs detail the movement since April 2023. In summary:

One risk decreased in score during April:

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 was decreased from a high score of 12 to a moderate score of 6 and approved at the System Quality Group held on 2nd May 2023.

One risk decreased in score during June:

Risk 15: *The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI.*

This risk was decreased from a high score of 9 to a moderate score of 6 and approved virtually by Audit and Governance Committee members on 12th July 2023.

4. CONCLUSION

The ICB Board are requested to consider the report and provide any comment they feel appropriate.

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

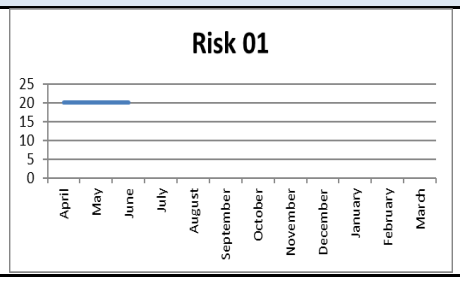
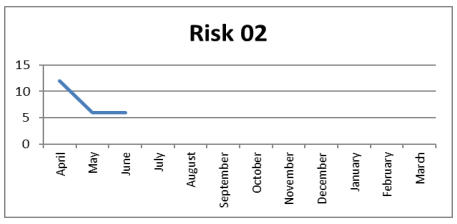
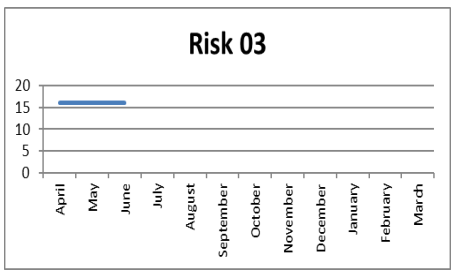
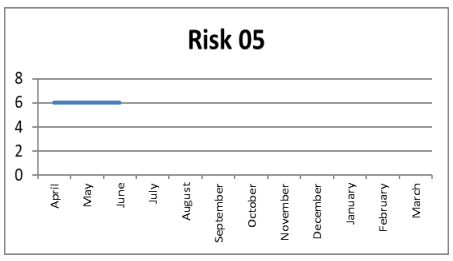
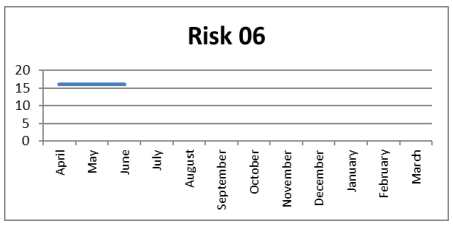
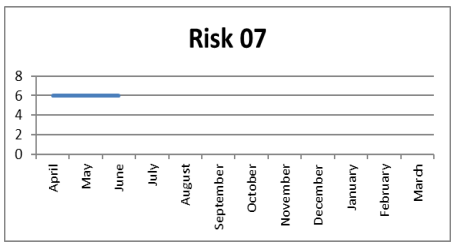
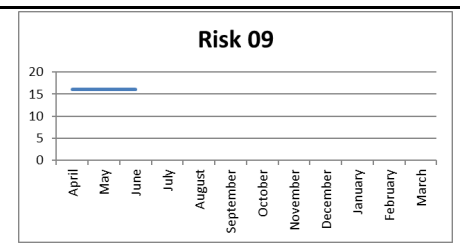
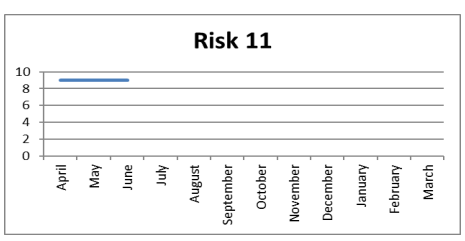
NHS
Derby and Derbyshire
Integrated Care Board

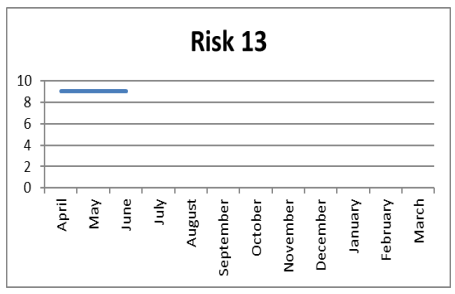
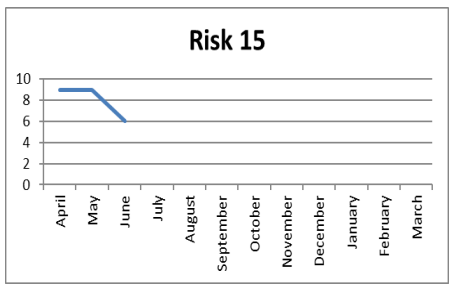
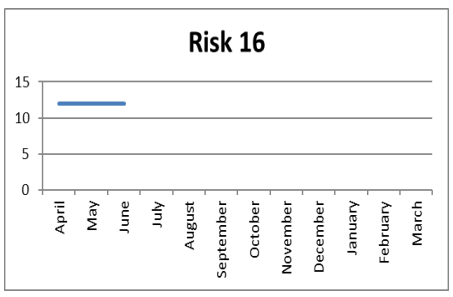
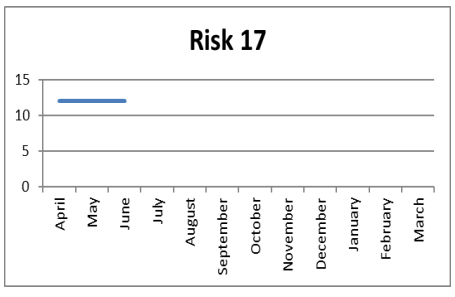
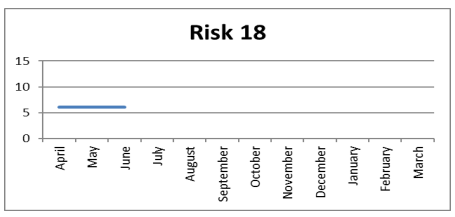
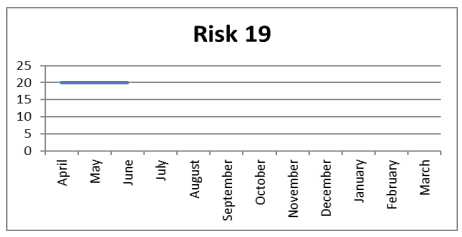
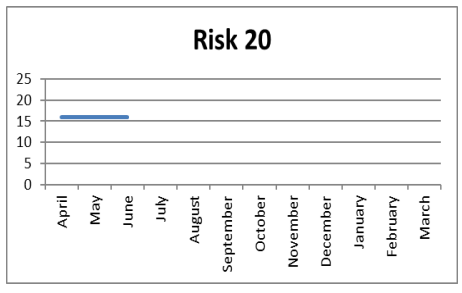
Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or 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 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.	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. - Providers across the Derbyshire Health and Social Care System meet weekly as part of the System Operational Resilience Group. 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. - All providers participate in the System Escalation Calls. These meetings are stood up by exception only. - The 22/23 Surge plan is currently being developed to support the times of escalation and extreme pressure for the remainder of the year (this will include plans for both summer and winter). There will be an agreed process in order for this to be monitored and actioned - This will feed into the UECC Board. •Non- Work ongoing to establish a System Control Centre known as the Derbyshire Operational Co-ordination Centre (OCC) as described in the winter letters from NHSE. This was established on 1st of December, operating 7/7 from 8pm with on-call cover to support out of hours. System colleagues working collaboratively to design what this looks like for JUCD. Recruitment has commenced. First round of recruitment has been completed. Winter Plan for 22/23 has been approved and initiated. A process has been implemented to monitor this. It is reported and managed through SORG and then reported up into the UECC Board. The Winter initiatives that were put in place for winter 22/23 are being reviewed and discussions taking place regarding a plan for once the funding ends at the end of March 2023 regarding stepping down initiatives or whether we are able to continue you them. It is reported and managed through SORG and then reported up into the UECC Board. April: The 22/23 Winter initiatives step down plan is being finalised. It is reported and managed through SORG and then reported up into the UECC Board and TDG. May: Both acutes have been asked to provide an improvement trajectory for type 1 performance to get back up to 76% as per UEC recovery plan which was released in January 2023, improvement groups have been set up at both Acute trusts and an update will be shared with the UECCB in June. 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. Awaiting a go live date. - Improving ambulance handover times through increased senior ownership within EDs and applying Releasing Time To Care principles in EMAS. The HALO role has been approved (3 x WTE), recruitment processes have commenced. - 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 SORG 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. A further workshop is being planned for early May 2023 (delayed due to IA) to follow up on the workshop in February. The workshop will review the collated Opel Framework and Triggers for each system partner and agree a collaborative consistent approach. Action plans will also be refreshed - Daily regional 10am calls continue as Operational Coordination Centre (OOC) and Regional Control Centre (RCC) calls. - SORG meetings are weekly at 1.30pm with the option to increase as required. A SORG refresh is currently being undertaken to agree the future focus of the meeting. - The Derby and Derbyshire Clinical navigation hub is live and a monitoring and tracking group has been established to monitor and measure the impact. - Derby and Derbyshire Clinical Navigation Hub Plus DDCN(H+) is being stood up to support Industrial Action and Bank Holidays. - Review has taken place of the new draft UTC standards. Publication of the standards is awaited.	May 2023 performance CRH reported 77.2% (YTD 78.1%) and UHDB reported 73.2% (YTD 72.5%). CRH: The combined Type 1 & streamed attendances remain high, with an average of 178 Type 1 and 94 streamed attendances per day. UHDB: The volume of attendances remains high, with Derby seeing an average of 211 Type 1 adult attendances per day, 110 children's Type 1s and 131 co-located UTC. At Burton there was an average of 195 Type 1 attendances per day and 29 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 11 Resuscitation patients & 199 Major patients per day and Burton seeing 76 Major/Resus patients per day.	5	4	20	5	4	20	3	3	9	On going	3bc	Jun-23	Jul-23	Zara Jones Executive Director of Strategy and Planning	Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager
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 positon. 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 Paper prepared awaiting confirmation of which meeting the papers needs to be presented to.	2	3	6	2	3	6	3	3	9	July 2023	3bc	Jun-23	Jul-23	Brigid Stacey - Chief Nursing Officer & Deputy Chief Executive	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 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.	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. Clinical Governance Leads network for sharing best practice. **Primary Care Strategy** Refresh of the former CCG's Primary Care Strategy to take place during 2022/23. The former CCG financially supported the development of the GP Provider Board, who will be the single voice for General Practice, supporting the development of Quality Improvement initiatives relating to access and practice resilience. **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. 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.	Review and refresh of the former Derbyshire wide Primary Care Strategy. Primary Care Quality and Contracting Team to continue to work closely with practices to understand and respond to early warning signs including identification of support/resources available including practice support in discussions around workload transfer from other providers. Establishment of Primary Care sub-group to oversee and ensure compliance with ICB delegation requirements. First meeting to take place on 13th September 2022. October: OPEL dashboard for primary care to be finalised to identify practices at greater risk. Primary Care Hi-light Report draft to be taken to Primary Care sub group for review and agreement of content - to support early identification of practice resilience.	January: • review of Opel reporting by practice including update to definitions and guidance for practices developed by winter team (ICB, LMC, GPPB, DHU) • expansion of winter hub locations and appointments available as part of the winter plan • letter to practices 23/12 and follow up letter 23/1 to provide details of additional support to practices through a winter resilience payment where practices have diverted resources to support the increased urgent demand including during the system period of critical incident status • winter team meeting with practices reporting Opel 4 to undertake review against resilience checklist and support areas identified. No change recommended to risk score. February: Opel reporting embedded and over 100 practices reporting twice weekly. April: All GP practices now reporting twice weekly OPEL scoring. Any practices reporting level 4 are followed up and support and advice given where able. June/July: Review of practice Quality Outcomes Framework (QOF) and individual meetings scheduled with practices who have achieved less income in 2022/23 compared to 2021/22 during July 2023 as set out in the winter pressures letters to practices (23rd December and 23rd January). Continuation of weekly OPEL reporting. Risk score to remain the same due to ongoing pressures and continued risk of practices returning their contract.	4	4	16	4	4	16	4	3	12	On going	3bc	Jun-23	Jul-23	Zara Jones Executive Director of Strategy and Planning	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. New risk description: The ICB is currently non-compliant with the EPRR Core Standards set out by NHS England. This is attributed to temporary resourcing and a number of work programmes included during the change from Category 2 to 1 under the Civil Contingencies Act 2004	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	May Due to the impact of Industrial Action planning and response there is a delay in updating and embedding new EPRR processes into the ICB as well as the delay to system planning due to the wider impact of industrial action on providers within Derbyshire. The resourcing of the team at the ICB is now complete with sufficient workforce to deliver the programme of work however this may be impacted upon if there is future periods of industrial action affecting the NHS June The resourcing of the ICB EPRR team is now in place however these posts are fixed term, this will lead to a risk in circa 12 months if substantive funding is not gained, re-assessment of the EPRR Core Standards will commence post 31st August 2023 with an anticipated submission of partially compliant for the ICB, this will lead into the work plan for the next 12 months to further improve/enhance the EPRR arrangements for the ICB and the system	2	3	6	2	3	6	2	2	4	On going	3bc	Jun-23	Jul-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 and Estates Committee	Finance	4	4	16	June update: Development of the Delivery Boards' objectives, including their role in financial efficiency delivery.	June update: Understanding of the current year's position for the System and the delivery of cash releasing efficiencies using the ePMO system. 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.	June Update: At Month 2, YTD system performance was £11.6m deficit against £7.5m planned, driven by industrial action, pay award shortfall, and excess inflation. There is a shortfall in efficiencies delivered of £1.4m YTD. The risks to delivering the 2023/24 financial plan are: - the planned rate of delivery of efficiencies increases substantially in the coming months. If the YTD shortfall continues and equally increases, the financial position will be difficult to recover. - e-PMO not fully populated for efficiencies, however there is now intensive support to complete PIDs and ePMO reporting. - further work required to ensure ownership of financial plans at every level, particularly with quality, safety and risk. - capital programme in place with risks. Being overseen by a strategy group - liquidity risk should cash releasing efficiency schemes not be delivered. NHSE are due to announce the circular movement of cash around Systems, which will provide some mitigation against this.	4	4	16	4	4	16	2	3	6	On going	3bc	Jun-23	Jul-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.	January: Audit of HR files completed and the large majority of employees have an up to date electronic HR file. HR to review the paper HR files for current employees and resource required to scan any documents not held electronically onto the network. Leavers file to be sent to the ICB archive company Restore for storage. Risk score to remain unchanged. February: No change, work in progress. March: No change, work in progress. April: No change, HR team are working through the paper HR files for current employees and identifying documents for scanning onto the electronic files. May: Limited progress due in part to absences within the HR team. June: Limited progress due in part to workload within the HR team.	2	3	6	2	3	6	1	2	2	May-23	3bc	Jun-23	Jul-23	Linda Garnett, Interim ICB Chief People Officer	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 March : More information available as Q3 paper goes to SQG in April. Propose decrease risk score - await decision at SQG. Decision following SQG held on 04.04.23: There is further work to be undertaken to standardise the process used by both acute providers and further work to be done across DCHS before risk score reduction can be considered. April: No change this month. May: No changes this month. Awaiting Qtr. 4 feedback and discussion at SQG post feedback report. 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.	4	4	16	4	4	16	3	2	6	Jun-23	3bc	Jun-23	Jul-23	Brigid Stacey, Chief Nursing Officer & Deputy Chief Executive	Letitia Harris Clinical Risk Manager 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	June 2023 - 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 Quarter 1 - June 23 Highlight Reports reported to NHSE SRO Review Meeting with NHSE took place May 2023 and take place quarterly. NHSE Memorandum of Understanding for 2023/24 detailing 23/24 priorities expected from NHSE. 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	Nov-23	3bc	Jun-23	Jul-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.	•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.	3	3	9	3	3	9	2	2	4	tbc	tbc	Jun-23	Jul-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	3	3	9	2	3	6				tbc	tbc	Jun-23	Jul-23	Helen Dillistone - Chief of Staff	Chrissy Tucker - Director of Corporate Delivery
16	23/24	With the pending review of the 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.	May: Continued promotion of wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider - Confidential Care. Promotion of new NHS Looking after your team's health and wellbeing guide, Mental Health Awareness week (including activities to improve mental wellbeing and free apps/resources). Sickness absence levels have continued to reduce again in April to around 1.6%. June: Continued promotion of wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider - Confidential Care. Sickness absence levels increased in May to 2.65%.	4	3	12	4	3	12	3	2	6	Jul-23	tbc	Jun-23	Jul-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.	*- 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.	4	3	12	4	3	12	3	2	6	tbc	tbc	Jun-23	Jul-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, NHSE/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.	2	3	6	3	3	6	2	2	4	May-23	tbc	Jun-23	Jul-23	Zara Jones Executive Director of Strategy and Planning	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	1. Discharge Flow workstream 2. P1 Strategy events 3. POG actions re: Surge beds 4. Focussed work re: Stockport discharges 5. 100 day challenge 6. SEC and SORG interventions. 7. Overview of HHO delays and robust scrutiny of progress to delivery improvement trajectories. Performance management of workforce and abstraction rates to ensure necessary resources are in place to respond to demand 9. Implementation of EMAS Hospital Handover Harm Prevention Tool at Acute Trusts. 9. Ongoing work in commissioning Same Day Emergency Care and direct access to specialities 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. 10. Regular monitoring of Actions and risk by CQRG. 11. Local system governance structures to manage difficult decisions: Derbyshire System pressures quality review panel. Decisions and discussions held at SORG. 12. HALO - recruited to support both Acutes and crews with handover delays, directing appropriate patients to SDEC, supporting pinning off etc	System actions to reduce hospital handover delays. System urgent care improvement action plans. County Council re-launch of pathway 1 offer to improve access, capacity and flow. Consultation ends 7th May 23, planned start date Oct 23. Expectation to significantly improve P1 offer in county Pathway 1 work commenced with High Peak Locality focusing on LOS & opportunities to integrate health and social care. Launch date for integrated model 1st July. Plan to roll out to Amber Valley. Pathway 1 strategy : engaged with system leads regarding strategy. Operational workshops to look at transformation starting May 23, Strategic leads meeting to agree priorities May 23 Data : OPTICA tool to support with acute discharge planning to be implemented. Project commenced 23, due to be rolled out May 23 Strength based Approach to be rolled out at UHDB Medicine ward from November. Training completed March 23. Development of Model ward 311 UHDB with clarity of roles and outcomes and PDSA of impact ASC discharge fund investment : projects invested in which will increase number of discharges to support people to return home. Approval for initial projects to support discharge of patients back home including VCSE enhancement Pathway 3 - D2A pathway for those requiring Nursing care commenced – 4 beds block purchased. Process of admission and PDSA reviews in place Brokerage function at CRH and UHDB being reviewed to move to one process to discharge to care home from acute. 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 No update provided for June 2023	5	4	20	5	4	20	2	5	10	June 2023	tbc	Jun-23	Jul-23	Dr Chris Weiner Chief Medical Officer	Ruth Cumbers Integration Director 999111 – East Midlands 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 IAA 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.	April 2023- there are no current plans to reduce the number of Contingency Hotels in our geographical area. Therefore no reduction in the risk. 12/05/23 There are no plans to reduce / close the number of contingency hotels in the area - therefore unable to reduce the risk. Local agencies are working closely with SERCO and the Home Office in addressing any issues that arising in regard to the hotel settings. 21/06/23 ongoing pressures in regard to the contingency hotels in that the Home office and Serco have informed the system that two hotels in the county will have their bed capacity increased in order to meet the demands of asylum seekers needing to be accommodated. partners have expressed concerns to the Home office and Serco about this decision.	4	4	16	4	4	16	3	3	9	April 2023	tbc	Jun-23	Jul-23	Brigid Stacey Chief Nursing Officer & Deputy Chief Executive	Michelina Racioppi Assistant Director for Safeguarding: Children/ Lead Designated Nurse for Safeguarding Children

Appendix 2 - ICB Risk Register - Movement - June 2023

NHS Derby and Derbyshire Integrated Care Board

Risk Reference	Risk Description	Previous Rating (May)			Residual/ Current Risk Rating (June)			Movement - June	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
01	The Acute providers may 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	⟺	Derby and Derbyshire Clinical Navigation Hub Plus DDCNH+ is being stood up to support Industrial Action and Bank Holidays.	Zara Jones Executive Director of Strategy and Planning	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	⟺	A paper is prepared regarding the ongoing risk to the ICB of having a number of cases that are RAG rated Amber and Green which have not yet been submitted to the CoP.	Paul Lumsdon Interim Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding Michelle Grant, Designated Nurse Safeguarding Adults/MCA Lead	
03	There is a risk to the sustainability of the individual GP practices across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.	4	4	16	4	4	16	⟺	Risk score to remain the same due to ongoing pressures and continued risk of practices returning their contract.	Zara Jones Executive Director of Strategy and Planning	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	⟺	The resourcing of the ICB EPRR team is now in place however these posts are fixed term.	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	⟺	At Month 2, YTD system performance was £11.6m deficit against £7.5m planned, driven by industrial action, pay award shortfall, and excess inflation.	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	⟺	Limited progress due in part to workload within the HR team.	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	⟺	Every Provider is rated amber for one or more Key Performance Indicator.	Paul Lumsdon Interim 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	⟺	The risk score cannot be reduced until the ICS starts to achieve its targets through the action plan for 2023/24.	Helen Dillistone Chief of Staff	Suzanne Pickering Head of Governance	

Risk Reference	Risk Description	Previous Rating (May)			Residual/ Current Risk Rating (June)			Movement - June	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
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	⇔	Workshop with regional ICB communications leads looking at best practice resourcing models.	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	3	3	9	2	3	6	↓	Probability decreased to 2, on the basis that Notts ICB will be the host organisation and a Standard Operating Framework has been shared.	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 May to 2.65%.	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	⇔	Ongoing engagement planning to support Integrated Care Strategy and NHS Joint Forward Plan.	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 risk will remain until all practices are offering access to patient records for more than 50% of their patients.	Zara Jones Executive Director of Strategy and Planning	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	⇔	Workshops to transform Pathway 1 process and flow commenced.	Paul Lumsdon Interim Chief Nursing Officer	Ruth Cumbers Integration Director 999/111 – East Midlands 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	⇔	Ongoing pressures, the contingency hotels that the Home office and Serco have informed the system that two hotels in the county will have their bed capacity increased in order to meet the demands of asylum seekers needing to be accommodated.	Paul Lumsdon Interim Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

20th July 2023

Item: 048

Report Title	Partnership consultation for DCHSFT Organisational Strategy 2023-2028							
Author	Lucy Cocker, Project Manager Operational Planning and Strategy, DCHSFT							
Sponsor (Executive Director)	Tracy Allen, Chief Executive Officer, DCHSFT							
Presenter	Jayne Needham Director of Strategy, Partnership and Population Health DCHS							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☒
Appendices	Appendix 1 – DCHSFT Organisational Strategy Engagement Appendix 2 – Letter to ICS Partners re DCHSFT Organisational Strategy							
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 **DISCUSS** and **NOTE** the DCHSFT Organisational Strategy Refresh 2023-2028.
Purpose
The Purpose of the report and accompanying Slide Set at Appendix 1 and letter to ICS Partners at Appendix 2, is to consult and engage with the ICB as a key partner, on the DCHSFT 2023-28 Organisational Strategy refresh. All views received will be considered as part of the content of the final strategy document or will form part of the implementation process for delivery.
Background
During Autumn 2022, DCHSFT commenced an extensive consultation, engagement, and strategy development process to develop a refreshed Organisational Strategy which responded to the current focus of system level working, integration, prevention and personalisation of care. The strategy engagement process is detailed in full in the attached appendix and demonstrates the approach taken to ensure evidence, system level priorities, staff and patient feedback and partnership consultation have shaped the content of the Strategy.

This report forms part of the final partnership consultation process prior to publishing of the Strategy and explains the next steps DCHSFT will take to ensure the approach to implementation is led from across and within the Organisation.

Report Summary

The attached engagement slide set details in full for:

- the Process we have undertaken to develop the DCHS Organisational Strategy;
- the content of the DCHSFT draft Organisational Strategy including the four key themes;
- next steps to transition to implementation and internal continual planning process.

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.	☒			

No further risks identified.

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** As part of the implementation of the strategy, QIA's will be undertaken by DCHS where service changes may result in a Quality Impact
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings** As part of the implementation of the strategy, EIA's will be undertaken by DCHS where service changes may result in a

				Quality Impact. A EIA will be completed alongside the published document.

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:** As part of our engagement, we sought feedback from patients through our friends and family questionnaire. To avoid duplication for Patients and Public from the development of the ICP Strategy, we have worked with the JUCD insights team to understand what matters to patients and public. We have also worked with Health Watch and DHIP to ratify our themes from the data.

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

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

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

Details/Findings
The key theme of “focus on the future” encompasses the NHS Green, Anchor and sustainability agendas.

Derbyshire Community Health Services NHS Foundation Trust

Derbyshire Community Health Services NHSFT Organisational Strategy Engagement

Purpose of this presentation:

To present and engage with partners on the :

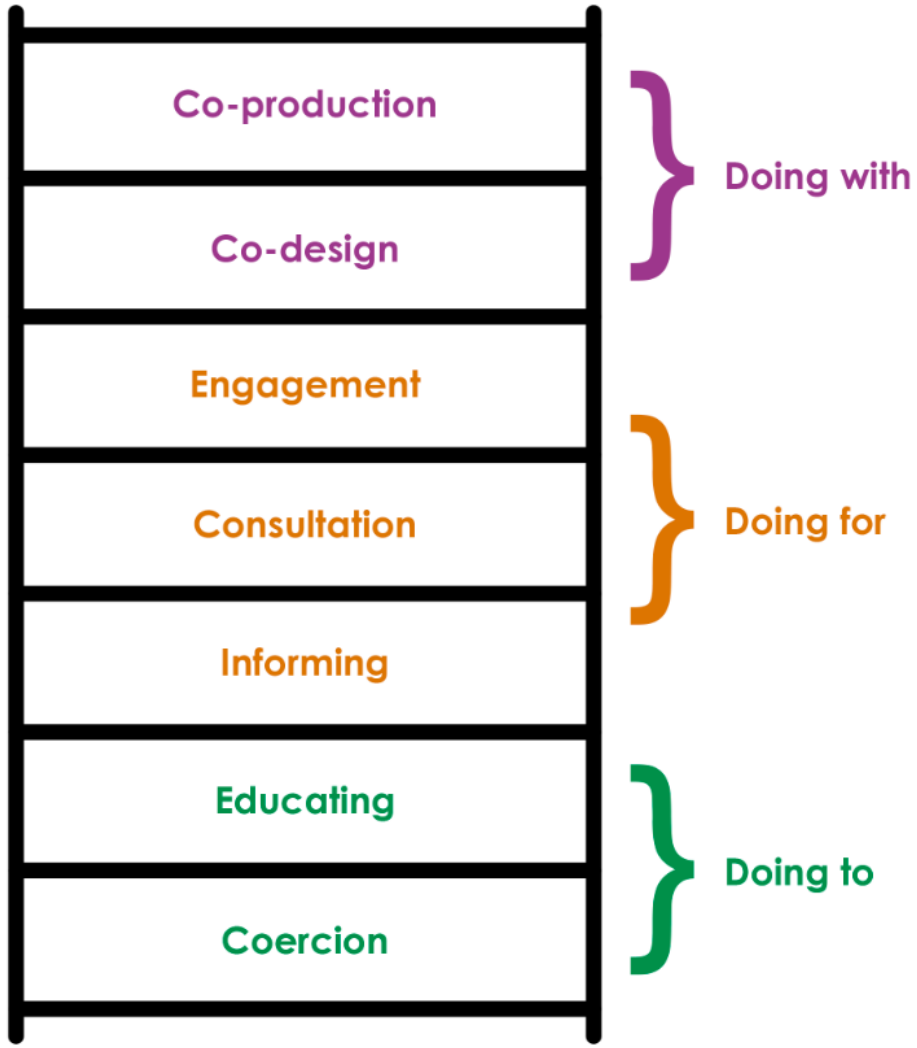
- Process we have undertaken to develop the DCHS Organisational Strategy
- The content of the DCHS NHSFT draft Organisational Strategy
- Next steps to transition to a continual planning process
- To share learning from developing the Strategy

Context

- DCHS's Clinical Strategy was due to be refreshed in June 2022.
- Due to the formation of Integrated Care Systems and limited time for engagement, a request was made to DCHS trust board, to extend the timeline for refreshing the Organisational Strategy.
- Set out to be clinically-led and evolved to be co-designed.
- The aim of the Strategy is to provide a framework in which decisions can be considered against the trusts Strategic priorities.

A co-designed strategy (image NAPPI UK)

- Co-production – means people are involved in an equal way in designing, commissioning, and delivering services (people could include staff, patients, communities).
- Co-production is a way of doing things with people, that increases the chance of getting things right for people (staff, patients, communities).
- There is a ladder of participation - from educating to engaging to co-production.
- To increase impact of this strategy, co-design approaches have been adopted where possible.
- Moving further towards 'doing with' in terms of strategy.



Context within Joined Up Care Derbyshire

Shaping Our Health

How all our Health Strategies link together

Joint Strategic Needs Assessment

This identifies the health needs of Derby and Derbyshire People.

It is produced by our two Local Authorities on behalf of the Health and Wellbeing Boards.

The information it provides helps us know where we should focus our efforts to improve the health of Derby and Derbyshire people. The information in the Joint Strategic Needs Assessment is used to help decide what we need to put into all our other key strategy documents

Integrated Care Strategy

This document uses the information provided in the Joint Strategic Needs Assessment to set out what the NHS, Local Authority and Voluntary Sector organisations will do to work together to improve the health of Derby and Derbyshire people at a local level. This is called Place.

It is written by our Integrated Care Partnership* which will ensure the voice of local people and our communities is included

Joint Forward Plan

This document takes the information from the Joint Local Health and Wellbeing Strategies and the Integrated Care Strategy and uses it to detail the actions NHS organisations will take to meet the physical and mental health needs of Derby and Derbyshire People

It is written by our Integrated Care Board*

Joint Local Health and Wellbeing Strategy

This document uses the information provided in the Joint Strategic Needs Assessment to identify where and how we need to focus our efforts to improve the health and wellbeing of Derby and Derbyshire People

It is written by our two Local Authorities and each Local Authority produces their own Strategy because the health of Derby and Derbyshire people is different

The Health and Wellbeing Strategy includes actions on employment, education, social isolation , housing and income because these issues affect everyone's health and wellbeing

Individual Organisational Strategies

Each NHS and Local Authority organisation can write its own strategy and plans.

These documents detail how the work of each individual organisation helps contribute to delivering the actions of the Integrated Care Strategy, Joint Forward Plan and Health and Wellbeing Strategies

Key

- Local Authority
- NHS
- Voluntary Sector

Definitions

Integrated Care Partnership: These are partnerships of NHS, Local Authority and Voluntary Sector Organisations that come together to plan and deliver joined up health and care services to improve the lives of people who live and work in their area.

Integrated Care Board: This is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in Derby and Derbyshire.

Joined Up Care Derbyshire · NHS · The Derbyshire VCSE sector Alliance · Derby City Council · Derbyshire County Council

Co-design approaches we have utilised

- Initial staff survey ‘If it matters to you, then it matters to us’. Responses received were slightly short of 95% confidence in saturation of the themes (36000 words)
- Priorities from the Board
- 15 Staff executive drop in’s- confirmed saturation of themes
- COG Strategy Sub-group
- Staff network feedback
- Patient survey feedback (4384 responses analysed) -Healthwatch Derbyshire endorsement of patient themes
- ICB and DHIP Community insight projects
- Focus sessions with line managers
- Focus sessions with local teams
- 2 Leadership development sessions
- Relevant national and local literature/ guidance (52 documents reviewed)
- Council of Governors (March 2023)
- Have we heard what matters to you survey to staff
- JUCD partners views (TBC)

Development of the DCHS Organisational Strategy

This slide outlines the themes from the initial staff survey ‘If it matters to you, then it matters to us’.

95% confidence in saturation of the themes was achieved and confirmed through executive staff drop-ins.

This data alongside the other data sources outlined, were used to develop our 4 strategic themes.

It matters to me, that...

NHS
Derbyshire Community Health Services
NHS Foundation Trust

At a system level	Our senior management	My line manager is	My team is	I am
We have good IT infrastructure	Have a Board ethos that reflects what matters to us	Good at listening and acts on what they hear	Listened to by our line manager, and senior management	Listened to, including when I have ideas
We have good pay and progression	Communicates well with us, and are connected to us	Supportive of our team, and me as an individual	Supported in our roles, and as individuals	Supported as a person, and in my role
We are integrated well	Have a commitment to listen and act	Valuing of me as an individual, and also of our team	Noticed, valued and praised	Valued and noticed in my role, and as an individual
We know who to connect with	Supports us to have do-able jobs	Committed to supporting us to have do-able jobs	Tasked with do-able jobs and appropriately staffed	Able to do my role in a sustainable way
We know what other services there are in the system	Notices us, values us, and praises us	Connected to our team	Connected to one another, and management	Passionate and motivated to make a difference
We acknowledge there are lots of different ways we can be integrated	Are committed to optimising pay, and progression for us	Fair and understanding	Good at communicat-ing with one another, and other teams	Connected to my manager and team
We have the time to integrate	Supports us to connect with the wider system	Supportive of new ideas I bring to improve the service and my role	Provided with core wellbeing support	Enabled to make a difference, including manageable admin

Our patients, citizens and communities

Are listened to, and that we have the time to listen	Have opportunities for early intervention and signposting	Are at the centre of services and how we do things	Experience care and support as personalised

Combined Strategic Themes

People at the centre	Working in Partnership	Healthy Communities	A focus on the future
Staff and patients- *W*ellbeing, Just and restorative culture, great place for all to work and experience care	***Thinking differently about Organisational boundaries-*** *S*hared goals, processes with partners, leadership, IT systems, co-production	***Communities at the centre-*** Those communities not accessing our services, prevention and addressing health inequalities	***Sustainability-*** Workforce**,** do-able jobs, allocation of resources, risk appetite and intelligence-led change

Vision, Mission and Values

Vision: Our vision is to see the health of local communities improve through partnership working, putting people at the centre and looking to the future.

Mission: Our mission is to improve the health and wellbeing of local people and communities through personalised, safe and effective community-based services.

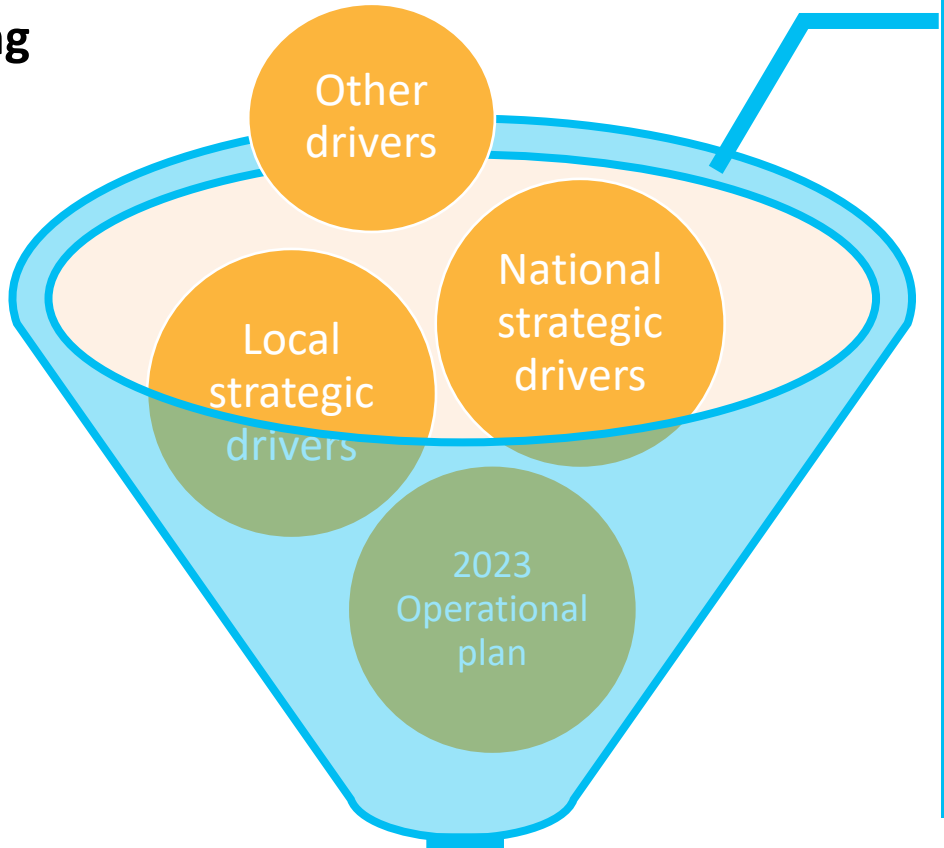
Values:

- To get the basics right- For each other, local people and communities
- To act with compassion and respect- For each other, local people and communities
- To make a positive difference- For each other, local people and communities
- To value and develop teamwork- With our partners and within DCHS
- To value diversity and inclusivity- Of each other, local people and communities

Strategy Summary

Strategic Theme	Outcome	Goal Statements
People at the centre 	DCHS is a great place to work and experience care	• Patients and carers experience great care that they actively participate in • Everyone is treated fairly, feels valued and that their wellbeing matters • Everyone is involved in improvement and feels able to take their ideas forward • Everyone feels able to speak up, we listen to and learn from people's experiences and act on what we hear
Working in partnership 	We work together in the best interests of people, no matter what organisation or team we are from	• Patients and carers experience great joined-up care, no matter how many people or organisations are involved • We work in teams centred around patient care rather than organisational boundaries • We work with partner organisations on shared goals, processes and systems • Service improvements are developed with the people they affect, using their diverse experiences to lead to better solutions
Healthy communities 	We improve the health of local communities, particularly for those who experience the greatest barriers to good health	• We have trusting relationships with local communities to promote good health for everyone • Prevention is our starting point, so people stay healthier for longer • We have high quality information which we use to make good decisions to improve community health • We focus on those who experience the greatest barriers to good health
Focus on the Future 	We are sustainable and play our part in meeting the future needs of staff, patients and communities	• We understand how local communities, patients and staff are changing and are ready to adapt, balancing opportunities and risk • We have a sustainable workforce, offering enjoyable, engaging and manageable careers • We use money and time well, balancing the requirement to plan for the future against immediate needs • We consider the environmental impact of everything we do

Next steps to transition to continual planning



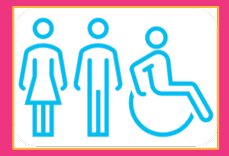
DCHS Organisational Strategy

Co-designed and co-delivered (clinically-led)

e.g. What does this mean to our team?
How will I/we take this forward?
What support do we need from DCHS?
How can we support with this across DCHS?

Focus

Steer

2024-28 Operational Plans
Planning activities


Development of the DCHS Strategic Plan

Strategic Objectives
Co-design process

- Joint Forward Plan
- Q Committees
- DCHS Teams
- Patients and communities
- **Today's sessions**: Board objectives
- COG-constituencies
- DCHS Members
- Staff networks
- JUCD partners

Data synthesis by Strategy and Planning team

Strategic Objectives approved by Board

DCHS 5-year **Strategic Plan**

DCHS Annual Operational Plan 2024/25

Measures of success/ KPI's/ Board Performance

Strategic Goals

Strategic Outcomes

- DCHS is a great place to work and experience care
- We work together in the best interests of people, no matter what organisation or team we are from
- We improve the health of local communities, particularly for those who experience the greatest barriers to good health
- We are sustainable and play our part in meeting the future needs of staff, patients and communities

DCHS NHSFT Vision:
Our vision is to see the health of local communities improve through partnership working, putting people at the centre and looking to the future.

Mission:
Our mission is to improve the health and wellbeing of local people and communities through personalised, safe and effective community-based services.

Timeline

May 2023 — **Nov/Dec 2023** — **April 2024** — **April 2028**

Learning from the journey so far…

- Starting out- we purposefully asked staff the open question of what matters to you?
- Avoiding duplication- due to the development of the ICS strategy we chose not to pursue separate consultation with patients and communities. We adapted our friends and family survey to find out what good would looked like and utilised feedback from the JUCD insights team
- Co-design principles and iteration- the strategy development has required ongoing iteration, engagement, checking back, to ensure we heard what matters
- Data analysis- we utilised skills of our improvement team to support survey data analysis and developed our own staff to undertake new analysis
- Writing group- we had a separate writing group to support the production of the content and this was tested regularly with stakeholders
- Closing the feedback loop- we were conscious about closing the feedback loop to show how people's contribution shaped the strategy
- Co-design and co-delivery of strategic objectives and future planning- by developing the strategy through co-design we are now seeking to do the same to implement the strategy and to set our strategic plan

Contact details to share feedback and comments

- Lucy Cocker Planning and Strategy project manager

lucy.cocker@nhs.net

- Ian Lawrence Clinical Director for Integration and CCIO

ian.lawrence@nhs.net

Appendix 2

Derbyshire Community Health Services
NHS Foundation Trust

Trust Headquarters
Ash Green Learning Disability Centre
Ashgate Road
Ashgate
Chesterfield
S42 7JE

01246 565000
www.dchs.nhs.uk

7 June 2023

Dear ICS Partner

Draft DCHS NHS FT Organisational Strategy 2023-2028

We are writing to you today to invite you to engage and feedback on the draft Derbyshire Community Health Services NHS Foundation Trust (DCHS) Organisational Strategy 2023-2028.

We started the process for refreshing our Organisational Strategy in July 2022, and it has been developed through co-design principles to ensure we have heard what matters to people. We would really like to hear your feedback on the content, to ensure the Strategy reflects what matters to you.

We have four combined strategic themes which have been derived through analysis of multiple data sources. These are:

- People at the Centre
- Working in Partnership
- Healthy Communities
- A focus on the future

Some of our goals and ambitions clearly relate to you as ICS colleagues and therefore we are keen to hear your views. You will find the content of the Strategy summarised in the slides attached to this letter.

Whilst we have sent this request through by email, we plan to present the Strategy in several JUCD forums over the coming month. If your team would like us to come to a particular meeting, then please let us know by getting in touch with lucy.cocker@nhs.net

It would be helpful if you could direct any feedback or comments on the draft Strategy to lucy.cocker@nhs.net before **Friday, 21st July 2023**.

Thank you for your support.

Kind regards

Tracy Allen
Chief Executive

Julie Houlder
Chair

Enc.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

20th July 2023

Item: 049

Report Title	Joint Forward Plan – Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28							
Author	Craig Cook, Director of Planning, Performance, Contracting							
Sponsor (Executive Director)	Zara Jones, Executive Director of Strategy and Planning							
Presenter	Zara Jones, Executive Director of Strategy and Planning							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☒
Appendices	Appendix 1 – Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Population Health and Strategic Commissioning Committee (at various stages of development).							

Recommendations

The ICB Board is recommended to **NOTE** the Joint Forward Plan and support the work proposed to progress the implementation of the plan.

SUPPORT is also requested to map the governance requirements through our ICB sub-committees and other relevant forums to ensure oversight and assurance is in place to ensure delivery of the different elements the plan. This work will be led by the ICB Chief of Staff.

Purpose

To brief Members on the Derby and Derbyshire Integrated Care Boards 'Joint Forward Plan' for the next five-years and to indicate the next steps for implementation.

Background

The Derby and Derbyshire Integrated Care Board's 'Joint Forward Plan' – referred to in the remainder of this document as the 'NHS Plan' - was published on 30 June 2023.

The plan, required under legislation, sets out the priorities of the local NHS for the next five years (2023/24 to 2027/28) and has been influenced by a series of national and local imperatives, including the NHS The NHS' Long-Term Plan (published in 2019) and the Derby and Derbyshire Integrated Care Strategy (published in 2023).

Report Summary

The Derby and Derbyshire NHS' Five Year plan was produced over the course of a three-month period, with a wide-ranging set of stakeholders involved in its construction and it was published on 30th June 2023.

In undertaking this work, the fundamental assumptions, strategies, and tactics employed over the last 10-15 years to improve healthcare were reassessed, particularly in the context of the future challenges that we will face. This resulted in a Plan to reset the NHS' approach and strengthen its contribution to achieving better health for all communities in Derby and Derbyshire.

The NHS Plan sets out five core guiding policies to direct coherent and co-ordinated action over the next five-year period:

1. Allocate greater resource to activities that will prevent, postpone, or lessen disease complications and reduce inequity of provision

During the period covered by this NHS Plan, the Derby and Derbyshire NHS will allocate a greater proportion of its resources – financial, human and estates – to enhance both the scale and quality of its prevention activity. It is fully recognised that there will be short to medium term issues and risks – quality, performance and finance related – that we will need to explicitly trade-off, given that our collective resource is limited. This requires detailed work up, including modelling over the five-year period.

This represents a different approach to what has gone before, and we are choosing it because it is a pre-requisite for putting our local NHS on a more sustainable footing.

Key actions will include:

- Strengthening primary care, specifically General Practice – both in terms of financial investment and clinical workforce.
- Re-purposing the function of acute based general medical provision and integrate it with general practice chronic care management provision, in a more substantive way.
- Reallocating primary and community care resource between localities – so that people with the poorest health outcomes have greater access to services.

Delivering this action will allow us to build a more preventative model to how the NHS currently operates across Derby and Derbyshire. However, it is also important that we define what type of preventative activity we want to enhance the scale and quality of.

In every interaction between a clinician and a patient, it is vitally important that interventions designed to prevent disease or injury before it happens, are being utilised by the people who would benefit. As such, the NHS' support role in primary prevention will be strengthened over the five-year period of this plan. However, in full recognition that introducing and scaling *impactful* primary prevention interventions at a population level is something that goes well beyond the boundaries of the NHS, the health system in Derby and Derbyshire will prioritise providing high quality, evidenced based secondary and tertiary prevention services.

2. Give the teams working in our localities, the authority to determine the best ways to deliver improvements in health and care delivery for local people

The first guiding policy focusses the NHS to act on the prioritisation of resource to deliver *more* and *better* preventative activity. However, this on its own is not enough to have the impact we need.

Therefore, the second guiding policy over this NHS Plan period, will focus action to create the infrastructure and incentives that are necessary to bring about a fundamental shift in how preventative activity is delivered – powering the creation of multidisciplinary teams (consisting of staff from the NHS, wider public and voluntary sector) to deliver improvement to the health of the populations they serve.

The further development of multi-disciplinary teams of professionals, working in and with local communities over the next five-years, will mean that they will possess greater insight into the specific needs, challenges, and cultural considerations of these communities. This **new** form of 'organisation of professionals' offers significant opportunities for greater innovation and flexibility – quickly adapting to errors and fixing problems.

To harness this collective power, our actions will focus on the following:

- Training and capacity building - developing an achievable workforce plan that focusses on transitioning the current workforce to deliver the requirements described in this Plan.

- Decision making – creating the right conditions for organisations (and their staff) to make decisions together, including the allocation of resource, for the benefit of improving population health, as opposed to being driven by individual organisation's needs and priorities.

- Performance incentives – designing a performance improvement approach that incentivises the *right* type of work being undertaken in the *right* way.

- Management support – ensuring an increased focus across our NHS organisations on (i) a high-quality data and analytics service to provide local teams with a clear analysis of local problems and assets; (ii) communication and engagement teams to design and deliver more effective ways of engaging with marginalised and disadvantaged communities; and (iii) high quality project management support to manage change.

3. Give people more control over their care

Establishing the first two guiding policies sets the direction for action in relation to the type of activity delivered and giving a new mandate for a different 'organisation of professionals' to deliver it.

This third guiding policy builds on this by focussing attention on the person receiving the healthcare.

Giving people more control over their care is therefore a guiding policy of this NHS Plan, with focussed work required to establish a set of coherent, scalable, evidence-based actions to advance the following aspects, across all areas of provision:

- Promoting health literacy, helping people to understand their conditions and the choices they can make – particularly amongst people living in some of the most disadvantaged communities in Derby and Derbyshire, as a way of improving self-management of conditions.

- Ensuring tailored information and support for individuals ensuring equality, diversity, and inclusivity. For example, information being provided in different languages. Also ensuring that inequity is not created through systems and processes which are not easily accessible for some communities.

- Personalised care and support planning – giving people access to all the information about their health that the NHS holds and supporting patients.

- Shared decision making - embedding this as the default way of working.

- People will be able to source health care provision outside of routinely funded services where this would meet their identified health needs.

4. Identify and remove activities from the provision of care which result in time and cost being expended but do not materially improve patient outcomes

This fourth guiding policy builds on the first three, by focussing action on the fundamental redesign of the process by which care is delivered, thus guiding action to achieve a more systematic approach to reducing inefficiency from the process.

Developing action to deliver this guiding policy will be complex and complicated, with more immediate focus on:

- Reframing the Derby and Derbyshire NHS efficiency improvement programme – by focusing on identifying waste as an organising principle and reducing waste as a core objective, we will be able to address the issue of 'inefficiency' in a more holistic and scalable way, across different care and service settings.

- Connecting experts on our key change programmes – When it comes to 'improvement' and delivering 'transformation', our experts – the people who support and deliver care – are spread too thinly and are not always focussed on working collectively to address agreed system priorities.

- Re-prioritising projects within our efficiency improvement programme – focusing resource on identifying and redesigning clinical and administrative work that is generalisable to many different care settings and sectors so we can achieve change at a greater scale.

5. Prioritise the improvement of the System's Intelligence Function and the capacity and capability of its research programme

The people who work in the Derby and Derbyshire NHS are its most valuable resource. The knowledge, skills, expertise, and experience of our people is vital for the long-term success of the service and contributes significantly to achieving better health for the Derby and Derbyshire population.

However, the next five-years will see technology fundamentally change how care is delivered, with vast amounts of new data being generated. Health and Care Systems which can effectively collect, analyse, and leverage data to gain insights, make informed decisions and drive innovation will create a competitive edge, in the following ways:

- Enabling predictive and preventative care –by leveraging data strategically, we can develop predictive models to anticipate disease outbreaks, identify individuals at risk of developing chronic conditions, and intervene proactively.

- Supporting research and innovation –building new collaborations and strengthening existing ones with academic, public, voluntary, and private sector stakeholders – advancing knowledge, improving practice, and creating opportunities for new financial revenues to flow into our health system.

- Enhancing operational efficiency – moving away from treating data as a 'by-product' of operational care processes and treating it as a strategic asset will provide us with the means to get better insight into how to optimise these operational processes, identify bottlenecks and improve resource allocation.

To achieve the above, action will be focussed on:

- Developing the skill of our analytical workforce – training in new forms of analytical techniques and methods.

- Developing a strategic approach to system intelligence and evidence which enables all teams involved in the planning of care to have access to a shared data set, with support from skilled analysts where they need it.

- Changing the nature of the work that analysts do - with teams working on a project basis focussed on clear, high impact questions, set in an environment which commits to embracing the outputs in planned decision-making processes.

- Developing the ICS' data model – synthesising a wide range of patient level datasets relating to the interaction of citizens with services and creating joint workspaces for local analysts to use it and collaborate.

- Collaborating with regional and national analytical networks - so that knowledge and evidence can be shared across the NHS.

What next then?

Implementing these guiding policies into practice will involve difficult decisions, such as reallocating resources, restructuring operations and divesting from certain areas to invest in new capabilities. In terms of strategic commissioner leadership, it is proposed we focus our initial attention on three aspects over the next six-months.

1. **Creating a Strategic Commissioning Prioritisation Policy**

This is a policy framework to enable the ICB to prioritise (and thus deprioritise) which healthcare interventions are to be commissioned during the 5-year period.

This will enable Providers of NHS care (at both an individual and collaborative level) to focus their efforts on creating the operational plans that are necessary to deliver the interventions within scope.

The proposed ICB Exec leads for this work are the Chief Medical Officer and Executive Director of Strategy and Planning. The timescale for completion is proposed as 30th September to ensure it is in place ahead of 2024/25 operational planning.

2. **Undertaking an economic projection of the future "state" of NHS resource supply and consumption – with different outcomes modelled relating to activity/performance, workforce, and finance**

This will establish a set of parameters - relating to capacity supply and utilisation, finance, and operational performance – for providers to work within when establishing operational plans for 24/25.

The proposed ICB Executive Leads for this work are the Chief Financial Officer, Chief People Officer and Exec Director of Strategy and Planning. The timescale for completion is proposed as 30th September to ensure it is in place ahead of 2024/25 operational planning.

3. Linking to the 2 items above, developing a PLACE level financial allocation policy

This is a policy which guides the equitable and efficient distribution of NHS financial resources to PLACEs across the Derby and Derbyshire ICB jurisdiction, relative to need.

This will establish PLACE level financial budgets and give local PLACE teams and Providers of NHS care, a transparent and evidence-based framework within which to allocate financial resources for the provision of NHS services.

The proposed ICB Exec leads for this work are the Chief Finance Officer, Exec Director of Strategy and Planning and IPE leaders. The timescale for completion is proposed as 30th September to ensure it is in place ahead of 2024/25 operational planning.

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.	☒			

No further risks identified at this stage.

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?**
Financial impact will be better understood as implementation actions progress. Finance colleagues are part of the work programme governance overseeing the implementation of the plan.	Executive Team supported the paper which includes the CFO.

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** Not at this stage – to follow
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings** Not at this stage – to follow
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings** Not at this stage – to follow

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:** Not at this stage – to follow

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:** Not at this stage – to follow

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None identified at this stage.

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

Details/Findings
Work will continue to deliver key aspects of the ICS' recently published 'Green Plan' – further details can be found on page 64 of the report.

NHS
Derby and Derbyshire
Integrated Care Board

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

Contents

Foreword

Through the continued development of our Integrated Care System across Joined up Care Derbyshire, we recognise and value the importance of positive relationships and collaboration in order to deliver the best possible health care for the citizens of Derby and Derbyshire.

To best meet their health and care needs, we must be clear on the role the NHS 'family' will play over the next few years to have the highest impact, particularly in supporting an approach to deliver more preventative health care and closing the inequality gaps we see between our many different communities.

In producing this five-year plan for the NHS across Derby and Derbyshire, we have engaged with our Integrated Care Board and Integrated Care System partners to best reflect the views, experiences and recommendations for how we significantly reset our approach to delivery. We are clear that we must fundamentally develop our approach, particularly in how we allocate our resources, become more efficient in our care and ensure people and patients are in more control over the decisions concerning the care they receive.

As described in our recently published Integrated Care Strategy, the health of our population in recent times has been negatively impacted owing to many factors, including the Covid pandemic and the cost of living. We have a difficult balancing act to achieve of focusing on today's challenges, whilst also tackling more strategic issues over the medium and long term.

Through creating the right conditions for our multi-disciplinary teams to determine the best ways to deliver improvements in health and care delivery and by fostering an environment that builds on our collaborative working to date, we will deliver better care, in a more co-ordinated and joined up manner.

As the Chair and Chief Executive of the Derby and Derbyshire Integrated Care Board, we think this Plan sets a clear direction of travel for the next few years. Publishing this Plan is not the end of the process, but instead the start of ensuring the Derby and Derbyshire NHS is prioritising effectively and adapting its approach to delivering improved health for the local population.

Richard Wright
Chair

Chris Clayton
Chief Executive

Acknowledgements

We are grateful to our partners for providing extensive feedback in the formulation process of our Plan. We recognise there is more work to do beyond this initial publication and more time is required to fully reflect on all the feedback and to further iterate our Plan together. We will therefore publish an updated version of this plan in Autumn 2023 so that we are on the front foot in ensuring this strategic Plan drives the 2024/25 NHS Operational Plan (year two of the five-year plan) and the years up to 2027/28.

Written feedback has been received from the following organisations and groups:

- Chesterfield Royal Hospital NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust
- East Midlands Ambulance Service NHS Trust
- University Hospitals of Derby and Burton NHS Foundation Trust
- Provider Collaborative Leadership Board
- Derby City Health and Wellbeing Board
- Derbyshire Health and Wellbeing Board
- Integrated Place Executive
- GP Provider Board
- Clinical and Professional Leadership Group

The feedback received and how it has been considered falls into three broad categories.

Recommendations that fall outside of the scope of the agreed parameters for this NHS Plan and are more appropriate for inclusion in other system strategies and plans

Some of the feedback received are within the scope of Health and Wellbeing Strategies, the detailed implementation plans for the Integrated Care Strategy, the annual NHS Operational Plan, or plans overseen by System Delivery Boards. We have sought to avoid duplicating content in this NHS Plan but will ensure relevant feedback is shared with partners for action.

Based on the feedback received we have however added content that emphasises the critical links between the aims in this Plan and the wider determinants of health, including referencing the Turning the Curve indicators. These wider determinants of health are not explored in detail in this NHS Plan given the roles of the Health and Wellbeing Boards and the Local Authorities in leading on these areas, but additional content has been included on NHS responsibilities for primary, secondary, and tertiary prevention and its contribution to a much wider partnership effort – led by our Health and Wellbeing Boards.

Some comments related to specific operational and enabling requirements, for which plans are agreed through the annual NHS Operational Plans and are overseen by the System Delivery Boards. This in no way denudes the importance of the issues flagged, but this document is the not the right vehicle for including more detailed improvement plans.

Recommendations that are within the scope of this Plan and need to be addressed in the next version

Several recommendations are pertinent to the scope and purpose of the Plan, and support implementation of the guiding policies, but they have not been included or fully incorporated at this stage. This is due to the need for further discussion and co-production, during Quarter 2, which will result in further content being included in the next iteration of this NHS Plan relating to the themes listed below.

Themes:

- More specific and measurable actions under the guiding policies, including timescales.
- Triangulated plans covering finance, workforce, and activity for the five-year period, and how we will deliver challenging financial savings working in partnership.
- Co-produced approach for how investment and disinvestment, and resource re-distribution decisions will be made, particularly given the current financial constraints
- Further engagement with communities and patients.
- Greater focus on buildings and the estate as key enablers.
- Need for more specific actions to tackle health inequalities.
- More visibility of public health commissioned (NHS delivered) services.
- How the workforce challenges will be addressed, including specific challenges relating to the fragility of services.
- Clarity on accountability, responsibility and authority for decision making and implementing the content of this Plan.
- More information on how we will re-design key pathways including the roles of primary care, clinical networks, and the ambulance service.
- Further recognition and exploration of the importance of relationships within the system.
- Increased focus on the role of anchor institutions and the anchor partnership.

Recommendations that have resulted in changes to the content of this Plan

This includes comments now reflected through the proposed actions under the guiding policies, as well as comments received on wording and emphasis within the document.

Themes:

- Greater clarity on the purpose and collective responsibilities for this Plan.
- Support for strengthening the approach to shift care and associated resources into preventative, proactive, community-based models.
- Increased reference to Health and Wellbeing Strategies and the role of the NHS in implementation.
- Focus on delivery of the 23/24 Operational Plan.
- The challenge of prioritising actions to improve population health and quality of life, whilst focusing on delivering Year 1 operational targets, given the extremely challenging operating environment.
- The need to stay within our resources.
- The need to translate the content into a narrative that the public and all staff can understand and engage with.

- Increase the focus on mental health, learning disabilities and autism – *noting that whilst additional content has been included, we will continue to test whether we have the balance right between physical and mental health.*
- Increased emphasis on research, innovation, and system intelligence.
- Increased emphasis on the role of the NHS in prevention.
- Increased content on our sustainability plans (more information is included in the Duties Document attached to this Plan).

List of Figures and Tables

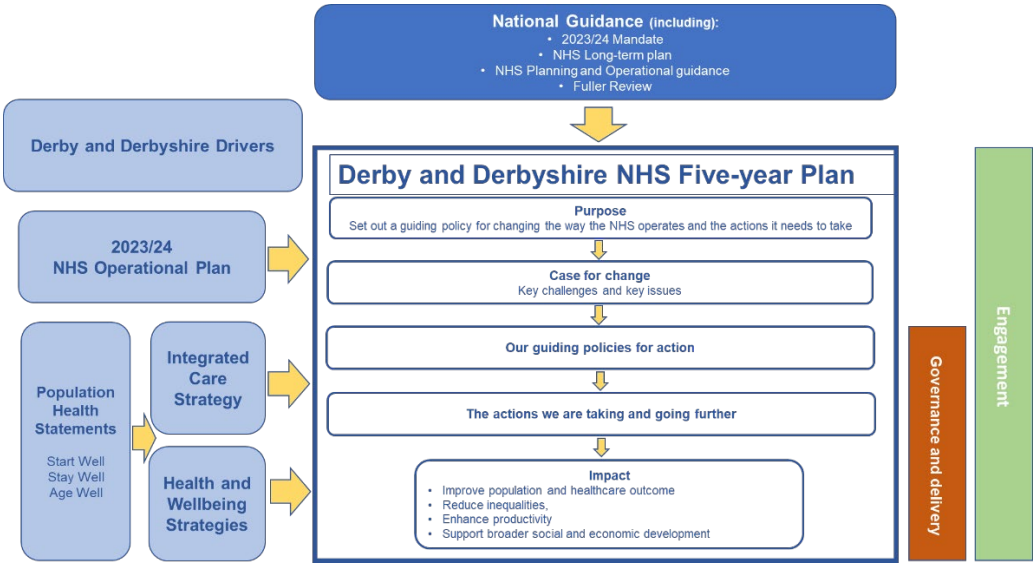
Figures

Tables

Executive Summary

This is our five-year Derby and Derbyshire Plan for the period 2023/24 to 2027/28. It sets out a guiding policy for changing the way the NHS operates and the actions it needs to take to improve population and healthcare outcomes, reduce inequalities, enhance productivity, and support broader social and economic development.

The following schematic summarises the expected requirements for this Plan and how is its structured:



The Plan should be read alongside the Derby and Derbyshire Integrated Care Strategy, which sets out broader Integrated Care Partnership ambitions to ensure all citizens start their lives well, live well, and age well, and the strategies produced by our two Health and Wellbeing Boards. The aim is to ensure this Plan aligns with these key local strategies and provides clarity on the role the NHS will play in helping to implement them.

The case for change included within this Plan is compelling, the challenges include:

- Deterioration in avoidable mortality and infant mortality in Derby and the reduction in the wellbeing of the Derbyshire population
- 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
- The growth in multi-morbidity intersected with older age is going to require a fundamental shift in how the NHS in Derby and Derbyshire operates.
- Evidence shows that patients feel less in control over the healthcare they receive, despite wanting it. It is imperative that we tackle this particularly given the proven benefits of better clinician relationships, improved adherence to advice and increased satisfaction with the outcome of treatment.

- The growth and expansion of new technology will revolutionise healthcare over the next five years and beyond, presenting both opportunities and challenges for us.
- The recruitment and retention of General Practitioners and community-based nurses is a pre-requisite over the next five year-period.
- The financial, productivity and environment challenges over the next five-year period go hand in hand. There are significant opportunities to reduce waste which must be realised to get the system on a better financial footing.
- Whilst the causes of these challenges are multifactorial and complex, we can positively affect them by reforming: (i) what our clinical workforce does in the future and type of skills we invest in; (ii) the way in which we allocate financial resource within the NHS and (iii) changing the nature of the care that we deliver for patients.

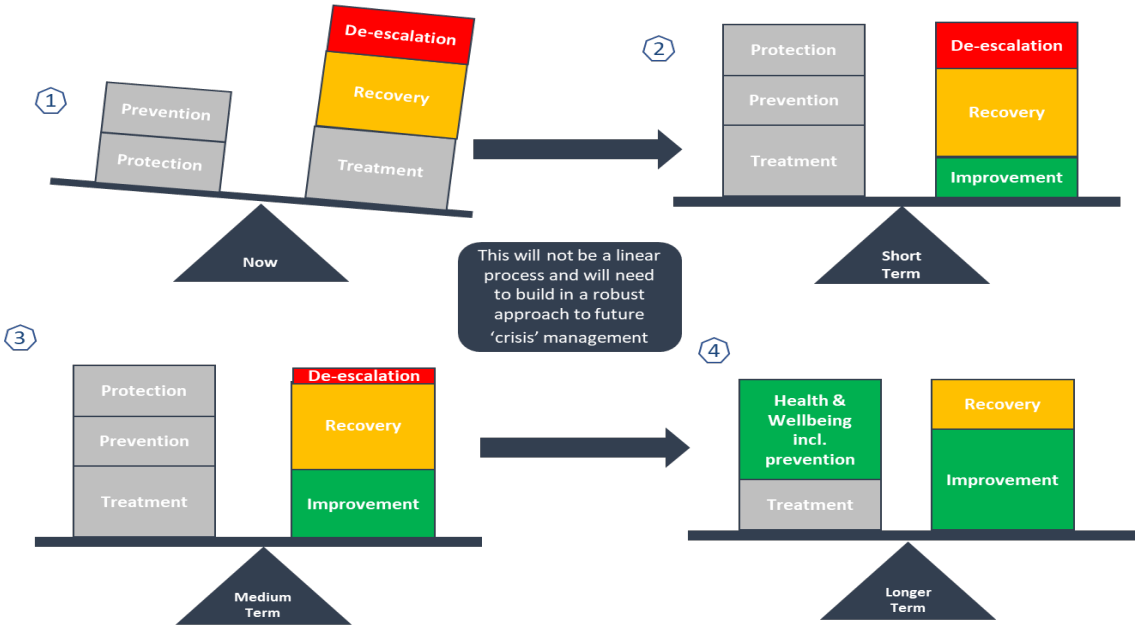
The guiding policy headings for this Plan and the actions that sit beneath them will drive annual NHS operational planning over the next five years and guide the development of a joined up and strategic approach to the commissioning and provision of healthcare across Derby and Derbyshire - to address the challenges we face, building on existing improvement activities.

Guiding policy headings:

1. Allocate greater resource to activities that will prevent, postpone, or lessen disease complications and reduce inequity of provision.
2. Give the teams working in our localities, the authority to determine the best ways to deliver improvements in health and care delivery for local people.
3. Give people more control over their care.
4. Identify and remove activities from the provision of care which result in time and cost being expended but do not materially improve patient outcomes.
5. Prioritise the improvement of the System's Intelligence Function and the capacity and capability of its research programme.

We are currently three months into implementing the NHS Operational Plan for 2023/24, and there is an unwavering focus on delivering Year 1 targets, including access, and waiting times across primary, community, mental health and acute pathways, across our NHS organisations. A summary of the 2023/24 plan can be read on the ICB's website.

It is within this context that we must agree improvement actions for the four following years, recognising the careful balancing act of managing immediate and short-term operational priorities with longer-term ambitions, as illustrated in the diagram below:



During the development of this Plan, we have heard from NHS providers of the current challenges they face in prioritising actions that will improve population health and quality of life, at the same time as focusing on delivering Year 1 operational targets, given the extremely challenging operating environment.

Recognising this constraint, we will work collaboratively with partners and the public during Quarter 2 of 2023/24 to agree and prioritise improvement actions and implementation timescales, and in parallel produce triangulated and aligned financial, workforce and activity plans for the next five years.

Improvement actions should build on examples of good practice in Derby and Derbyshire, such as our 'Team Up' approach for the development of community services. Staff from across the NHS, local authorities, and the voluntary sector work together as one team, so when people need care in their home, including people with complex needs, an integrated team delivers this care. This approach is a great illustration of our guiding policy in action.

There are several key considerations for implementing the guiding policy included in this Plan, many of which present challenges that need to be overcome, these include:

- Allocating our NHS resources more proportionately towards activities which will prevent, postpone, or lessen disease complications and reduce inequality in provision is one of the actions we wish to take. Within this, we must operate within the allocations we receive each year to commission and provide a range of health care services. To do this we will need to focus on being as productive and efficient as we can, so that we can target our resource at the areas which need it most.

- People are a key pillar to our overall local NHS Plan. From a staff perspective, our workforce on the front line of delivery, working at Place and locality level, require the capacity of teams working in and across communities to deliver improvements in health care.

- Our citizens and patients require more autonomy and control over their healthcare. This needs to be achieved through initiatives to improve their active involvement in decision-making in relation to their healthcare.

We are grateful to our partners for providing extensive feedback in the formulation process of our Plan. We recognise there is more work to do beyond this initial publication and more time required to fully reflect on all the feedback and to further iterate our Plan together. We will therefore publish an updated version of this plan in Autumn 2023 so that we are on the front foot in ensuring this strategic Plan drives the 2024/25 NHS Operational Plan (year two of the five-year plan) and the years up to 2027/28.

Finally, for this Plan to be impactful, the content will need to be converted into a set of key messages to engage staff and the public, in ways that create excitement and prompt debates about future plans for healthcare services and how the ambitions stated in this document can be delivered. We are therefore publishing a shorter guide for the public, staff, and our stakeholders, to sit alongside the complete Plan.

Engagement

Engagement activity undertaken to date to help produce this Plan

To produce this plan, an extensive range of perspectives have been sought from organisations across the NHS in Derby and Derbyshire, partners from the wider Integrated Care Partnership as well as insights drawn from the Public via a recent engagement event about the NHS@75.

However, this is just the start of a substantive period of engagement with all stakeholders, as we are committed to ensure that it connects with people who both deliver and receive the care that this plan is about. We therefore expect the content to change and develop over time.

Going further

We are committed to working in partnership with people and communities to form the right plan of action to improve the health service and build trust with the people that we serve. Moreover, we recognise that trust is an outcome, generated by decision making that is open and transparent, inclusive, and deliberative.

To therefore ensure we develop and implement a systematic approach to involving people and communities in developing this plan, the NHS in Derby and Derbyshire and its partners will deploy a range of supporting frameworks to guide the work that is necessary. These frameworks are in different stages of development and being produced with system partners, people, and communities:

Governance Framework	Critical to the success of all our frameworks, providing the necessary interface between people, communities, and the ICS, allowing insight to feed into the system and influence decision-making.
Insight Framework	Looks at how we identify and make better use of insight that is already available in local communities to inform the work of the ICS. All components of this framework have been or are currently being co-produced with a wide range of system partners.
Engagement Framework	The most developed of the frameworks and outlines a range of methods and tools available to all our system partners to support involvement of people and communities in transformational work.
Co-production Framework	Will embed, support and champion co-production in the culture, behaviour, and relationships of the ICS, including senior leadership level. This is still in the early stages of development and will be underpinned by the other frameworks.
Evaluation Framework	It is important that we are continually examining our public involvement practice and the impact this has on our work, people, and communities. It will outline how we measure and appraise our range of methods and support ongoing continuous improvement. This is in the early stages of development.

The intelligence gained via the deployment of our Insight Framework will support the continuous conversation that needs to take place around the plan. This activity will take place alongside specific engagement pieces, to ensure that we are constantly appraising the views of the public so that we are better placed to make informed decisions.

1. Introduction

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

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

The purpose of this Plan is to set the NHS in Derby and Derbyshire on a course over the next five-years to change the way it operates. In doing so it has formed a set of guiding policies for action, informed by a detailed analysis of the challenges that the NHS faces and the issues it needs to grapple with. Turning this into specific actions is the next step and as part of this, choices will need to be made.

The course, as set out in this Plan, will see the NHS changing its operating model so that it becomes more preventative in nature; more personalised for the citizen; intelligence led; and the clinical sectors/organisations are integrated by design in how they interact with patients and citizens.

By all partners committing to this course and taking the action that is necessary, we will be able to improve the quality of provision, reduce cost and maximise the NHS' contribution to the wider agenda of improving population health.

For this NHS Plan to be impactful, the content will need to be translated into a set of key messages to engage our staff and the public, in ways that create excitement and prompt debates about future plans for healthcare services and how the ambitions stated in this document can be delivered.

The content has been produced to reflect the requirements of the national guidance to create a "Joint Forward Plan"[1].The duties relating to the production of this Plan are covered in a separate Annex. This document is Derby and Derbyshire's Joint Forward Plan but is referred to as an "NHS Plan" throughout its content, to be clear to the reader what the scope of its ambitions and priorities are.

[1] NHS England – Guidance on developing the joint forward plan. B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf (england.nhs.uk).

1.1. Policy and Legislative considerations

The content of this NHS Plan has been influenced by a series of national and local imperatives, including those set out below.

The Long-Term Plan (2019)[2]

The NHS Long Term Plan (LTP) established a series of ambitious health improvement objectives for the NHS to deliver, including but not limited to:

- Halving the neonatal mortality rate.
- Reducing the number of heart attacks and strokes by 10%.
- Increasing the number of cancers diagnosis at stage 1 and 2 level.
- A major expansion in the number of adults and children who receive care for their mental ill health.

The COVID-19 pandemic had a significant impact on our improvement plans for the first three-years of a ten-year time horizon. Therefore, this NHS Plan period constitutes the most substantive part of the LTP timeline, which requires improvement at a pace and scale that will be ambitious and unprecedented.

The Derby and Derbyshire Integrated Care Strategy[3]

The recently published Derby and Derbyshire Integrated Care Strategy (DDICS), establishes a vision for population health and a set of supporting strategic aims for how the Integrated Care Partnership (ICP) will work together, to improve the health of the Derby and Derbyshire population – as shown in Figures 1 and 2.

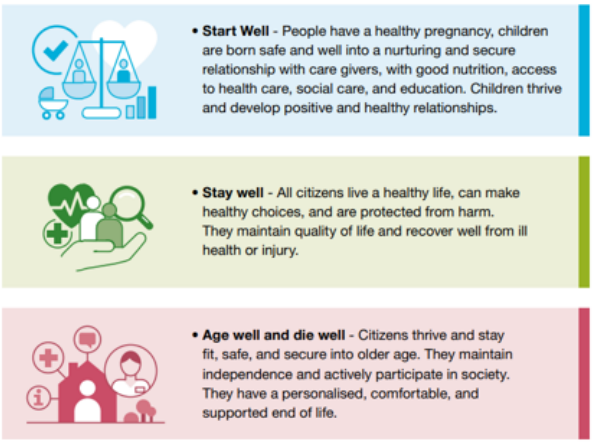


Figure 1. Vision for Population Health in Derby and Derbyshire. Derby and Derbyshire Integrated Care Strategy, 2023.

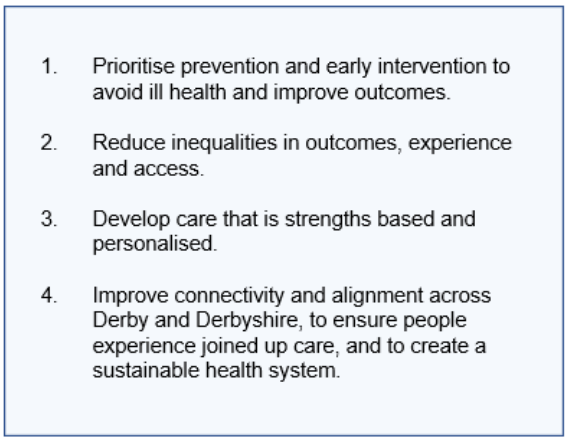


Figure 2. Strategic aims for integrated care. Derby and Derbyshire Integrated Care Strategy, 2023.

The DDICS has been developed in the context of the two Joint Local Health and Wellbeing Strategies and the two Local Authority plans, which are expected to be updated during 2023.

[2] NHS England. NHS Long Term Plan, 2019.
[3] Joined Up Care Derbyshire – Integrated Care Partnership. Derby and Derbyshire Integrated Care Strategy, 2023.

A major focus of the DDICS is on increasing life expectancy and healthy life expectancy and reducing inequalities – by tackling the leading causes of early death and time spent in ill-health.

On this front, the current situation is stark. As summarised at Figure 3, in Derby, the life expectancy and healthy life expectancy of both males and females is either lower or the same as it was almost a decade ago. Across Derbyshire (viewed at a county level), whilst the life expectancy of a male has slightly increased over the last decade, more of that time is living in ill-health. For females there has been no discernible improvement or decline.

Life expectancy at birth (years)

Local Authority	Derby		Derbyshire		England	
Period	2009-11	2018-20	2009-11	2018-20	2009-11	2018-20
Male	78.1	77.7	78.9	79.2	78.8	79.4
Female	82.2	81.5	82.8	82.8	82.7	83.1

Healthy life expectancy at birth (years)

Local Authority	Derby		Derbyshire		England	
Period	2009-11	2018-20	2009-11	2018-20	2009-11	2018-20
Male	63.2	57.7	62.6	61.5	63.0	63.1
Female	61.6	61.6	62.3	62.6	61.6	63.9

Inequality in life expectancy at birth (years)

Inequality in healthy life expectancy at birth (years)

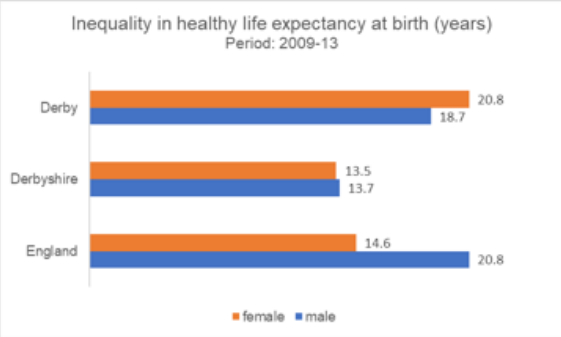


Figure 3. Life expectancy, healthy life expectancy and the inequality in both – Derby, Derbyshire, and England[4]

The inequality in both life and healthy life expectancy, as shown at Figure 3, clearly demonstrates the impact of deprivation. Poorer outcomes are linked to areas of socio-economic deprivation and certain groups including, but not limited to, those from Black, Asian, and minority ethnic backgrounds, those with serious mental illness, people living with disabilities, LGBTQ+ people and people currently homeless.

In response to this, the DDICS has set out a range of markers – referred to as 'Turning the Curve' indicators – that the ICP are aiming to affect, tackling key risk factors for early death, ill-health (physical and mental) and health inequalities.

[4] Office for Health Improvement & Disparities – Fingertips – Public Health Profile. **Life expectancy at birth** is a measure of the average number of years a person would expect to live. **Healthy life expectancy at birth** is a measure of the average number of years a person would expect to live in good health. **Inequality in life/healthy life expectancy at birth** is a measure that shows how much life/healthy life expectancy varies with deprivation.

'Turning the Curve' Indicators

1. Reduce smoking prevalence
2. Increase the proportion of children and adults who are a healthy weight
3. Reduce harmful alcohol consumption
4. Improve participation in physical activity
5. Reduce the number of children living in low-income households
6. Improve mental health and emotional wellbeing
7. Improve access to suitable, affordable, and safe housing
8. Improve air quality.

Next steps for integrating primary care: Fuller stocktake report[5]

The Fuller Report sets out a new vision for integrating primary care, improving the access, experience, and outcomes for communities, which centres around 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; and

- Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

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.

[5] NHS England, May 2022.

The Major Conditions Strategy[6]

The Government has launched a call for evidence to inform its landmark Major Conditions Strategy to tackle the main causes of ill-health, ensure care is patient focussed and relieve stress on the health and care system. Their call for evidence seeks views on how best to prevent, diagnose, treat, and manage six major groups of conditions that contribute to the burden of disease in England, specifically:

- Cancers;
- Cardiovascular (or circulatory) diseases, including stroke and diabetes;
- Chronic respiratory disease;
- Dementia;
- Mental ill health; and
- Musculoskeletal disorders

The significance of this development through 2023 going into 2024, has contributed to the framing of action within this NHS Plan to date and will continue to do so.

The NHS Mandate 2023[7]

The NHS Mandate for 2023 sets out the Government's priorities for the NHS for this year:

- Cutting NHS waiting lists, recovering performance for cancer, A&E, ambulance category 2 response times and general practice access;
- Supporting the workforce through training, retention and modernising the way staff work;
- Delivering recovery using data and technology; and
- Delivering financial balance.

These priorities make clear the need for our local NHS to continue to prioritise recovery and access in conjunction with our strategic aim to improve population health and to reduce inequalities.

[6] Department for Health and Social Care. Major Conditions Strategy: Call for evidence, 2023.
[7] Department for Health and Social Care. The government's 2023 mandate to NHS England, 2023.

How all the different strategies 'fit together'

This section demonstrates the significant amount of work that has been (and continues to be) undertaken to align the strategies of a range of actors that have a role in improving the health and wellbeing for our local population. The relationship between the key strategic outputs generated by various partners within the Health and Care System is shown in Figure 4.

However, the one thing that links all partners in the Health and Care System together is the unified clarity of purpose to deliver the strategic aims of the Integrated Care System (ICS):

- Improve outcomes in population health and healthcare;
- Tackle inequalities in outcomes, experience, and access;
- Enhance productivity and value for money; and
- Help the NHS support broader social and economic development.

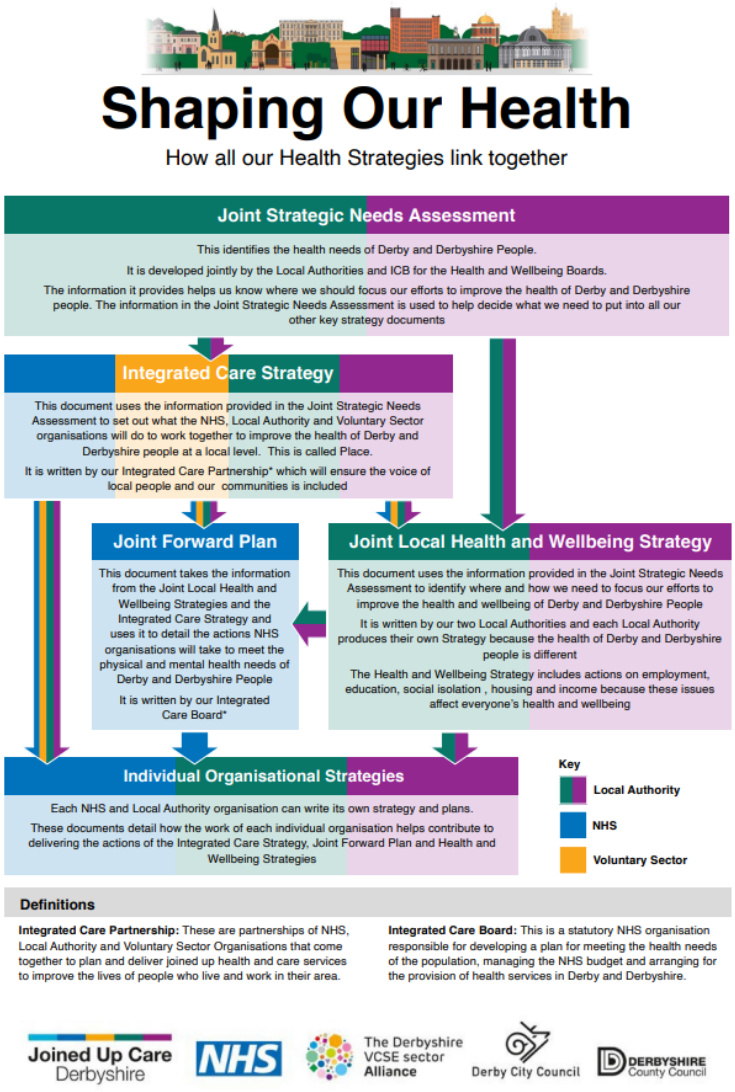


Figure 4. how all the different Strategies fit together

1.2. Derby and Derbyshire Healthcare System Development

This five-year period will see the continued development of how the NHS operates as part of the Integrated Care System. This will involve changes to the responsibilities and functions of different parts of the NHS, including where and how decisions are taken.

The Derby and Derbyshire Integrated Care Board as a Strategic Commissioner

The Derby and Derbyshire Integrated Care Board's (DDICB) role in the new architecture of the NHS, is focused on created a systematic and proactive approach to planning, procuring, and delivering NHS services for all communities of the Derby and Derbyshire population.

As a new organisation formed in 2022, the DDICB is evolving to achieve its ambition to be seen as a valued partner in the wider collective effort to improve population health and reduce the inequity in healthcare provision. Indeed, the broader constituency of the Board provides us with the means to do this and maximise performance against our statutory duties.

In this context, the recently published 'Strategic Framework' for the DDICB – as shown in Figure 5 – provides clarity of purpose for the organisation over this five-year period and the key leadership role it has in driving the integration of health and care services.

Purpose	To support people in Derby and Derbyshire to live their healthiest lives, creating a sustainable, joined-up health and social care system for now and the future.			
Vision	We will improve the health and wellbeing of people across all communities in Derbyshire by leading and supporting change, being a great partner and making progress easier across all sectors.			
Goals	**Enable and prevent** Support people across all communities in Derbyshire to maximise their health and wellbeing, with a shift from treatment to prevention.	**Health and care equity** Reduce health inequalities throughout Derbyshire communities by working with partners to address the factors influencing people's health.	**Impact and learnings** Prioritise evidence-based actions that will have the greatest sustainable impact, utilise data and digital solutions, and share our learnings across organisations, populations and sectors.	**Clarity and connection** Consistently provide clarity to our people, partners, and Derbyshire communities on the ICB's contributions and its overarching ambitions, priorities and responsibilities.
Values	**ONE TEAM**	**COMPASSIONATE**	**INNOVATIVE**	
Behavioural expectations	We are **collaborative**, a peer and a partner; we role-model integrated, collaborative working.	We are **kind** and respectful.	We **listen** to our communities and colleagues, fostering two-way communication and embracing co-production.	
	We are **open** and transparent in engaging with others and worthy of their trust.	We are **inclusive**, embracing diversity for all people across the organisation, the system, and the communities we serve.	We **learn** with, develop and grow our people, staying curious and bold in challenging convention.	
	We are **accountable**, visible and responsible leaders in our communities.	We are **supportive**, celebrating each other's skills, accomplishments and contributions.	We are **flexible** and adaptable, taking decisions that best serve the needs of staff and our communities.	

Figure 5 – The Derby and Derbyshire Integrated Care Board's Strategic Framework.

The design and delivery of care at PLACE

Our Places, which are our City and County footprints coterminous with our Local Authority boundaries and within these, our smaller alliance of partnerships at a locality level, have been developing in Derby and Derbyshire for several years. This enables the system to ensure a population focus alongside the traditional service or organisational ways of planning and delivering services and for achieving engagement, planning and delivery at a local community level.

> *"Empowering people to live a healthy life for as long as possible through joining up health, care and community support for citizens and individual communities".*
>
> The vision for PLACE based working in Derby and Derbyshire

This NHS Plan comes at a time where we have moved from informal networks and 'coalitions of the willing' to an operating model for Place with clear structure, purpose, and accountability. This governance will support the ability to identify and act in the areas of population need and service offer where there is most benefit from an integrated approach.

Furthermore, the Integrated Place Executive (IPE) is responsible for the design and delivery of Place development and has identified the fundamental need to model a set of new behaviours to generate the culture that is required to bring true integration about.

Aspirations for 'PLACE behaviour'

- Continue to work on and be brave in challenging each other to embody the attributes and behaviours of distributed leadership.
- Shared, democratic, collaborative decision making.
- Non-hierarchical.
- No idea off the table - not more of the same.
- Clear communication between all parties.
- Empowering all staff to work in partnership.

Provider Collaboration

The JUCD Provider Collaborative provides a single forum for all providers of NHS services to work together and take collective responsibility for the delivery of priorities within the NHS, enabling vertical as well as horizontal integration at scale.

The collaborative includes the following organisations:

- Chesterfield Royal Hospital NHS Foundation Trust
- Derbyshire Community Health services NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust
- DHU Healthcare
- East Midlands Ambulance Service NHS Foundation Trust
- University Hospitals of Derby and Burton NHS Foundation Trust
- GP practices - represented by the GP Provider Board

> *" Working together as providers to achieve tangible improvements to the way care is delivered ".*
>
> The vision for provider collaboration in Derby and Derbyshire

As the Provider Collaborative matures over the period of this NHS Plan, it is anticipated that significant, value adding benefits will arise in the form of:

- Developing and delivering collaborative approaches to specific challenges within providers' gift to resolve;
- Addressing efficiency, productivity and sustainability through collaborative working, integration, or the consolidation of service delivery or corporate functions;
- Developing partnership relationships, strengthening communication between providers, sharing approaches to challenges and opportunities;
- Reducing inequalities of access and unwarranted variation, where provider collaboration can best achieve this; and
- Taking on some commissioning responsibilities within the ICS where this will align better with operational delivery and transformation, improve decision making and accelerate change.

1.3. Our NHS Plan – its positioning and core focus

This NHS Plan has been constructed with clear recognition of the extent to which good healthcare provision contributes to health. As shown in Figure 6, the Plan's scope focuses exclusively on how the NHS in Derby and Derbyshire can 'maximise the 20%', by addressing a series of structural design issues which has hampered our ability to improve.

Indeed, delivering this plan will mean that the NHS will become the best partner it can be, collaborating with other sectors to shift the system towards health opportunities for all communities[8].

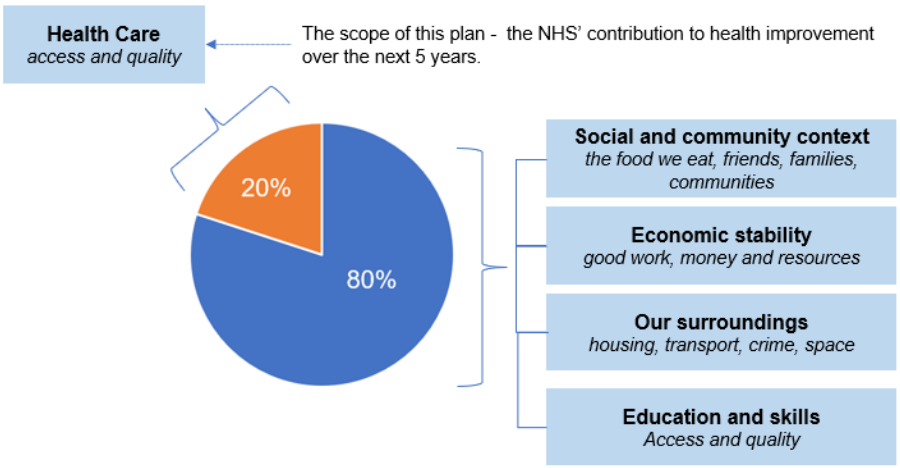


Figure 6. Drivers of health[9][10]

The NHS Plan within the wider effort to improve population health

The Derby & Derbyshire ICB's definition of Population Health Management (PHM), that the local health economy is coalescing around is:

> *An approach that identifies communities of people with shared or like characteristics, and then intervenes with socio-economic or healthcare interventions for that community in order to improve health outcomes, reduce service need whilst also improving the sustainability of health and care services.*

The local approach to deliver effective Population Health Management brings together:

- A focus on agreed high priority health issues
- The effective reduction in health inequalities, and
- Primary, secondary, and tertiary prevention.

[8] Alberti PM, Pierce H. A population health impact pyramid for medicine. Millbank Quarterly, 2023.
[9] Health Foundation, 2019.
[10] Blumberg et al., 2021.

The high priority clinical areas of focus within Derby & Derbyshire are already identified and agreed as:

- Cardiovascular disease (including diabetes);
- Respiratory disease;
- Cancer; and
- The early years of life (pre-school).

There is a recognition that experience of good health in our communities is not equal. There are individuals and communities that experience poorer health outcomes than others, for example individuals within deprived communities, people within minority groups and from specific cultural or ethnic groups and people with other underlying conditions such as severe and enduring mental health concerns.

To address health inequalities and deliver on the prevention agenda, we recognise the need to ensure the better targeting of healthcare resources upon those individuals in greatest need and greatest ability to benefit from those resources. We are now establishing approaches that will deliver both Population Health Management and improved health outcomes, within the communities that we serve.

However, in producing this NHS Plan, it is important to stress that we want to avoid *medicalising* the population health and health equity agenda. We therefore try to avoid conflating "health" with "healthcare" – fully recognising that healthcare is one of the many factors that contribute to population health.

Furthermore, whilst developing a more comprehensive approach to PHM over the next five-years, we recognise it is not a silver bullet to improving the health of population. This is particularly important when considering the limited effectiveness of PHM *interventions* relative to large scale structural change that addresses disadvantage, risk and exposures that have accumulated over a lifetime[11].

The significance of Primary Care in the NHS Plan

A core assumption which underpins this NHS Plan is that Primary Care is the cornerstone of the Derby and Derbyshire NHS' contribution to improving population health. Therefore, over the course of this NHS Plan period, action will be prioritised to strengthen Primary Care, with a programme of work being developed to:

- Integrate 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;
- Improve access to urgent and same day care in primary and community settings;
- Reduce inequalities of access, outcomes, and experience associated with care;
- Develop and make best use of JUCD resources - workforce, financial and physical; and
- Support the integration of pharmacy, optometry, and dental primary care services.

[11] Lantz PM. The medicalisation of population health: who will stay upstream? Millbank Quarterly, 2019.

A summary of this Programme, which is developed and overseen by the Primary Care and Community Delivery Board, is included under Section 5.

The structure of this document

This NHS Plan is organised into six sections:

- Section 2 – The case for change - discusses a series of key challenges that the NHS in Derby and Derbyshire will face over this five-year period (and beyond) and identifies the critical issues for the NHS to resolve.

- Section 3 – Our guiding policies for action – sets out an approach for dealing with the challenges and critical issues as identified in section 2 – by establishing five guiding policies for action.

- Section 4 – The action that we are taking in 2023/24 – describes the action that we are taking in 2023-24, as the first year of this five-year plan, to carry out these guiding policies.

- Section 5 – Building on this action and going further – sets out a range of works which will be developed and delivered by system partners in future years of this plan, building on the progress that we make in 2023/24.

- Section 6 – Governance – describes the governance arrangements relevant to this Plan and the key strategic risks that need to be considered.

2. The Case for Change

Summary points:

- There are aspects to the deterioration of the population's health over the last eight years which are of particular concern – specifically avoidable mortality and infant mortality in Derby and the reduction in the wellbeing of the Derbyshire population.

- In addition to the above, improvement works within the NHS must target the conditions which drive the disease burden across the Derby and Derbyshire population - Cancer; Cardiovascular disease, Musculoskeletal disorders; Mental disorders, neurological disorders, and chronic respiratory disease.

- Crucially though, it is the growth in multi-morbidity intersected with older age which is going to require a fundamental shift in how the NHS in Derby and Derbyshire operates.

- Evidence shows that patients feel less in control over the healthcare they receive, despite wanting it. It is imperative that we tackle this particularly given the proven benefits of better clinician relationships, improved adherence to advice and increased satisfaction with the outcome of treatment.

- The growth and expansion of new technology will revolutionise healthcare over the next five years and beyond, presenting both opportunities and challenges for us. The issue that the Derby and Derbyshire healthcare system will need to grapple with isn't whether we choose to adopt these technologies, rather how best to prepare for the change ahead.

- The recruitment and retention of General Practitioners and Community based nurses is a pre-requisite over the next five year-period.

- The financial, productivity and environment challenge over the next five-year period go hand in hand. There are significant opportunities to reduce waste which must be realised to get the system on a better financial footing.

- Whilst the causes of these challenges are multifactorial and complex, we can positively affect them by reforming: (i) what our clinical workforce does in the future and type of skills we invest in; (ii) the way in which we allocate financial resource within the NHS and (iii) changing the nature of the care that we deliver for patients.

2.1. Key challenges for the Derby and Derbyshire Health System

A backdrop of a deterioration in the population's health

The Office for National Statistic's Health Index[12] provides a single value for health in England and local authorities each year. The index uses a broad definition that aligns with the World Health Organisation's definition of health[13], incorporating a range of indicators that relate to health outcomes and health related behaviours in addition to the place where people live, as summarised in Figure 7.

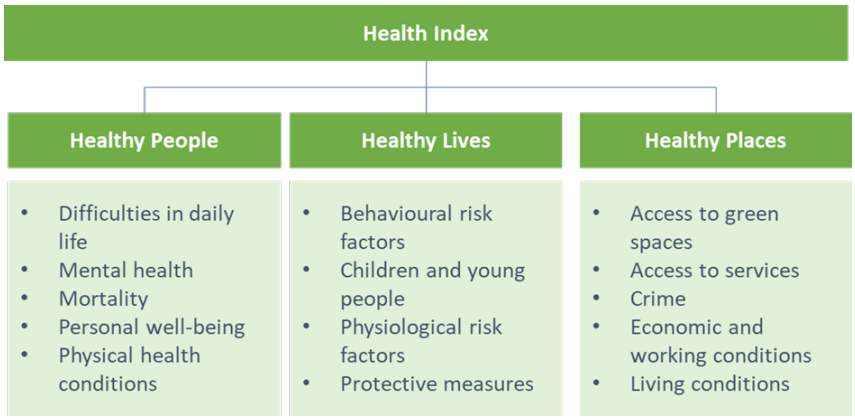


Figure 7. The construct of the Office for National Statistics (ONS) Health Index[12]

All scores are relative to the 2015 baseline, so a higher score indicates improving health, and a lower score indicates deterioration in health.

The health of the Derby and Derbyshire population

At a macro level, the health of Derby population was on average lower in 2021 compared to 2015 (index score of 90.4 in 2021 vs. a score of 92.3 in 2015) and marginally higher for the Derbyshire population at a county level (index score of 108.7 in 2021 vs a score of 108.1 in 2015). However, the 'healthy people' domain score for both local authority areas was significantly lower in 2021 relative to 2015 – as shown in Table 1.

	Derby			Derbyshire		
	2015	2021	variance	2015	2021	variance
Overall Health Index score	**92.3**	**90.4**	**(1.9)**	**108.1**	**108.7**	**0.6**
Healthy people domain score	92.5	87.2	(5.3)	100.8	96.6	(4.2)
Healthy lives domain score	93.9	92.2	(1.7)	107.1	107.5	0.4
Healthy places domain score	94.4	96.4	2.0	112.5	117.9	5.4

Table 1. Health Index Score with domain breakdown – Derby and Derbyshire[14]

[12] Office for National Statistics (ONS), release date 09 November 2022, ONS website, methodology article, Title: Health Index contents and definitions.
[13] Constitution of the World Health Organisation.
[14] Office for National Statistics (ONS) released 16 June 2023, ONS website, Methodology, Health Index methods and development: 2015 to 2021.

Given that the 'Healthy People' domain draws on indicators that are pertinent to the activities of the NHS, it is a concern that this aspect of health has deteriorated so much in the last eight years.

So, what has caused this deterioration?

The decline in **Healthy People** has predominantly been seen in the following sub-domains of the measure: 'personal well-being' (a 11.0-point reduction in Derbyshire and 2.6-point reduction in Derby); 'mortality' (a 5.5-point reduction for Derby specifically) and 'difficulties in daily living' (a 2.6- point reduction in Derbyshire and 12.3 reduction in Derby) - as shown in Figure 8.

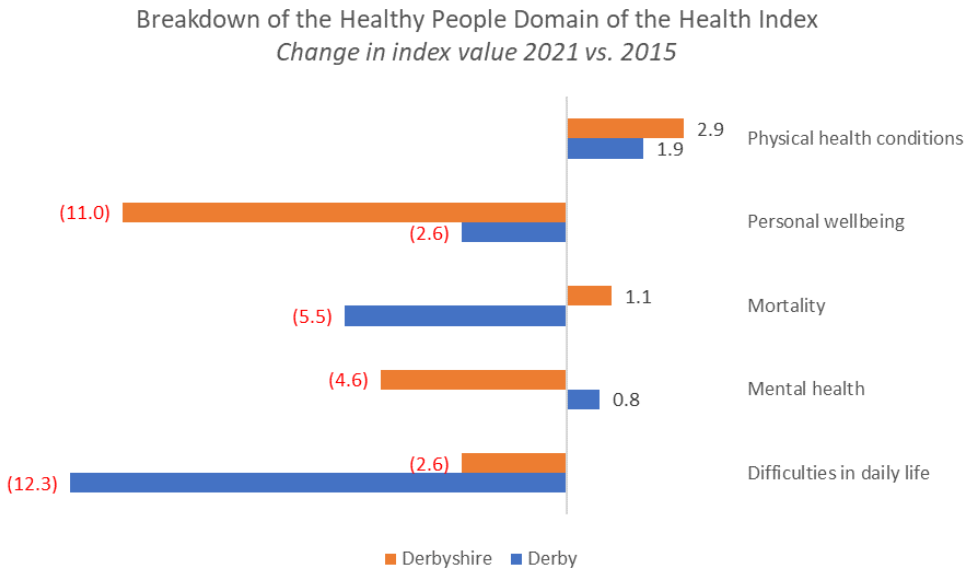


Figure 8. The sub-domain elements of the Healthy People Measure of the Health Index – *difference between the 2021 measure and the 2015 baseline index value*[14]

A full breakdown for each of the elements listed in Figure 8, is detailed in Appendix A for information but the most significant findings are that:

- **The adverse change in the mortality index seen across Derby is a concern** - with all aspects of this measure – mortality from all causes; life expectancy; infant mortality and avoidable mortality - recording a lower index value in 2021 relative to the 2015 baseline.

- **The reduction in the level of personal wellbeing felt by people living in Derbyshire**, is driven by people feeling, on average, less satisfied within their life, less happy, more anxious and feeling that activities in life are less worthwhile than in 2015.

- **The reduction in the difficulties in daily life score across both Derby and Derbyshire,** is due to a greater proportion of working age adults registered as disabled under the Equality Act or work-limiting disabled.

The burden of disease

The latest Global Burden of Disease Study[15] shows that the top six causes of disease burden, as measured through the Disability Adjusted Life Years[16], across the Derby and Derbyshire population are: Cancer; Cardiovascular disease, Musculoskeletal disorders; Mental disorders, neurological disorders, and chronic respiratory disease – with the burden of mental and neurological disorders increasing over the last three decades, as shown in Figure 9.

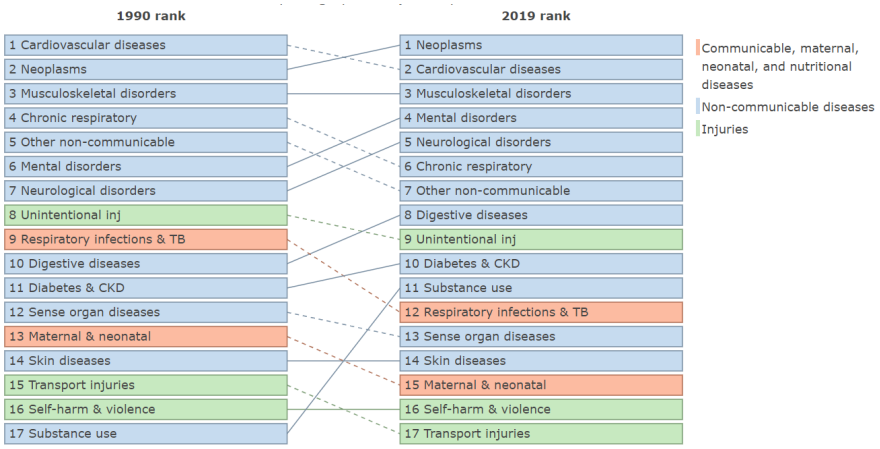


Figure 9. Disability Adjusted Life Years (DALYs) per 100,000 population[13]

All these conditions are non-communicable with the main causes of them relating to tobacco use, high fasting glucose levels, high body mass index, dietary risk and high blood pressure and cholesterol, as shown at Figure 10.

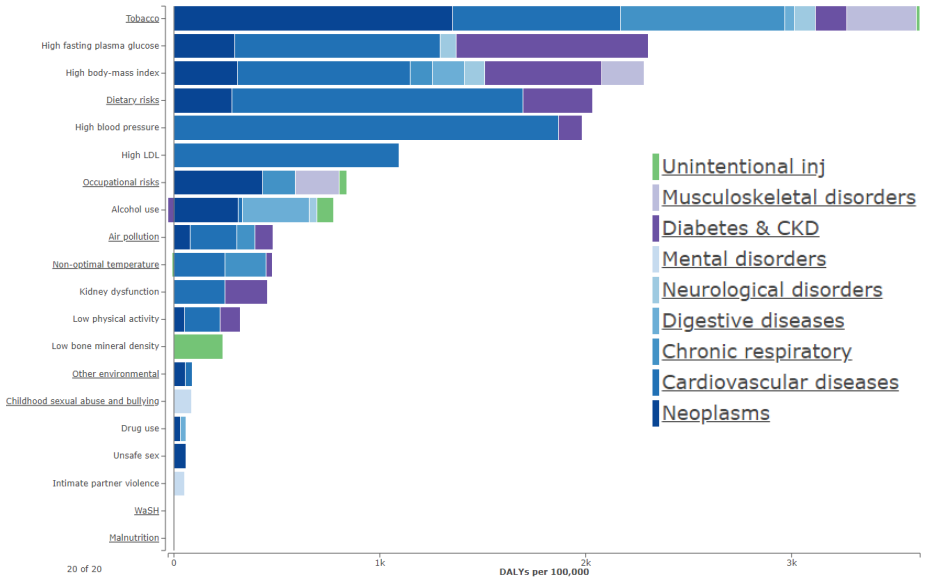
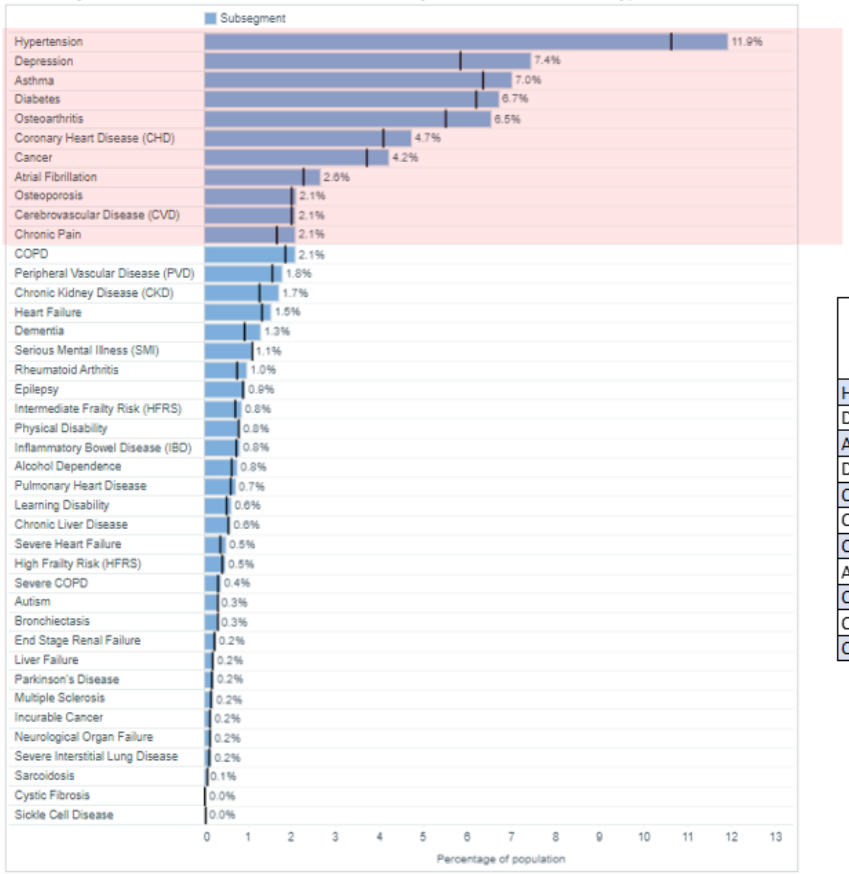


Figure 10. Cause of Disability Adjusted Life Years (DALYs) per 100,000 population[13]

[15] Global Burden of Disease, 2019. Institute for Health Metrics and Evaluation – University of Washington, 2023. https://vizhub.healthdata.org/gbd-compare/ accessed 7 June 2023.
[16] Disability Adjusted Life Years – DALYs: the total number of years of 'healthy life' lost due to illness and/or death

Whilst dealing with the impact of these conditions over the next five-year period is going to present a series of complex challenges for the NHS, it is the growth in multi-morbidity intersected with age (see next point) which is going to require a fundamental shift in how the NHS in Derby and Derbyshire operates.



Proportion of people with these conditions who are multi-morbid

Condition	% of population with 2 or more conditions	Count of comorbidities					
		0	1	2	3	4	5
Hypertension	61%	15%	24%	20%	14%	10%	18%
Depression	39%	39%	22%	13%	8%	6%	12%
Asthma	37%	41%	22%	13%	8%	5%	11%
Diabetes	53%	29%	19%	16%	12%	8%	17%
Osteoarthritis	62%	18%	20%	18%	13%	10%	21%
Coronary Heart Disease	74%	9%	17%	18%	15%	12%	29%
Cancer	51%	28%	22%	16%	11%	8%	16%
Atrial Fribrilation	82%	7%	11%	15%	15%	14%	38%
Osteoporosis	70%	14%	15%	15%	13%	11%	32%
Cerbrovascular Disease	77%	9%	14%	15%	14%	12%	36%
Chronic Pain	75%	8%	18%	18%	15%	12%	30%

Figure 11. Proportion of the Derby and Derbyshire population with a range of clinical conditions – snapshot as at 30/06/21[17]

[17] NHS England. Population and Person Insights Dashboard. Accessed 7 June 2023.

Preparing for the change in demography

Whilst over the next five-year period, we expect all age population to be bigger in 2028 relative to 2023 (1% Derby and 3% Derbyshire), the fastest growing sector of the Derby and Derbyshire population is the older adult, those aged over the age of 65. We expect this population to be 10% and 9% larger in 2028, in Derby and Derbyshire respectively.

Furthermore, it is expected that two-thirds of adults aged over 65 will be living with multiple health conditions (multi-morbidity) by 2035 - 17% living with four or more diseases, double the number in 2015 and one-third of these people would have a mental illness like dementia or depression.

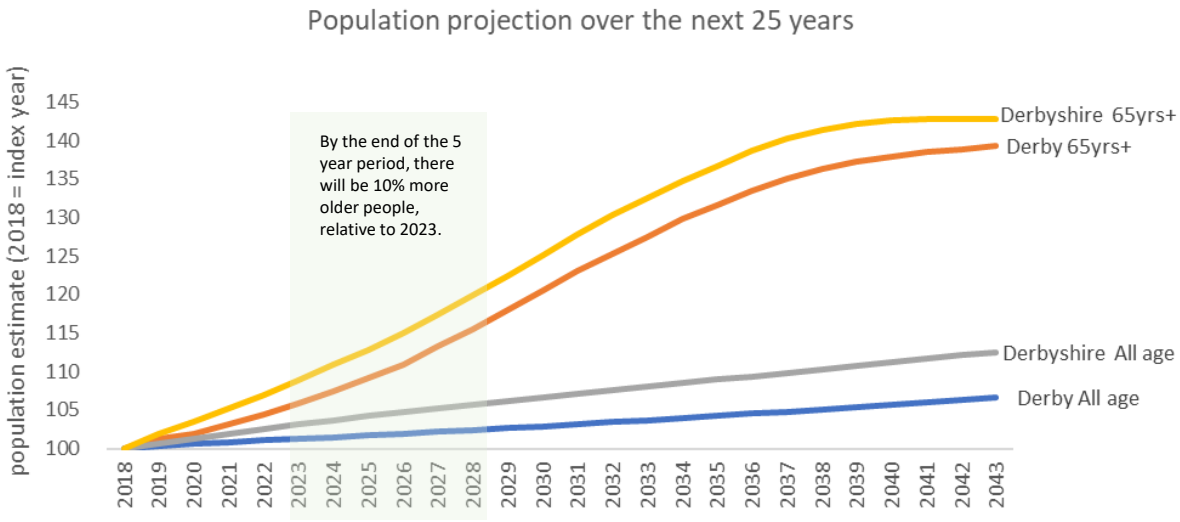


Figure 12. Derby and Derbyshire population projections. Office for National Statistics[18]

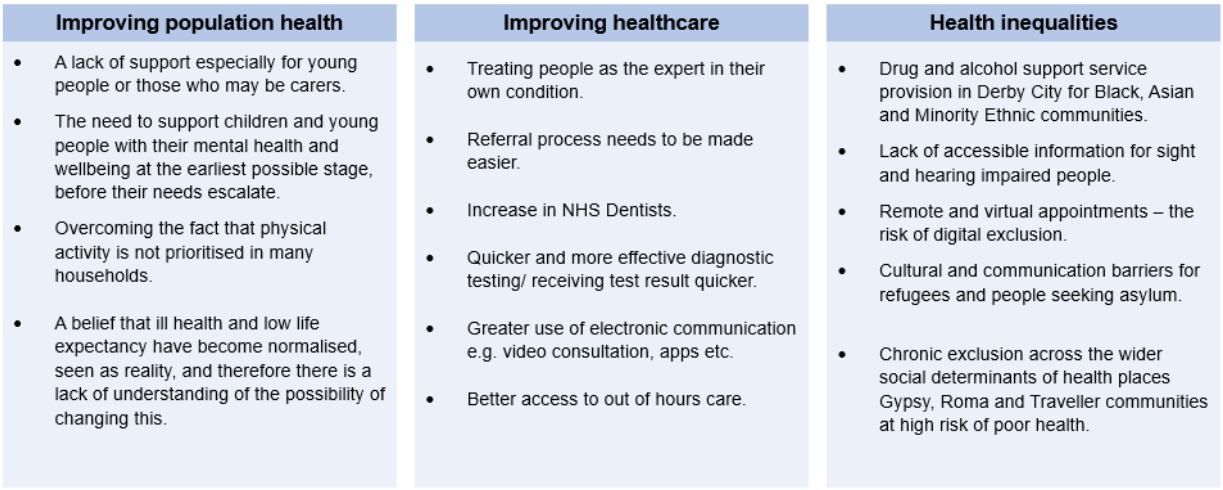
Public expectations and insights

Public expectations regarding healthcare have evolved over time, with patients and their families seeking more active involvement in decisions regarding their care. However, the evidence shows that patients feel less in control over the healthcare they receive. For example, the latest population survey of General Practice found that 44.6% of patients want more involvement than they currently have in their healthcare decisions – the highest proportion since the question was first asked in 2018[19]. Similar findings arise in other aspects of provision, including community mental health services and acute inpatient services[20].

[18] Office for National Statistics (ONS), National population projections: 2018-based, October 2019.
[19] Personalised Care Institute https://www.personalisedcareinstitute.org.uk/2022/09/06/new-data-shows-patients-want-more-involvement-in-healthcare-decisions
[20] The Nuffield Trust. Patient experience: do patients feel involved in decisions about their care? https://www.nuffieldtrust.org.uk/resource/do-patients-feel-involved-in-decisions-about-their-care#:~:text='%2038%25%20said%20they%20were%20involved,2020%20to%2026%25%20in%202021.

In this context, giving patients better control over their care – shared decision making, health literacy and the provision of better information - is a challenge that the Derby and Derbyshire NHS must meet over the next 5 years, particularly given the proven benefits of better clinician relationships, improved adherence to advice and increased satisfaction with the outcome of treatment.

In addition to this, insight gathered from recent engagement exercises relating to development of the DDICS and for 'NHS@75' – summarised in Figure 12, illustrates some of the pressing drivers for change from the public's perspective across the start well, stay well, and age well life course.



Improving population health	Improving healthcare	Health inequalities
• A lack of support especially for young people or those who may be carers. • The need to support children and young people with their mental health and wellbeing at the earliest possible stage, before their needs escalate. • Overcoming the fact that physical activity is not prioritised in many households. • A belief that ill health and low life expectancy have become normalised, seen as reality, and therefore there is a lack of understanding of the possibility of changing this.	• Treating people as the expert in their own condition. • Referral process needs to be made easier. • Increase in NHS Dentists. • Quicker and more effective diagnostic testing/ receiving test result quicker. • Greater use of electronic communication e.g. video consultation, apps etc. • Better access to out of hours care.	• Drug and alcohol support service provision in Derby City for Black, Asian and Minority Ethnic communities. • Lack of accessible information for sight and hearing impaired people. • Remote and virtual appointments – the risk of digital exclusion. • Cultural and communication barriers for refugees and people seeking asylum. • Chronic exclusion across the wider social determinants of health places Gypsy, Roma and Traveller communities at high risk of poor health.

Figure 13: Summary of issues arising from the NHS @75 engagement event.

Advancements in technology

The growth and expansion of new technology will revolutionise healthcare over the next five-years and beyond, presenting both opportunities and challenges for us. Medical breakthroughs, such as genomics, precision medicine and machine learning hold the potential for us to personalise the care we give in a more efficient and effective way.

The issue that the Derby and Derbyshire healthcare system will need to grapple with isn't whether we choose to adopt these technologies, rather, the issue is one of preparedness – with a range of challenges to work through.

Improving productivity

The recently published report by the Institute of Government[21] examines the issue of why hospital activity has not increased in line with funding and staff. Clearly, the productivity challenge is not only limited to hospital-based care. However, given that significant investment has gone into the sector in the recent past is it reasonable to focus on the challenges of this sector as a priority.

The key area of improvement required over the next five-year period relates to the productivity of elective acute care services, where the level of input (the number of medical Full Time Equivalents FTEs working in surgical specialties) has increased by 20% since 2016, but the level of output (the number of completed RTT admitted and non-admitted pathways) has reduced – as shown in Figure 14.

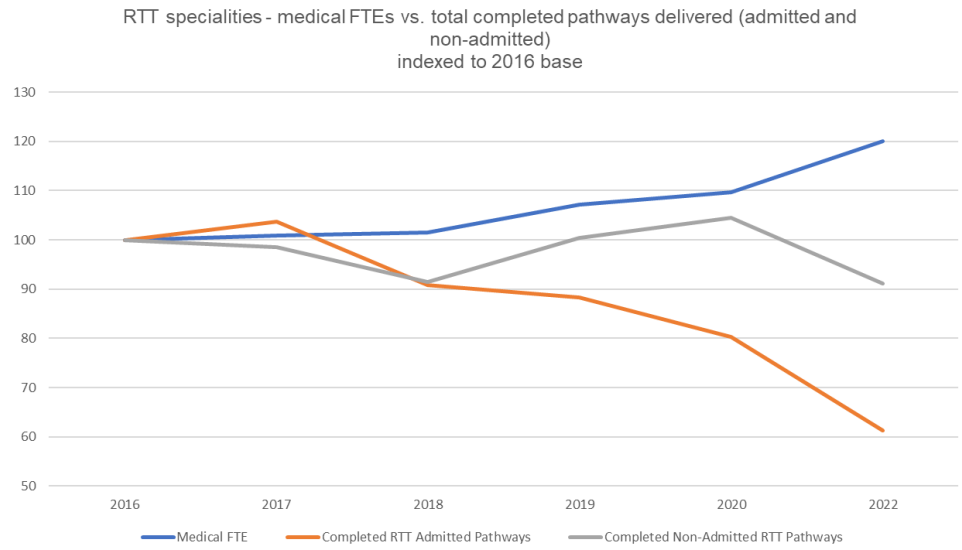


Figure 14: Number of Medical FTEs working in elective care specialities and the total number of RTT admitted and non-admitted pathways – with 2016 as the base year[22]

Whilst the causes for the lag in elective productivity are complex and multifactorial, there are two underlying issues at play, which need to be resolved if we are to improve the situation.

- Reducing general medical acute demand. The use of surgical bed provision to manage medical demand because it can't be safely managed within the medical bed footprint, has become normalised in day-to-day practice.

- The c.200 patients currently who are ready to go home but are in delay. The opportunity cost of delayed discharge is significant, due in part to a lack of suitable capacity outside our acute hospital (c.60% of the problem) in addition to poor internal discharge processes (c.40% of the problem).

[21] Freedman S, Wolf R. The NHS productivity puzzle: Why has hospital activity not increased in line with funding and staffing? Institute for Government, 2023.
[22] Medical FTEs relating to: Cardiology, Dermatology, Gastroenterology, General Surgery, Neurology, Gynaecology, Ophthalmology, Oral and MaxFacs, Orthodontics, Otolaryngology, Rheumatology, Trauma and orthopaedic surgery, Urology, Vascular Surgery. RTT service relate to: Cardiology, Dermatology, Ear Nose and Throat, Gastroenterology, General Surgery, Gynaecology, Neurology, Ophthalmology, Oral Surgery, Plastic Surgery, Rheumatology, Trauma and Orthopaedic, Urology.

The care quality gap

Over this five-year period, there are significant opportunities to improve the quality of healthcare provision as shown in Figure 15. This will not only have a demonstrable positive effect on the health and wellbeing of our population but also enable the Health System to save money.

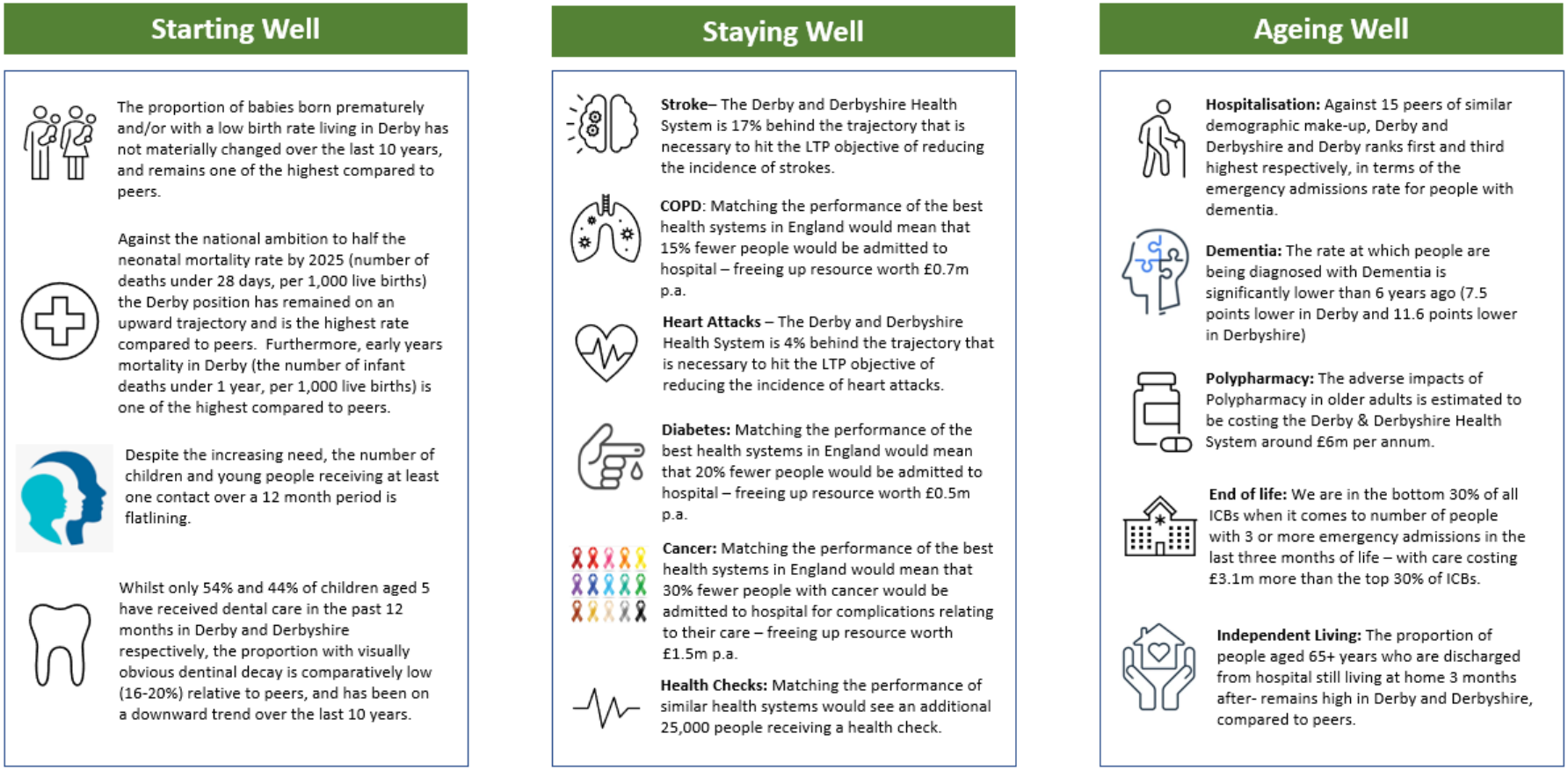


Figure 15: Summary of opportunities to improve specific aspects of healthcare over the next five-years.

The cost of provision

The environmental challenge

NHS England in its 2020 report, *delivering a Net Zero National Healthcare Service*, sets challenging targets for the NHS to decarbonise healthcare delivery. This includes achieving net zero carbon emissions by 2040 and requires the NHS in Derby and Derbyshire to remove 23,000 tonnes of carbon emissions per year, during this NHS Plan period, from both direct and indirect aspects of healthcare provision.

The financial challenge

In the context of the economic situation, it is highly likely that the next five years will see the NHS in Derby and Derbyshire continue to operate within a constrained financial environment. To clear the underlying deficit over the next 5-year period will require a cumulative reduction in the cost of delivering care of around £363m (assuming a 4.4% reduced level of spend is delivered in 2023/24 and recurrent savings of 2% are delivered in years 2-5). Meeting this challenge will require all parts of the Derby and Derbyshire health system to fundamentally change at significant scale, how NHS care is delivered and have a much greater focus on reducing different aspects of waste from the process of delivering care – as summarised in Figure 16.

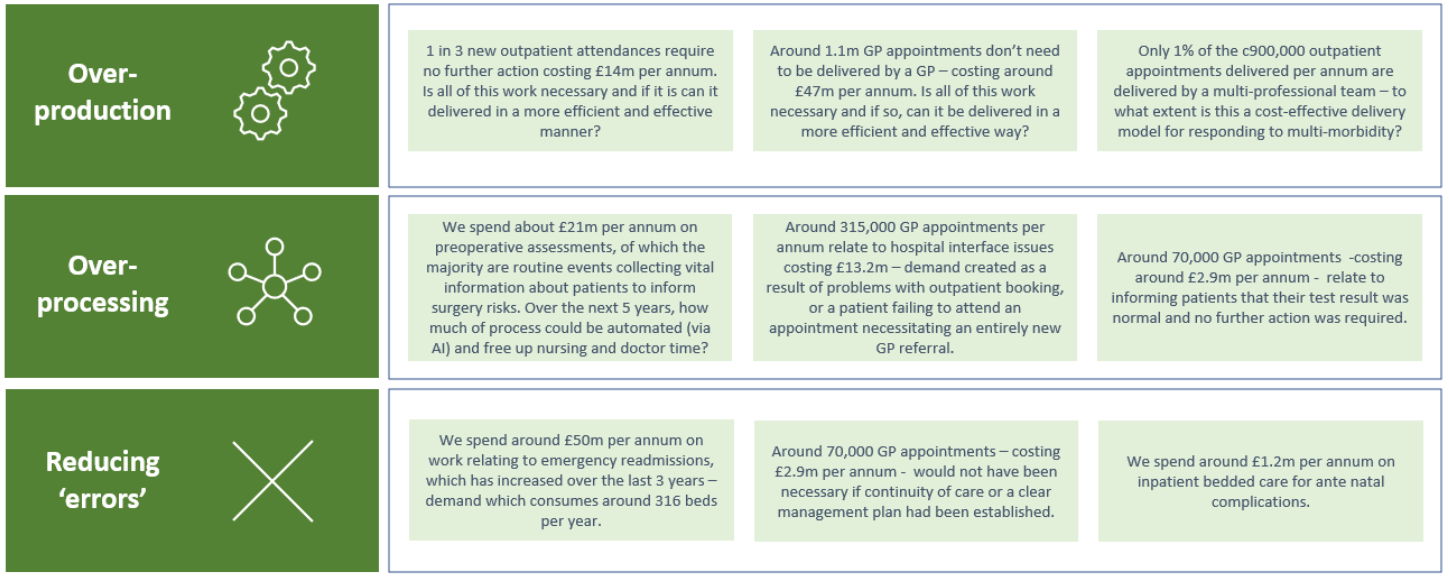


Figure 16. Some examples of waste inherent in the way care is currently delivered

Our estate

Over the next five-years, the Derby and Derbyshire NHS is likely to face several challenges in relation to its estate.

Ageing infrastructure

NHS Provider Trusts operating in Derby and Derbyshire occupy estate that predates the formation of the NHS (22%) or is more than 30 years old (65%).

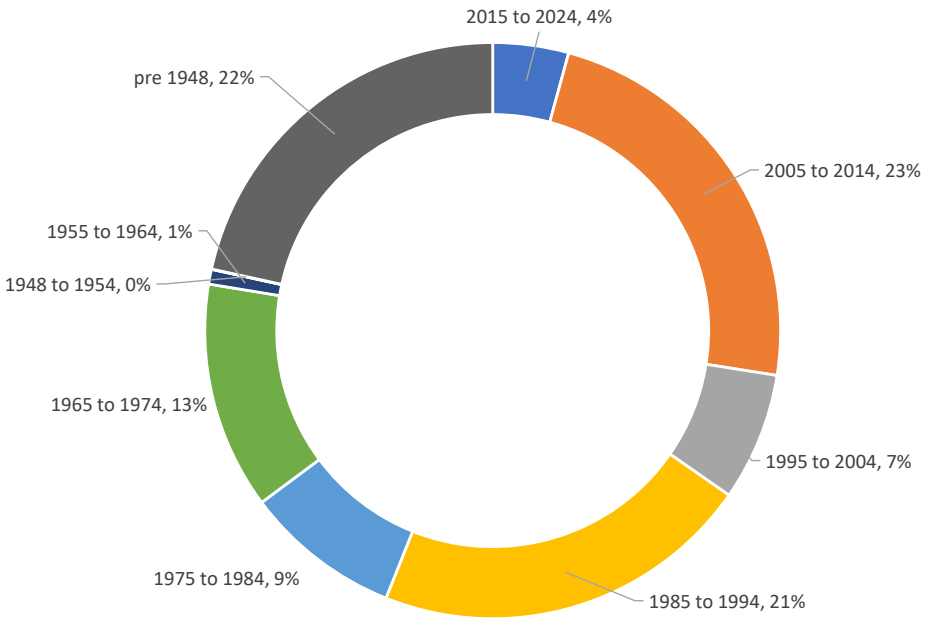


Figure 17. Age of the Derby and Derbyshire NHS Provider estate[23]

While this is not always a problem, as some older buildings have been upgraded to meet modern standards of care, it is still too often the case that the NHS is operating in inadequate facilities. Unfortunately, no equivalent national data is collected on the maintenance of the primary care estate; however, anecdotal evidence suggests the age and condition of the primary care estate is no better than that owned by NHS provider trusts[24].

The impact of this can be seen in the levels of backlog maintenance – estimated to be valued at around £43m in 2021/22[24].

Sustainability and Climate Change

Achieving net zero by 2040 will require a transformation in how we make our NHS estate more energy efficient using renewable energy sources.

[23] NHS England. Estates Returns Information Collection (ERIC) 2021/22 - October 2022.
[24] Naylor, R. NHS Property and Estates – Why the estate matters for patients. March 2017.

Changing models of care

Transitioning the operating model of the NHS in Derby and Derbyshire to one that is truly community based and integrated, will require a reconfiguration of estate to support the move. In addition, the adoption of new technology and digital systems as a way of transforming the care delivery model over the next five-years (e.g. electronic health records, telemedicine capability and smart infrastructure) will require careful planning and investment.

Adapting to pandemics and health emergencies

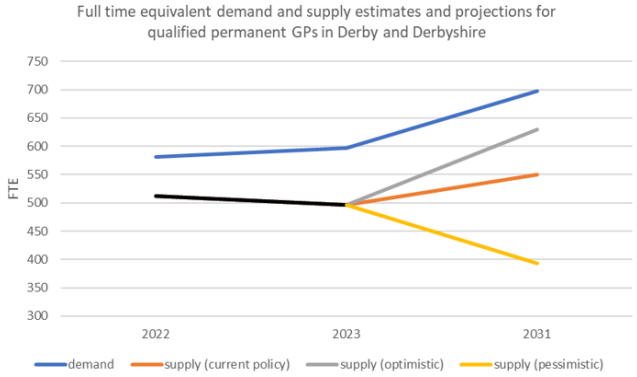
The COVID-19 pandemic highlighted the need for flexible, adaptable, and resilient healthcare facilities. It is therefore vital that the preparedness work that we do over the next period examines this important issue, so that we can handle surges in demand and deliver infection control measures effectively.

Delivering improvement with significant workforce constraints

The clinical workforce pressures that the Derby and Derbyshire NHS has experienced over recent years, reflects the challenge that is seen across many parts of the NHS across England. Indeed, whilst the clinical workforce has increased over the recent period, much of the healthcare that has been delivered in recent years has been done with 'deficit level' of demand. This is particularly the case for General Practitioners and nurses across NHS Hospital and Community Health Services (HCHS).

The need to recruit

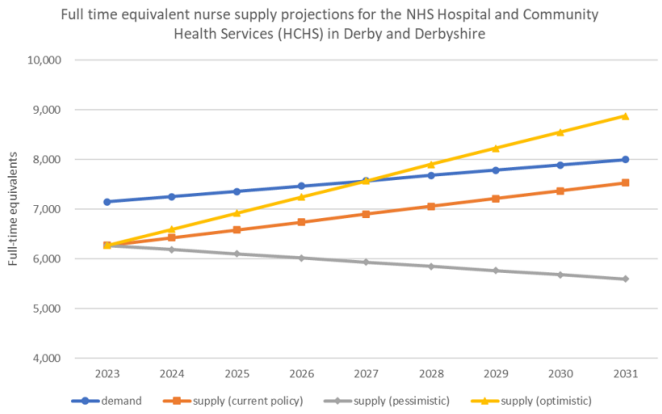
The importance of effective workforce planning for this five-year period cannot be under-estimated and is urgent. Applying the work of The Health Foundation[25] to the Derby and Derbyshire health system poses significant questions about general practice workforce supply for Derby and Derbyshire with a projected ~30% deficit in General Practitioner FTEs by the end of the NHS Plan period (as displayed at Figure 18) which poses a material risk to the sustainability of the section.



Variable	Current policy	Optimistic scenario	Pessimistic scenario
Number of newly qualified GPs joining the workforce	Increases	Increases	Increases
Other (not newly qualified) GPs joining the workforce	Reduces	Increases	Reduces
GP leaver rates	Increases to 24/25 than unchanged thereafter	Year on year increase	Reduces year on year
International GP recruitment	Unchanged	Reduces year on year	Increases year on year

Figure 18. Projection of fully qualified permanent GPs in Derby and Derbyshire needed vs. forecast supply.

Furthermore, HCHS nursing is projected to continue operating at a deficit over the period – equating to a ~8% gap by the end of the NHS Plan period, as displayed in Figure 19.



Variable	Current policy	Optimistic scenario	Pessimistic scenario
New starts – undergraduate nursing degree programme	Unchanged	Increases to 24/25 and constant thereafter	Reduces to 24/25 then constant thereafter
Nurse student attrition rate	Unchanged	Reduces in 23/24 and constant thereafter	Reduces in 23/24 and constant thereafter
International recruitment rate	Increases to 24/25 than unchanged thereafter	Year on year increase	Reduces year on year
Retirement rate prior to 55 years	Unchanged	Reduces year on year	Increases year on year
Retirement rate 55 and over	Unchanged	Reduces year on year	Increases year on year
Nurse to FTE headcount ratio	Unchanged	Unchanged	Reduces year on year

Unchanged = relative to 2020/21 position

Figure 19. Projection of registered nurses in Derby and Derbyshire needed vs. forecast supply.

[25] Shemavnekar N, et al. NHS workforce projections 2022. The Health Foundation, 2022.

The need to retain

Retaining our clinical workforce is of paramount importance, particularly when considering how it mitigates the workforce shortages summarised earlier and is also better for the quality of care provided to patients. Whilst there are issues at an individual service line level within organisations, at a macro level, the current situation across the Derby and Derbyshire Health System is broadly positive - albeit with some clear pressure points.

General Practitioners

During the last financial year (2022-23), England saw more fully qualified General Practitioners leave the workforce relative to the number joining – a net 1.2% reduction. This is a similar position seen across the Derby and Derbyshire patch, with a net 1.5% reduction, as shown at Figure 20. A continuation of this performance into the following years, against a backdrop of a structural deficit of GP supply relative to demand poses a significant set of risks for the Derby and Derbyshire Health System over the five-year period.

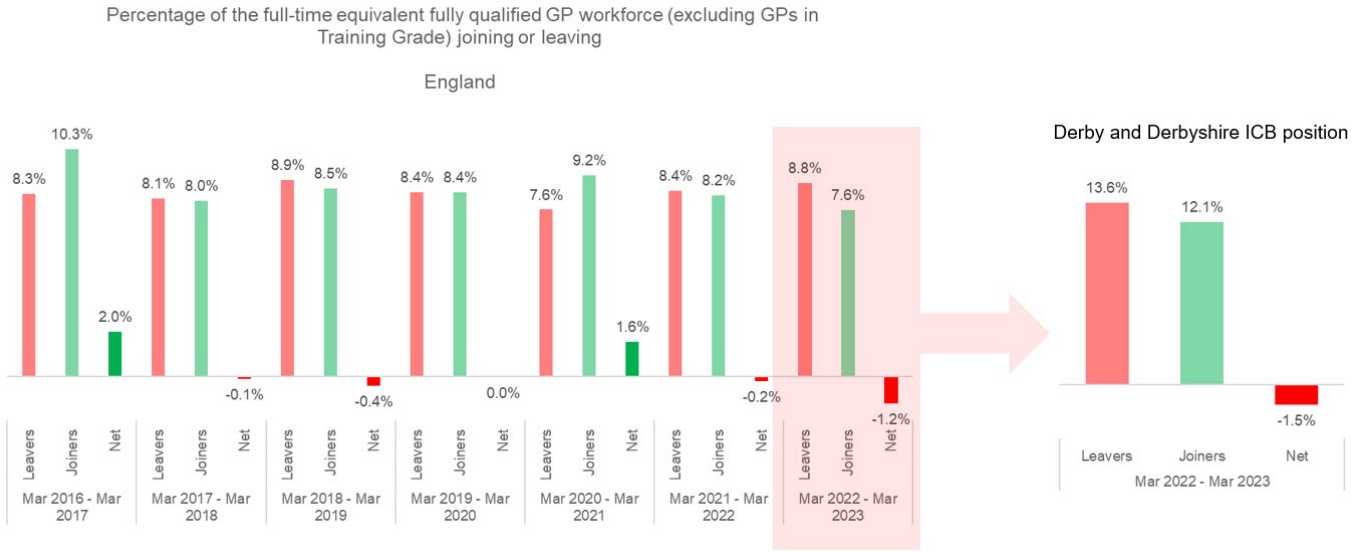


Figure 20: Percentage of the full-time equivalent fully qualified GP workforce (excluding GPs in Training Grade) joining or leaving. Source: NHS Digital, General Practice Workforce, England, GP Joiner and Leaver Tables, March 2023.

Nursing

When benchmarked against other Providers across England, the rate of people leaving the Chesterfield Royal Hospital NHSFT, University Hospitals of Derby & Burton NHSFT and Derbyshire Health NHSFT is in a good position relative to other Trusts. However, the position of Derbyshire Community Healthcare Services NHSFT is of a concern, with a leavers rate higher than the median position across England.

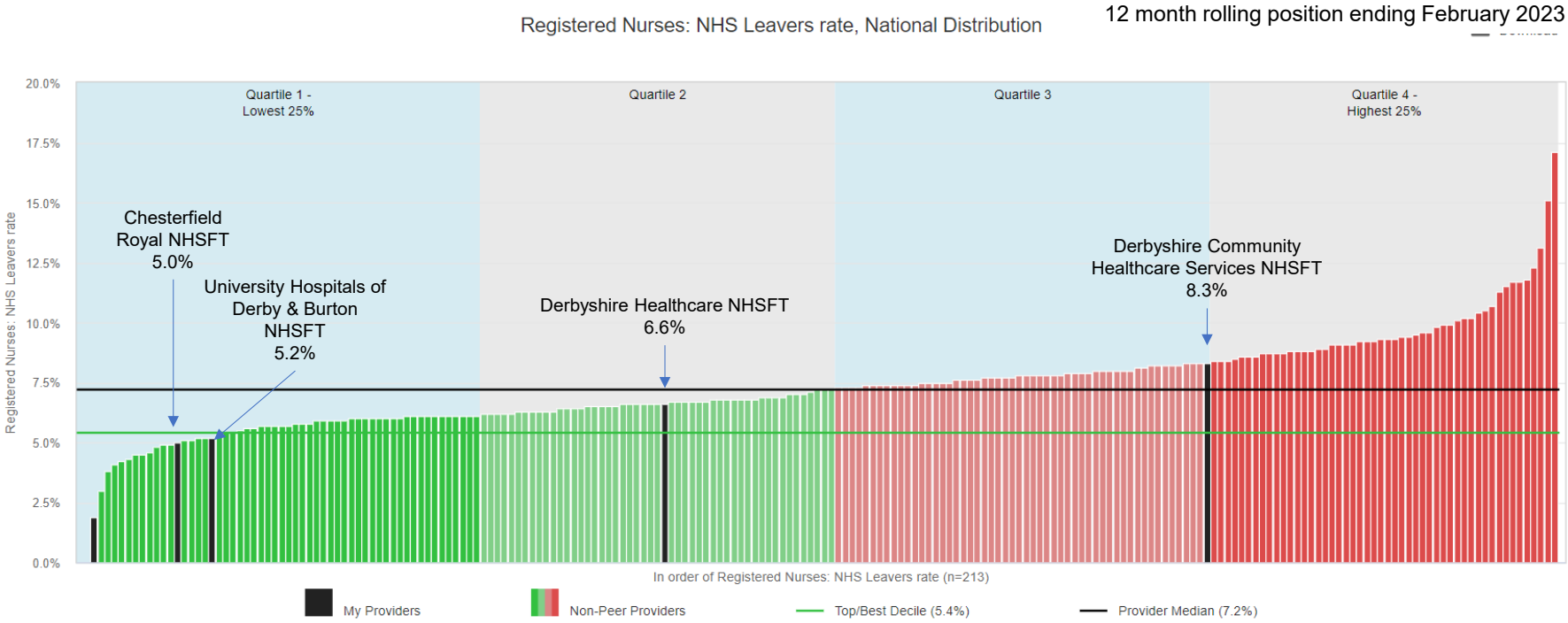


Figure 21: NHS Leavers Rate (Registered Nurses) – 12 month rolling position ending February 2023. Source: NHS Model System.

Midwifery

When benchmarked against other Providers across England, the rate of people leaving the midwifery services of Chesterfield Royal Hospital NHSFT and University Hospitals of Derby & Burton NHSFT and Derbyshire Health NHSFT is in a good position relative to other Trusts.

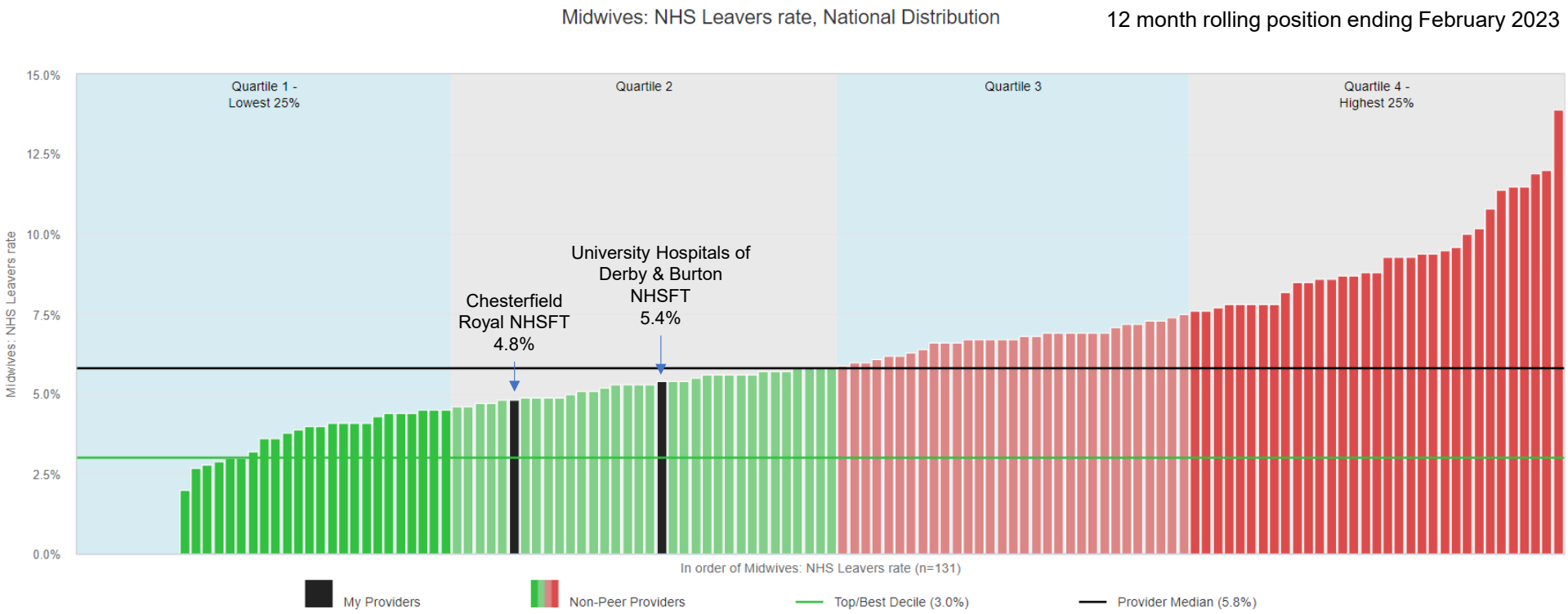


Figure 22: NHS Leavers Rate (Midwifes) – 12 month rolling position ending February 2023. Source: NHS Model System.

Medical and Dental

The rate of medical and dental professional leaving our Provider organisations is like that of other organisations across England, apart from Derbyshire Community Healthcare Services NHSFT which is high.

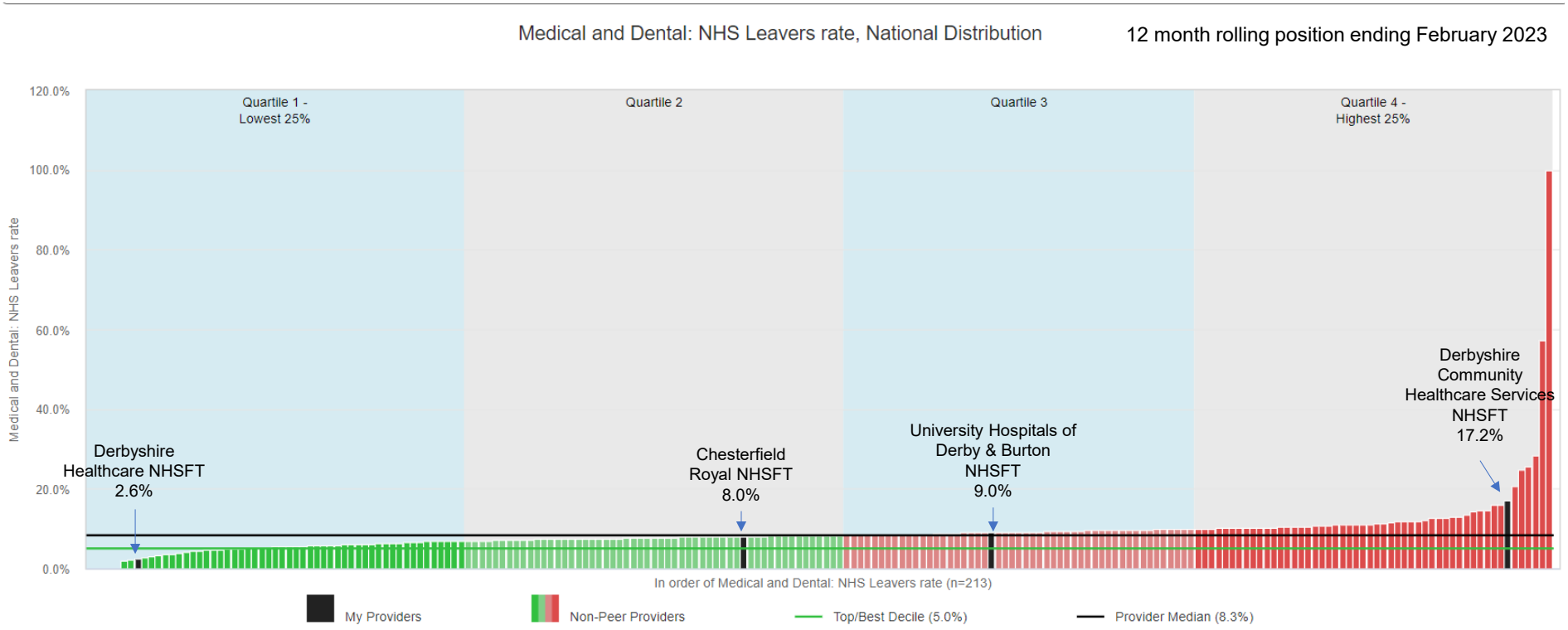


Figure 23: NHS Leavers Rate (Medical and Dental) – 12 month rolling position ending February 2023. Source: NHS Model System.

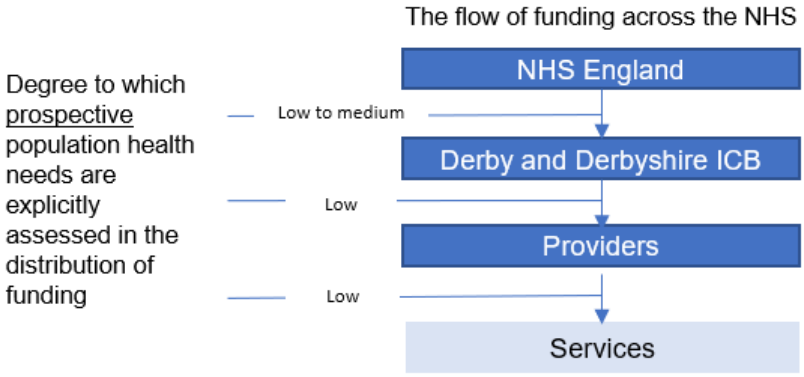
2.2. Key issues that the Derby and Derbyshire NHS will seek to resolve

Whilst the causes of the challenges detailed in section 2.1 are multifactorial and complex, there are some fundamental aspects of design – both from the perspective of policy (e.g., finance and workforce) and operations (e.g., how care is delivered) which, if properly addressed, would allow the NHS to meet these challenges in a more effective way.

How we invest financial resource to bring about the change we need

Whilst the evidence on the relationship between financial incentives and quality improvement is mixed[26], the powerful role in how financial resource is allocated cannot be underestimated.

Over recent years, the desire to direct resource to services which can reach into the most disadvantaged communities, has not been met with any substantive, practical change in how the £3bn worth of revenue expended each year is distributed. Funds have been allocated on an institutional basis and largely based on what has happened retrospectively, reflecting how services have been delivered in the past - rather than what the local population health needs are now and are to be in the future.



Most financial resource flows in a 'blocked' way and is not linked to the delivery of clear and agreed health outcomes. This also means funding can be out of line with changes in patient demand. Pooling financial resource between providers is a critical component for places to design and deliver interventions to improve health and wellbeing of communities. However, the pooling of financial resource between providers of NHS services and NHS services with local authority and voluntary sector provision, is limited and under-developed.

Finally, the way in which service transformation is funded within the Derby and Derbyshire health system needs to be reviewed – with many critical improvements being funded via non-recurrent means, thus impeding our ability to scale interventions quickly.

[26] Financial incentives, healthcare providers and quality improvements – a review of the evidence. Christianson et al. The Health Foundation (2007)

The type of workforce that we invest in over the next 5 years

The historic way that the NHS has been funded, has incentivised a greater proportion of the monies available to propagate specialist and acute care - rather than primary and community-based physical and mental ill health care.

This has reduced the ability of primary care to deliver effective population health management by preventing, postponing, and lessening disease complications and playing its full potential role in delivering integrated and proactive care, working alongside other parts of the system. This is illustrated in Figure 24, which shows growth in general medical acute doctoring and nursing outstripping the growth in general practice and community-based provision over the last six-year period.

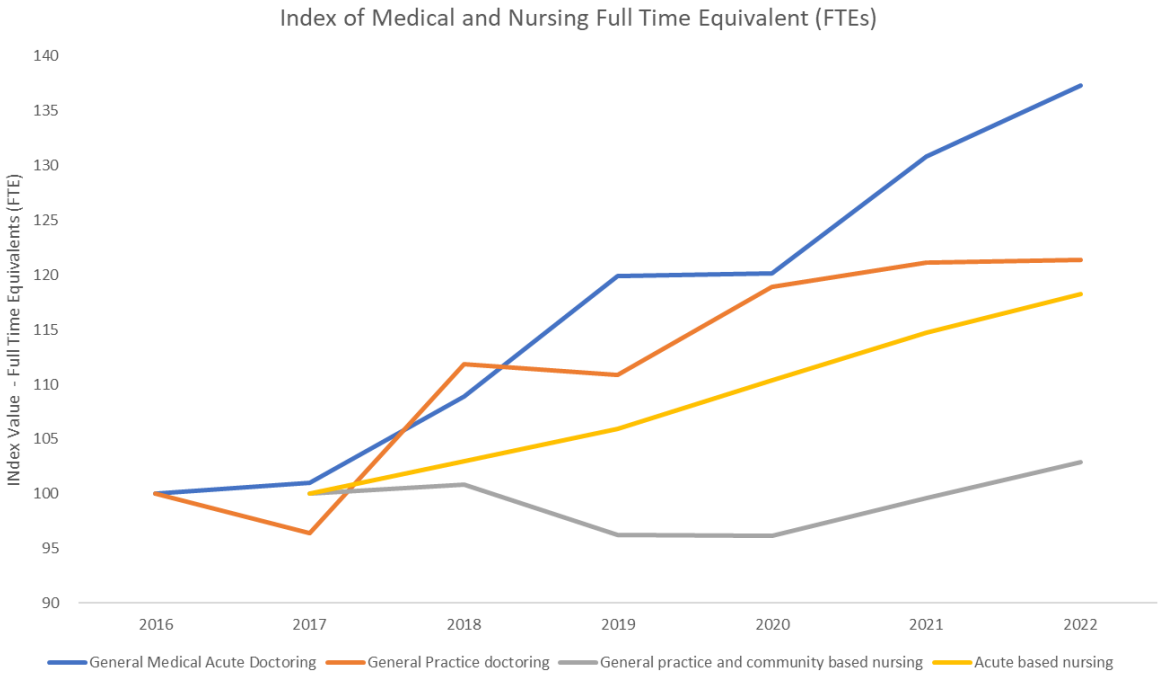


Figure 24: General Medical Acute Doctoring Index vs. General Practice Doctoring Index (2016 as the base year) and General Practice and Community Based Nursing Index vs. Acute Based Nursing Index (2017 as the base year)

Reversing this approach is a fundamental prerequisite to improving the structure and quality of chronic and multimorbidity disease care over the next five-years and beyond and thus reducing the cost of preventable care. Addressing this will also require the NHS to rethink the way that different professional groups are deployed, ensuring that there is enough capacity and the right skills to deliver an integrated, community-based model of care at the scale required.

The nature of the care that we deliver

The adverse health impacts and financial inefficiency as discussed in Section 2.1, are due in part to fragmented and reactive care delivery with restrictive access points, poor continuity and co-ordination across pathways and a fundamental gap between the policy aim of greater personalisation and actual routine clinical practice.

Over the period of this NHS Plan, there are several issues relating to the operating model which therefore need to be resolved, including but not limited to the following:

- In many areas of provision, patients can be made to feel remote from decision-making relating to their care, due in part to fixed arbitrary points where information is exchanged between a patient and the clinician/care team. The opportunity cost of this is that vital information about a patient's condition and/or general health and wellbeing and opportunities to intervene can be missed.

- Targeting limited clinical resource to those people who are most at risk of their health deteriorating and thus developing a more proactive care offering, can be improved by the further development of risk stratification technologies.

- There has been little progress on restructuring the way that clinicians work across different settings of care, to combine the collective power of the specialist and expertise of the generalist within integrated clinical networks.

- Acute hospitals respond to acute medical and surgical, social, and primary care needs and it is important that people's needs are met in an integrated and holistic way wherever they present. All too often, the demand for emergency medical care hampers other care pathways. We need to improve alternatives to admission and more rapid discharge of patients and design hospital pathways to protect planned care, diagnostics and surgical provision for the patients requiring them.

- The model of hospital provision needs to be reviewed so that it is fit for the future, harnesses the benefits of new technology and reflects best clinical practice.

3. Our guiding policies for action

The purpose of this section is to outline an overall approach for the NHS Derby and Derbyshire NHS, for overcoming the obstacles highlighted in Section 2. This approach has been embodied in the creation of five guiding policies to channel the action that is required over this NHS Plan period, to change the way in which the NHS operates.

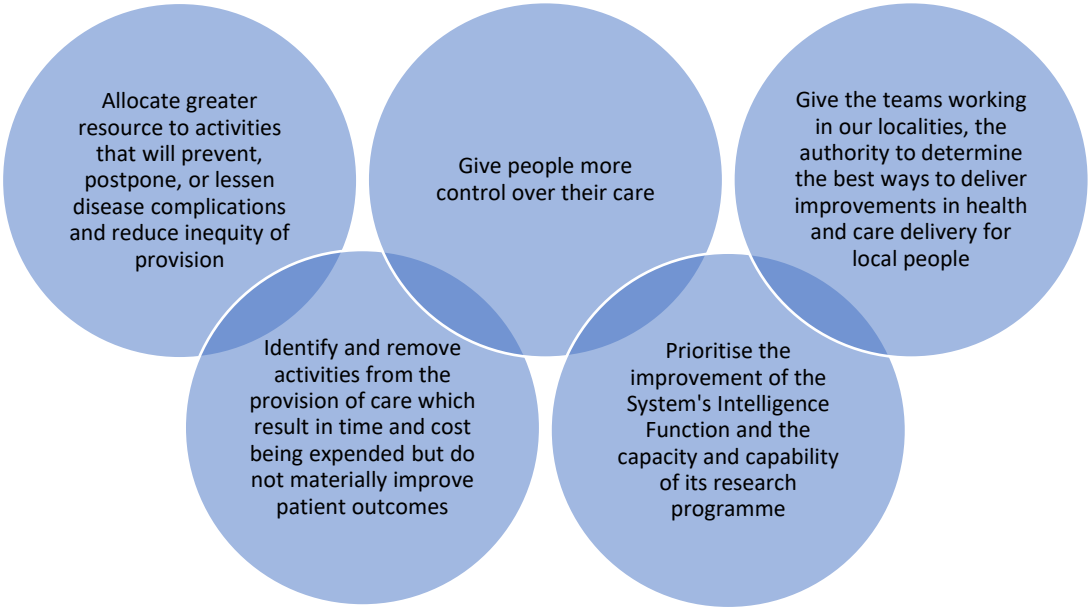


Figure 25. The five guiding policies of our NHS Plan for the next five years

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

During the period covered by this NHS Plan, the Derby and Derbyshire NHS will allocate a greater proportion of its resources – financial, human and estates – to enhance both the scale and quality of its prevention activity. It is fully recognised that there will be short to medium term issues and risks – quality, performance and finance related – that we will need to explicitly trade-off, given that our collective resource is limited. This requires detailed work up, including modelling over the five-year period.

This represents a different approach to what has gone before, and we are choosing it because it is a pre-requisite for putting our local NHS on a more sustainable footing.

Key actions include:

- Strengthening primary care, specifically General Practice – both in terms of financial investment and clinical workforce.

- Re-purpose the focus of acute based general medical provision and how it integrates with general practice chronic care management provision.

- Reallocate primary and community care resource between localities – so that people with the poorest health outcomes have greater access to services.

Delivering this action will allow us to build a more preventative model to how the NHS currently operates across Derby and Derbyshire. However, it is also important that we define what type of preventative activity we want to enhance the scale and quality of.

In every interaction between a clinician and a patient, it is vitally important that interventions designed to prevent disease or injury before it happens, are being utilised by the people who would benefit. As such, the NHS' support role in primary prevention will be strengthened over the five-year period of this plan. However, in full recognition that introducing and scaling *impactful* primary prevention interventions at a population level is something that goes well beyond the boundaries of the NHS, the health system in Derby and Derbyshire will prioritise providing high quality, evidenced based secondary and tertiary prevention services.

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

The first guiding policy discussed above focusses the NHS to act on the prioritisation of resource to deliver *more* and *better* preventative activity and strengthening how this is delivered between clinical professions. delivering the activity (e.g., general, and general medical specialists). However, this on its own is not enough to have the impact we need.

Therefore, the second guiding policy over this NHS Plan period, will be focussing action to create the infrastructure and incentives that are necessary to bring about a fundamental shift in how preventative activity is delivered – powering the creation of multidisciplinary teams working in localities - consisting of staff from the NHS, wider public and voluntary sector and enabling them to deliver improvement to the health of the populations they serve.

The further development of multi-disciplinary teams of professionals, working in and with local communities over the next five-years, will mean that they will possess greater insight into the specific needs, challenges, and cultural considerations of these communities. This form of 'organisation of professionals' offers significant opportunities for greater innovation and flexibility – quickly adapting to errors and fixing problems.

To harness this collective power, our actions will focus on the following:

- Training and capacity building - developing an achievable workforce plan that focusses on transitioning the current workforce to deliver the requirements described in this Plan.

- Decision making – creating the right conditions for organisations (and their staff) to make decisions together, including the allocation of resource, for the benefit of improving population health, as opposed to being driven by individual organisation's needs and priorities.

- Performance incentives – designing a performance improvement approach that incentivises the *right* type of work being undertaken in the *right* way.

- Management support – ensuring an increased focus across our NHS organisations on (i) a high-quality data and analytics service to provide local teams with a clear analysis of local problems and assets; (ii) communication and engagement teams to design and deliver more effective ways of engaging with marginalised and disadvantaged communities; and (iii) high quality project management support to manage change.

Give people more control over their care

Establishing the first two guiding policies sets the direction for action in relation to the type of activity delivered and giving a new mandate for a different 'organisation of professionals' to deliver it. This third guiding policy builds on this by focussing attention on the person receiving the healthcare.

Over this NHS Plan period, it is vital that the NHS in Derby and Derbyshire changes its operating model, so that the exclusion of patients from decision-making in the process of delivering care, as discussed in section two, is overcome. Without it, the opportunity for people to become active participants in their healthcare will not be realised.

Giving people more control over their care is therefore a guiding policy of this NHS Plan, with focussed work required to establish a set of coherent, scalable, evidence-based actions to advance the following aspects, across all areas of provision:

- Promoting health literacy, helping people to understand their conditions and the choices they can make – particularly amongst people living in some of the most disadvantaged communities in Derby and Derbyshire, as a way of improving self-management of conditions.

- Ensuring tailored information and support for individuals ensuring equality, diversity, and inclusivity. For example, information being provided in different languages. Also ensuring that inequity is not created through systems and processes which are not easily accessible for some communities.

- Personalised care and support planning – giving people access to all the information about their health that the NHS holds and supporting patients.

- Shared decision making - embedding this as the default way of working.

- People will be able to source health care provision outside of routinely funded services where this would meet their identified health needs.

Identify and remove activities from the provision of care which result in time and cost being expended but do not materially improve patient outcomes

This fourth guiding policy builds on the first three, by focussing action on the fundamental redesign of the process by which care is delivered, thus guiding action to achieve a more systematic approach to reducing inefficiency from the process.

Developing action to deliver this guiding policy will be complex and complicated, with more immediate focus on:

- Reframing the Derby and Derbyshire NHS efficiency improvement programme – by focusing on identifying waste as an organising principle and reducing waste as a core objective, we will be able to address the issue of 'inefficiency' in a more holistic and scalable way, across different care and service settings.

- Connecting experts on our key change programmes – When it comes to 'improvement' and delivering 'transformation', our experts – the people who support and deliver care – are spread too thinly and are not always focussed on working collectively to address agreed system priorities.

- Re-prioritising projects within our efficiency improvement programme – focusing resource on identifying and redesigning clinical and administrative work that is generalisable to many different care settings and sectors so we can achieve change at a greater scale.

- There are some 'here and now' examples linked to the operational challenges we face including:

    - Enhancing diagnostic capacity so that there is sufficient capacity to support elective recovery, delivered closer to where patients live.
    - Deliver a step change in the effectiveness of discharge provision so that hospital bed capacity is utilised effectively, and patients go home as soon as they are able.
    - Supporting more people with complex mental ill health, learning disabilities and/or autistic people to live happy, safe, and well lives within our local communities and reduce the reliance on hospital-based services.

Prioritise the improvement of the System's Intelligence Function and the capacity and capability of its research programme

The people who work in the Derby and Derbyshire NHS are its most valuable resource. The knowledge, skills, expertise, and experience of our people is vital for the long-term success of the service and contributes significantly to achieving better health for the Derby and Derbyshire population.

However, as discussed in Section 2, the next five-years will see technology fundamentally change how care is delivered, with vast amounts of new data being generated. Health and Care Systems which can effectively collect, analyse, and leverage data to gain insights, make informed decisions and drive innovation will create a competitive edge, in the following ways:

- Enabling predictive and preventative care –by leveraging data strategically, we can develop predictive models to anticipate disease outbreaks, identify individuals at risk of developing chronic conditions, and intervene proactively.

- Supporting research and innovation –building new collaborations and strengthening existing ones with academic, public, voluntary, and private sector stakeholders –

advancing knowledge, improving practice, and creating opportunities for new financial revenues to flow into our health system.

- Enhancing operational efficiency – moving away from treating data as a 'by-product' of operational care processes and treating it as a strategic asset will provide us with the means to get better insight into how to optimise these operational processes, identify bottlenecks and improve resource allocation.

To achieve the above, action will be focussed on:

- Developing the skill of our analytical workforce – training in new forms of analytical techniques and methods.

- Developing a strategic approach to system intelligence and evidence which enables all teams involved in the planning of care to have access to a shared data set, with support from skilled analysts where they need it.

- Changing the nature of the work that analysts do - with teams working on a project basis focussed on clear, high impact questions, set in an environment which commits to embracing the outputs in planned decision-making processes.

- Developing the ICS' data model – synthesising a wide range of patient level datasets relating to the interaction of citizens with services and creating joint workspaces for local analysts to use it and collaborate.

- Collaborating with regional and national analytical networks - so that knowledge and evidence can be shared across the NHS.

- Improving data quality (accuracy, completeness, consistency, validity, uniqueness, timeliness) as an enabler to consistent and joined up data capture.

- Ensuring different but related workstreams are joined-up, with identified named leads to enable this. These workstreams need to be connected to ensure maximum value is realised. This may present challenges, for example, because of traditional contractual arrangements between one constituent organisation and a supplier.

4. The action that we are taking in 2023/24

The 2023/24 financial year represents the first year of this NHS Plan. Over the course of this 12-month period, a series of targeted actions are being taken by the NHS in Derby and Derbyshire, working closely with our partners, to carry out the five guiding policies.

4.1. Allocate greater resource to activities that will prevent, postpone, or lessen disease complications and reduce inequity of provision

The prevention agenda features prominently in the Derby and Derbyshire ICB's Operational Plan for 2023/24, with action being taken to focus on all aspects of prevention, with particular emphasis on secondary and tertiary provision.

Primary prevention

In full recognition that scaling impactful primary prevention interventions at a population level is something that goes well beyond the boundaries of the NHS, our focus is on a few select schemes as a contribution to a much wider partnership effort – led by both of our Health and Wellbeing Boards.

The focus of the NHS over the next 12 months is on:

Circulatory diseases, including stroke and diabetes	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.
Smoking	Increasing the number of people who smoke being referred 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.
Obesity	Increasing 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).

Secondary prevention

The first year of this NHS Plan sees the health system focussed on restoring and extending a range of secondary prevention interventions – particularly to population groups that had low uptake before the pandemic.

On the understanding that secondary prevention is evidence based, preventative measures to help stop or delay disease, taken during an interaction between an individual patient and a clinician[27], the focus of the NHS in Derby and Derbyshire over the next 12 months is on the following areas:

Dementia	We will improve the number of people being seen in memory assessment services to enable more people to be diagnosed early with the signs of dementia. Our aim is to achieve the national diagnosis rate of 67%.
Circulatory diseases, including stroke and diabetes	For those who are pre-diabetic, we will increase the take-up of the diabetes prevention programme. We will 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%.
Mental Health	We will double the number of women accessing specialist perinatal mental health services over the next 12 months.
Cancer	We will 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. We will increase uptake of the National Cancer Screening Programmes.
Diagnostics	We will reduce the number of people waiting for a diagnostic test by 30% over the next 12 months and, on average, 85% of people requiring a test will get one within 6 weeks.

[27] Whitty C et al. Restoring and extending secondary prevention. British Medical Journal, 2023.

Tertiary prevention

Frailty induced falls	• In 2023/24 the Health System is planning to reduce the incidence of frailty related falls by 15%.
Musculoskeletal disorders	• We will reduce the waiting list for community MSK and Physiotherapy Service by 20% (as at the start of April 2023) by March 2024. • We will reduce the number of people waiting for a hip and knee replacement by 22% over the next 12 months.
Circulatory diseases, including stroke and diabetes	• We will increase the number of people with heart problems who are referred to and uptake a programme of cardiac rehabilitation. • We will increase the percentage of patients with hypertension treated to NICE guidance to 77% by March 2024.
Mental Health	• We will increase the number of adults with a diagnosed mental illness accessing a mental health service by a third, over the next 12 months. • We will reduce the number of adults who are autistic, have a learning disability or both, who are in beds commissioned by the ICB and our Provider Collaborative to 23 and 13 respectively, by March 2024. • We will reduce the number of inappropriate out of area placement beds days by 40% over the next 12 months. • We will increase the number of children and young people accessing a mental health service by a third, over the next 12 months.
Chronic respiratory	• Over the next 12 months we will increase the number of people with a chronic respiratory condition who are referred to and uptake a programme of pulmonary rehabilitation.

Cancer	• We will reduce the number of people waiting for their first definitive treatment for cancer by 30% over the next 12 months, and no patient will be waiting longer than 62 days for this treatment by the end of March 2024.

4.2. Give the teams working in our localities, the authority to determine the best ways to deliver improvements in health and care delivery for local people

The next 12 months sees the 'Team-up' approach to integrating services become core to delivering key service improvements – specifically in relation to:

- **Providing an urgent community response (UCR) to older adults with complex health needs, within 2 hours.** This intervention sees the augmentation of rapid response nursing and therapy services, falls recovery services, home visiting services and short-term adult social care, into a co-ordinated offering, working at scale across all geographies of Derby and Derbyshire.

- **Delivering a holistic health and wellbeing support offering to people with severe mental illness – through the Living Well Derbyshire Programme.** This sees us building a new and strengthened model of caring for people with mental illness in the community – combining the collective power of community mental health services, primary care, social care and the voluntary, community and social enterprise sector.

4.3. Give people more control over their care

1. The use of digital technologies

The next 12 months sees the Derby and Derbyshire Health System build on the strong foundations that has been set to extract maximum value from the use of digital technologies in the provision on healthcare, with works focussed on:

Uptake of the NHS App

The roll out of new functionality for the NHS App is a major transformation occurring over the next period. This new functionality will help people take greater control over their health and their interactions with the NHS - including better support to get to the right in-person or digital service more quickly, access to their patient records, improved functionality for prescriptions and improved support for hospital appointments.

In May 2023, just over half of people registered with a GP practice in Derby and Derbyshire are registered with the NHS App which is up 8 points on the position in May 2022.[28] Over the

[28] NHS England – NHS App Reporting Dashboard.

next 12-month period, the NHS in Derby and Derbyshire will seek to get more people registered with the App to give people an easier way into the NHS when it comes to vital information about their healthcare.

Remote healthcare

By the end of March 2024, the Health System will create capacity for a minimum of 255 people whose care is being managed remotely, through the operation of a series of condition specific 'virtual wards'. This innovation is being facilitated by a range of integrated technologies that will give patients and/or the carers the ability to take a range of health readings at home according to clinical need and be able to provide regular updates on a range of symptomatic issues.

Personal health tracking

Over the course of the next 12 months, focused action will be taken to increase access to real-time continuous glucose monitors and insulin pumps to children and young people with diabetes who live in the most deprived communities.

Self-management support

People with common musculoskeletal (MSK) conditions spend 99% of their time self-managing and almost all will benefit from safe and effective self-management to preventing over treatment. During 2023/24, people with a range of MSK conditions will be given access to a digital self-management platform - getUbetter' – which will provide people with support ranging from (a) being able to book treatment; (b) check symptoms and (c) monitor recovery.

2. Personalised Care

Delivering more personal care is a core part of the Derby and Derbyshire Health Care System's strategy to give people the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life.

We have made good progress over the recent period with:

- around 2,700 people receiving a personal health budget[29]
- around 33,000 people whose care has been discussed as part of a shared decision-making process[29]
- around 23,000 people having been referred to a social prescribing service since April 2019[29]

This represents good progress, and the Derby and Derbyshire Health System will continue to take the action that is necessary to increase their uptake and usage.

[29] NHS England – Personal Care Group Dashboard.

3. Choice of Elective Surgery

Our objective to reduce elective waiting lists over the next 12 months and give people more choice over where they receive their care, go hand in hand. To that end, the Derby and Derbyshire Health Care System will continue to ensure that people are given a legitimate and substantive choice about where they receive their care, with either an NHS or Private Provider.

4.4. Identify and remove activities from the provision of care which result in time and cost being expended but do not materially improve patient outcomes

1. Use of acute resource

Improving the use of our acute capacity is a priority for the NHS in Derby and Derbyshire in 2023/24 and beyond and is a prerequisite for delivering the extra treatments that are required, particularly in relation to MSK care.

Areas of focus include:

- Reducing general and acute bed occupancy to 92% on average.
- Fully utilising our theatre capacity. Whilst our overall utilisation benchmarks well across the NHS, with the system ranked in the upper quartile nationally, there are areas for improvement which will enable us to increase output by 15-20%.
- The Derby and Derbyshire Health System's Did Not Attend (DNA) rate is one of the best in the NHS, operating in the upper quartile of all systems nationally. However, we will seek to move to top-decile performance over the next 12 months.
- Increasing the use of Patient Initiated Follow-up (PIFU) as a way of saving patient and clinical time and recycling capacity for new work.

2. Urgent and Emergency Care triage

Over the next 12 months, the ICB will continue to pilot the Clinical Navigation Hub to support a faster and convenient way to direct more people to the right part of the health and care system in a timely manner. The pilot sees the introduction of a Multi-Disciplinary Team (MDT) made up of professionals including GP's, Advanced Clinical Practitioners, Nurses and EMAS Practitioners, forming a Hub working alongside Social Care to support frontline clinicians by maximising the opportunities to find the right care, first time for patients who have called 111 or 999.

4.5. Prioritise the improvement of the System's Intelligence Function and the capacity and capability of its research programme

In 2023/24, all major organisations of the Derby and Derbyshire Health System will work together to develop a new Health Intelligence Platform. This Platform will enable Analysts from across the Health System to collaborate and with access to new datasets enable to the creation of more advanced analytical work – vital to support the population health management agenda in Primary Care and PLACE more generally.

5. Building on this action and going further

The previous section describes the progress that we are planning to make on a range of fronts in 2023/24. However, we acknowledge that a significant amount of work is still required to change the way in which the NHS in Derby and Derbyshire operates. In this context, this section set out what we plan to do to create the conditions that are necessary for this change to happen and give more insight into some of the areas that we want to improve.

We recognise there is more work to do beyond this initial publication and more time is required to fully reflect on the feedback received from partners and to further iterate our Plan together. We therefore intend to review and update the aims and actions in Quarter 2, working collaboratively with partners and publish an updated version of this Plan ahead of winter 2023. The updated version will help ensure this Plan drives our 2024/25 NHS Operational Planning (year two of the five-year plan).

5.1. Creating the conditions for change to happen

Immediate issues that we will focus on – July 2023 to November 2023

Prioritisation

Prioritisation plays a crucial role in what is commissioned and ultimately delivered by the NHS in Derby and Derbyshire. This involves making decisions about which healthcare services and interventions should be funded and provided to meet the needs of the population within tight financial parameters.

Given the challenges and issues discussed in Section 2, it is vital that we have a clear and transparent framework to guide these decisions and ensure that we meet our guiding policies. To advance this, a Strategic Commissioning Prioritisation Policy for the next five-year period will be devised.

This policy will act as a framework to enable the ICB to prioritise (and thus deprioritise) which healthcare interventions are to be commissioned during the JFP period. This policy will be developed with partners in time for it to be used in the 2024/25 Operational Planning process.

Financial

Over the next five-month period, work will also commence on developing with partners a PLACE level financial allocation policy. This will complement the prioritisation framework described above and guide the equitable and efficient distribution of NHS financial resources to PLACEs across the Derby and Derbyshire ICB jurisdiction, relative to need.

Furthermore, over the next five-month period, an economic projection of the future "state" of NHS resources – both from a supply and consumption perspective - will be produced that will aim to model the impact of the changes to the operating model that we want to bring about. This projection will be developed with partners before the start of the 2024/25

Operational Planning Process – vital so that parameters for capacity supply, utilisation, finance, and operational performance can be set to inform the process.

Workforce

The next period will see work accelerate on defining what workforce model is required at each local PLACE to scale the offering that it currently operational. This is vital so that all partners are aware in a more specific sense of what is needed to enhance the integrated community care offering that we all want, and more specific action can be organised to bring it about. At the time of writing this plan, we await the publication of the government's national workforce plan. This will be incorporated into our local workforce planning and next edition of our NHS Plan.

Data

It is vital that the developing integrated care teams receive the intelligence they need to target individuals and / or parts of the community who are at greatest risk of needing resource intensive care. This is vital so that proactive action can be taken to reduce this risk. We are aware that local teams have this information and are acting on it so over the next period we will ensure that all teams are receiving consistent and timely information so they can advance their anticipatory care offering.

Other vital enabler development work

Working with the Voluntary, Community and Social Enterprises Sector (VCSE)

The VCSE sector already makes a significant contribution to health and social care through complementary as well as mainstream provision, often supporting people who are under the radar of statutory services. This was particularly evident during the pandemic. VCSE organisations can also support, engage, and articulate the needs of both communities of place, interest, and condition.

There is now the opportunity for a less transactional relationship with the VCSE sector where it can contribute at all points of the planning cycle; helping to define needs through soft intelligence, helping to design services so that they meet the needs of communities, as well as offering new and cost-effective approaches to service delivery.

Our focus will be on the following issues which have been identified as crucial to resolving:

- Supporting and developing the paid and volunteer workforce.
- Involving such a large and diverse number of VCSE organisations in a defined ICS structure and communicating with them.
- Finding investment, commissioning and support approaches that will make the most of what local VCSE organisations have to offer and develop longer term relationships.
- Stimulating greater VCSE sector engagement and delivery in key system initiatives such as hospital discharge.
- Building the capacity of VCSE organisations.

Estates

With the ICS' Estates Strategy in place and the priorities established[30], more detailed work will be scoped to set out the actions that are necessary to ensure we have an estate that is fit for purpose, in the right location and appropriately sized.

There are a range of service development proposals currently being considered by the ICS for capital investment. However, it is in Mental Health space where advancements to infrastructure will be made over the next period, with monies secured for the following developments.

- A new 14-bed psychiatric intensive care unit (PICU) at Kingsway Hospital in Derby - Derbyshire does not currently have a PICU and people who need this level of support currently need to travel outside of the county to access an appropriate bed.

- Refurbishment of the Radbourne Unit in Derby to create a dormitory-free acute 34-bed female unit.

- Relocation of the northern Derbyshire older adult's mental health inpatient service from Hartington Unit to Walton Hospital (12-bed relocation).

- Refurbishment of Audrey House at Kingsway Hospital - initially into a 10-bed decant ward, then into an eight-bed mental health 'Enhanced Care Unit' female unit.

Research and innovation

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

- Ensuring an appropriate skill mix at board-level and across registered professional leads to promote research and support collaboration.

- Ensuring research across local systems addresses ICB health and care priorities.

- Providing evidence derived from research to decision makers in a more intuitive and useful way.

- Attracting additional research investment into the ICS from external agencies.

[30] ICS Estate Strategy – main priorities: (1) Transform places and services - prioritise & maximise the use of the best quality estate, which is modern, agile, and fit for purpose to support patient care (2) A smaller better, greener public estate - Create an estate which is more efficient, effective and sustainable through optimisation; and (3) Partnership approach - Work with our partners to strengthen collaboration and benefit from multi agency working

Digital and Data

The next period will see work continue to deliver a range of impactful changes to how digital and data are used to achieve our strategic aims as an ICS. The key focus of work is on enhancing our technical infrastructure with three key programmes in play:

- **Delivering the Derbyshire Shared Care Record (DSCR) Programme.** The deployment of the DSCR will be expanded to include hospices, care homes, community pharmacies and other commissioned health and social care providers.

- **Deploying a new Electronic Patient Record (ePR) in our acute hospitals.** To enable collaborative working, faster care, pathway redesign and reduced clinical risk.

- **Digitising in Social Care (DiSC).** This includes the implementation of digital social care records for care homes and domiciliary care providers.

In addition to this, action will be taken to advance other aspects of the ICS' Digital and Data Strategy, including:

- Creating a data architecture to enable population health management to be embedded across the system to inform service planning and delivery. The ambition is to create a holistic view of citizens that incorporates wider determinants of health to improve physical and mental health outcomes.

- Digital and data innovation to support technology enabled care pathways to augment care delivery, efficiency, and citizen/ patient/ staff experience.

- Supporting and developing our citizens and workforce in the use and adoption of digital services.

Workforce and the People Services Collaborative

The Derby and Derbyshire ICS has a clear vision for our workforce:

“Anyone working in health and care within Derby and Derbyshire feels part of one workforce which is focused on enabling our population to have the best start in life, to stay well and age well and die well. Our workforce will feel valued, supported, and encouraged to be the best they can be and to achieve the goals that matter to them wherever they work in the system.”

To achieve this vision, we will act over the coming period to advance the following:

- Creating a single point of access for new recruits, with a “no wrong door” approach to seeing people as a system asset, to be deployed wherever their skills fit best.

- Developing an integrated system rather than organisational approach to assessing workforce supply requirements.

- Unifying our approach to leadership and talent development and organisational development (OD).
-

- Creating an inclusive talent approach as the driver for recruitment and development.

- Creating a high quality and consistent People Services offering.

- Using technology to enable ease of movement between organisations and reduce non-value adding processes.

- Creating a clearer sense of common purpose and agreement on priorities for where we can work together and share resources.

Furthermore, from a training and development perspective, we will progress work on the following aspects:

- Expand the scope of work, supported with adequate training and development, for people who are Acute Care Practitioners, Physicians Associates, Nursing Associates, and non-medical prescribers.

- Prioritise investment in training and development in prevention, personalisation, and health inequalities.

- Develop the digital skills of our workforce so they can embrace new technologies.

- Expand clinical placement capacity across all professional groups to meet future workforce demand and corresponding development of our educator workforce.

Lastly, the ICB will actively work with Equality, Diversity, and Inclusion (EDI) leads within the system and internally with the ICB Diversity and Inclusion staff network, to develop a workplan to deliver the six high-impact actions identified within National NHS EDI Improvement Plan. The aim of this plan is to address the widely known intersectional impacts of discrimination and bias, improve equality, diversity, and inclusion, and to enhance the sense of belonging for NHS staff to improve their experience.

Our Green Plan

Work will continue to deliver key aspects of the ICS' recently published 'Green Plan' – with specific areas that we are currently focussing on.

Area	What we are currently focussing on:
Medicines	• Using lower carbon inhalers • Encouraging patients to return old or unwanted inhalers to pharmacies for environmentally safe disposal through reminders and promotions • Transforming anaesthetic practice - using alternatives to desflurane.
Promoting active transport for both staff and patients	• Bicycle lease schemes in place for staff • A lift share policy and communication campaign • Considering ways to expand the installation of electric vehicle charging points.
Data	• Developing our data on carbon emissions to aid our understanding of organisation and service level carbon performance.
Decision making	• A Net Zero/ Green Quality Impact assessment is to be developed to support all business cases and programmes within Derbyshire.

Support broader social and economic development

The two local authorities, local NHS organisations and JUCD, Derby County Community Trust and the University of Derby are signatories to an Anchor Charter, and together with Rolls Royce, are members of Derbyshire’s founding Anchor Partnership.

Over this coming period, the Partnership has agreed to initially focus its combined influence and actions on the following two impact areas:

- Workforce and access to work.
- Social value in procurement.

5.2. The Integrated Care System's Improvement Programme

The Integrated Care System's (ICS) improvement programme consists of a variety of works that are aimed at improving the quality and efficiency of health care provision. In addition to this, there are numerous programmes in place that connects the NHS to the wider Integrated Care Partnership.

Hard wiring the objective reducing health inequalities in our improvement work

The Derby and Derbyshire ICS is using the CORE20PLUS5 framework as a strategic guide to its work to reduce health inequalities, with specific action already in play to have a positive effect on the following aspects.

For adults

- **Maternity:** ensuring continuity of care for 75% of people from Black, Asian and minority ethnic communities and from the most deprived groups.
- **Severe mental illness (SMI) and Learning Disabilities:** ensuring annual health checks for 60% of those living with SMI or learning disabilities.
- **Improving Vaccination uptake:** reducing inequalities in uptake of life course, COVID, flu and pneumonia vaccines.
- **Early cancer diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028.
- **Hypertension case-finding**: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

For children and young people

- **Asthma:** addressing over reliance on reliever medications and reducing the number of asthma attacks.
- **Diabetes:** Increasing access to real-time continuous glucose monitoring and insulin pumps for people living in the most deprived communities.
- **Epilepsy:** Increasing access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.
- **Oral health:** Reducing tooth extractions due to decay.
- **Mental Health:** Improving access rates to children and young people's mental health services.

Summary of improvement works

Urgent, Emergency and Critical Care Delivery Board

What improvement do we want to bring about?	Change programme/ initiative
Reducing emergency department attendances/ (Improving access to right care)	• Increasing the use of Urgent Treatment Centres • Introducing a Clinical Navigation Hub
Reducing emergency admissions and readmissions	• Increasing Virtual Ward capacity • Expanding the use of same day emergency care • Full review of front door model, streaming and re-direction and flow (to include Co-located Type 3)
Reducing hospital length of stay and improving flow	• Increase Virtual Ward capacity • Acute flow improvements • Review of front door model
Improving ambulance response times	• Ambulance handover improvement • Expand the use of Hear and Treat and See and Treat • Clinical Navigation Hub

Planned Care Delivery Board

What improvement do we want to bring about?	Change programme/ initiative
RTT wating list reduction	• Theatre utilisation • Outpatient Transformation • Referral optimisation • Integrated MSK Community offering • Ophthalmology
Cancer access - diagnosis and treatment, quality improvements	• Earlier and Faster Diagnosis • Treatment and Care: Treatment variation • Personalised care and Patient Experience • Core20PLUS5 Health Inequalities
Diagnostics –increasing capacity and reducing the waiting list	• Roll-out of Community Diagnostic Centres • Workforce and recruitment - endoscopy

Mental Health (MH), Learning Disabilities and Autism Delivery Board

What improvement do we want to bring about?	Aim
MH Urgent Care and Acute Services	• Improved responsiveness for people in Mental Health crisis
Community Mental health Services	• Improved responsiveness for people with diagnosed mental illness to enable condition management, improve wellbeing and reduce risk of deterioration/escalation of needs.
Talking Therapies Services	• Improved support for in relation to understanding and personal management strategies, for MH.
Neurodevelopmental Services	• Improved service responsive for people with diagnosed Learning Disability or Autism.
Dementia and Delirium Services	• Improved access to diagnosis and support services.
Children and Young People MH Services	• Improved support for C&YP in relation to MH understanding and personal management strategies, improved responsiveness for people in mental health crisis
Suicide Prevention, Reduction and Bereavement	• Reduction in total number of deaths by suicide.

Primary and Community Care Delivery Board

Priority/what are we trying to achieve?	Change programme/ initiative
Supporting the development of Primary Care Networks (PCNs) and neighbourhood teams	• PCN development programme • Integrated neighbourhood team development incl. place operational leadership • Integration of pharmacy, optometry and dental
Improved access to integrated urgent care in primary and community settings	• Same day GP access plan (23/24) • GP Access hubs (24/25 - TBC) • Integration with Team Up/ Urgent Care Response
Sustainability of primary care	• Response to Fuller Report • Embed GP Provider Board • Estates strategy and improvements • Workforce – GP HR Director, Additional Roles Reimbursement Scheme (ARRS) roles

Community Transformation Programme

Priority/what are we trying to achieve?	Change programme/ initiative
Transformation of integrated community services- Team up (Ageing Well)	• Continued expansion of integrated urgent community response • PCN home visiting • Anticipatory Care: case finding, proactive & preventative multi-disciplinary care for complex patients • Enhanced Care in Care Homes
End of Life (EoL)	• Compassionate communities, people driving change • Informed workforce, training, and education programme • sustainable commissioning, develop outcome framework • EoL shared-care record • Continue to shape the EoL Board and deliver the EoL Strategy • EoL dashboard and demand and capacity modelling • Develop the system EoL Operational Delivery Group
Falls	• Pilot enhancements to falls recovery services • Recommissioning informed by pilot outcomes (year 2) • Development of forward plan • Falls prevention (longer term year 2 focus)
Discharge	• Deliver Pathway 1 strategy: improve processes and capacity • Strengths based approaches • Single discharge capacity/flow database • VCSE support offer • Redesign Pathway 2 bed model/capacity

Children and Young People Delivery Board

Priority/what are we trying to achieve?	CYP Change programme/ initiative
Transform children's mental health services, reducing waiting times and improving access to prevent crisis care	• Mental Health Community • Mental Health Crisis • Mental Health Eating Disorders
Transform children's neurodevelopment services	• Neurodevelopment
Prevention and redesigned clinical pathways	• Long Term conditions – asthma, obesity, diabetes, and epilepsy • Oral health (oversight only) • Cancer/EOL

In addition to this programme, there are a range of improvement works currently in play which connects the NHS with the wider Integrated Care Partnership – overseen by the Integrated PLACE Executive.

Early Years (Start Well)

Initial works have commenced on drawing together a programme which incorporates the role of all key stakeholders in bringing about an improvement to the health, social, emotional, and physical development of children in their early years.

To date an outcomes framework has been developed which relate to:

- School readiness.
- Family factors relevant to school readiness.
- Factors relating to the child – more physical health related; and
- Factors relating to the wider public health system.

This will inform the next stage of works to determine what action needs to be taken to improve.

Circulatory Disease (Stay Well)

Based upon national modelling there are least 76,000 people in Derby and Derbyshire who have hypertension, but they are not aware they have the condition, and neither is the NHS. Furthermore, the NHS estimates there are approximately 5,000 people in Derby and Derbyshire with atrial fibrillation (AF) and have this recorded in their patient record but have no active treatment plan in place.

In this context, the key areas of focus in our response to this challenge includes:

- Undertaking a quality assurance process to understand why people with AF are not under active treatment.

- Ensuring primary prevention opportunities are maximised at every point of contact between the NHS and a patient e.g., tobacco dependency programme.

- Increasing early detection and management of common risk factors, for example:

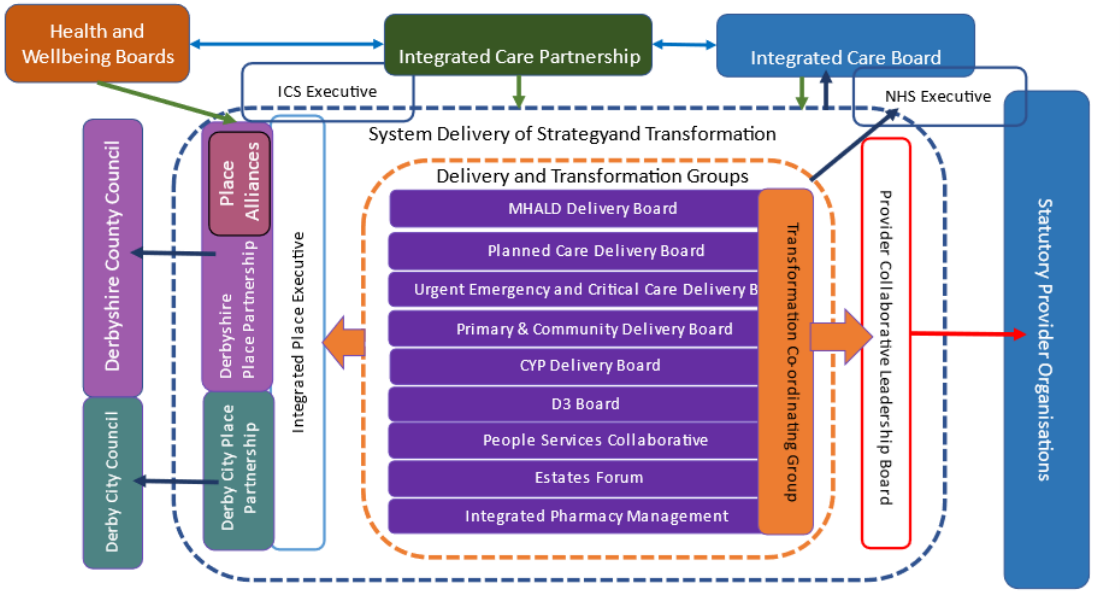
    - Increase diagnosis of and ensure optimum treatment of hypertension;
    - Improve detection and management of raised cholesterol;
    - Improve detection of and optimise anticoagulation of those with AF; and
    - Improve detection of type 2 diabetes, including in children and young people, increase uptake of Diabetes Prevention Programme (DPP), improve coverage of care processes

- Reviewing ‘post event’ interventions e.g., Cardiac Rehab post Percutaneous Coronary Intervention / Myocardial Infarction (PCI/MI), to reduce inequalities in uptake and maximise impact.

7. Governance and Delivery

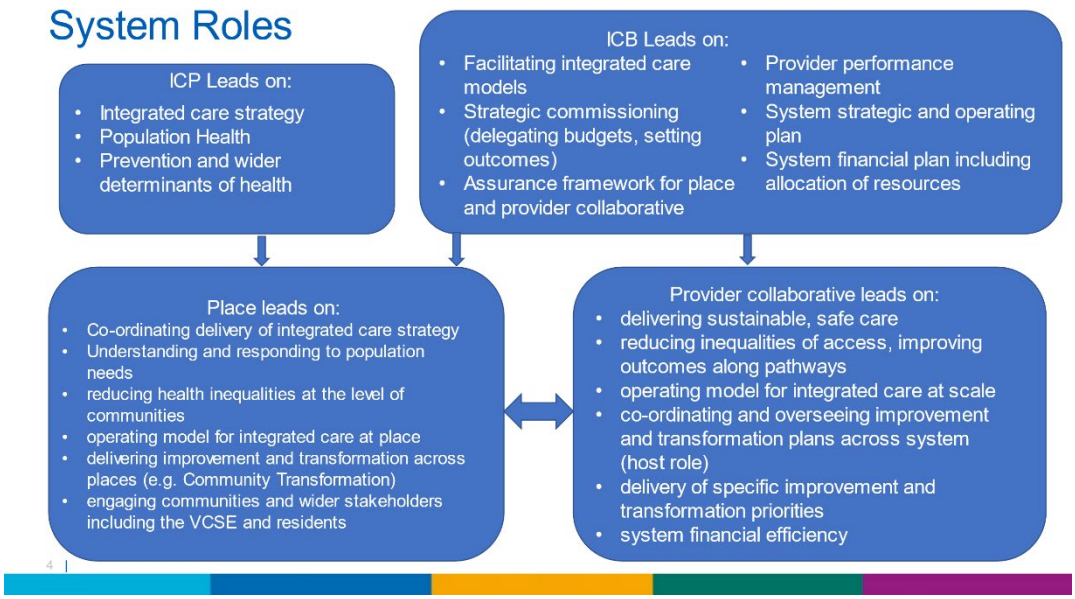
7.1 Oversight

The development of the Derby and Derbyshire NHS' Five Year Plan will be overseen by the Derby and Derbyshire Integrated Care Board, drawing on the input of partners from across the NHS (via the Provider Collaborative) and the wider Integrated Care Partnership (via the Integrated PLACE Executive).



7.2 System Roles

The following diagram is helpful in stating system roles across the ICP, the ICB, Place and the Provider Collaborative, in relation to accountabilities and responsibilities that relate to the Plan.



7.3 Improvement and change management methodologies

Improvement science and quality improvement methodologies need to play a key role in facilitating the move from agreed aims to delivering improved outcomes, and the use of the significant QSIR (Quality, service improvement and redesign) capability within the JUCD NHS system will be key in ensuring good quality application of improvement science.

Leaders will therefore need to consider the right balance between the use of 'planned' and 'emergent' change management approaches and focus on how partners work together, linked to culture and behaviours. This means a 'one-size fits all' change management approach will not work, and leaders will have a key role to play in supporting and facilitating the right conditions for emergent change to flourish.

7.4 Tracking delivery

Where it is not the case already, all improvement aims will need to be converted into tangible actions with a clear process for tracking, reporting and governing progress, this will include establishing clarity on the following:

- Key enabling actions
- Portfolio of improvement activities and programmes/ projects
- Objectives and expected outputs – covering each year of the Plan
- Outcomes
- Reporting arrangements
- Governance – including the accountable and responsible officers and forums

The JUCD "e-PMO," the system level programme management office, will oversee the approach to reporting on the Plan, and in bringing together the outputs from the responsible bodies listed in the table above.

7.5 Risks

At this stage of development. we are conversant of the following strategic risks that we will seek to understand, appraise, and ultimately mitigate via the formation of our operational plans over the coming period.

Workforce

People are our single most important resource, and we will not be able to deliver on our Plan unless we can develop, attract, and retain staff. Staffing shortages in several sectors, including nursing and the medical workforce have been the biggest challenge facing local trusts and providers and this poses the biggest threats to fulfilling the aims and objectives set out in our Plan.

Financial

Immediate pressures and operational requirements (NHS annual planning targets) have the potential to drive us into allocating resources based on short / medium term priorities and preventing us from investing in the long terms activities that will help us deliver the outcomes

we aim to achieve and ultimately limiting our ability to realise the efficiency or operational returns that are expected.

Our workforce and financial plan therefore need to be driven by the type of outcomes and activities we desire to achieve. Going forward we will need to ensure our activity, workforce and financial plans are developed in an integrated manner both within the NHS 'family' and across our broader partnerships.

The rising demand for NHS services

It is accepted that the ageing population has significant rising demand for NHS services across Derbyshire. However, there are other factors that contribute to rising demand which are not yet fully understood for example, wider socio-economic factors such as housing, employment, and changes to benefits and universal credit. We therefore need to ensure we design and develop a true, evidence-based programme of transformation which complements operational improvement and delivery plans and supports the quality, safety and economic commitments made by the system partners.

Ways of working

The current financial pressures in both the NHS and local government poses a significant risk and will make partnership working that bit more challenging. We will need to ensure we have appropriate governance arrangements and support partner organisations and their staff to adapt to the new ways of working.

Conclusion

This five-year plan represents a significant milestone in the ongoing commitment to providing high-quality healthcare services to the people living and working in Derby and Derbyshire. At the end of this five-year period, the NHS in Derby and Derbyshire will operate differently to how it does now, to the benefit of our citizens, patients, and staff.

There are three aspects of this plan to emphasise:

- **The importance of patient-centred care, focusing on prevention, early intervention, and personalised treatment options.** By placing patients at the centre of decision-making processes, this NHS Plan ensures that services are tailored to individual needs, promoting better health outcomes and overall satisfaction.

- **Enhancing patient outcomes, improving access to care, and promoting efficiency in service delivery are key.** By pooling resources, expertise and knowledge, healthcare providers can work together to streamline processes, reduce duplication, and optimize the use of available resources.

- **The significance of engaging and involving stakeholders, including patients, healthcare professionals, our VCSE sector and our local authority partners.** By fostering collaboration and partnership, the plan aims to build a stronger healthcare system that is responsive to the diverse needs and aspirations of the community it serves.

Finally, this Plan reflects our NHS commitment to continuous improvement and innovation in healthcare delivery. By working together, we will create a more integrated and efficient system that meets the challenges of today while ensuring a sustainable tomorrow. The plan sets a clear pathway towards a healthier and thriving community, where individuals receive the care and support they need, when they need it.

Appendix A – Derby and Derbyshire Health Index

The figure below shows a breakdown of the Health Index for the Derby and Derbyshire PLACEs, with the England position also shown.

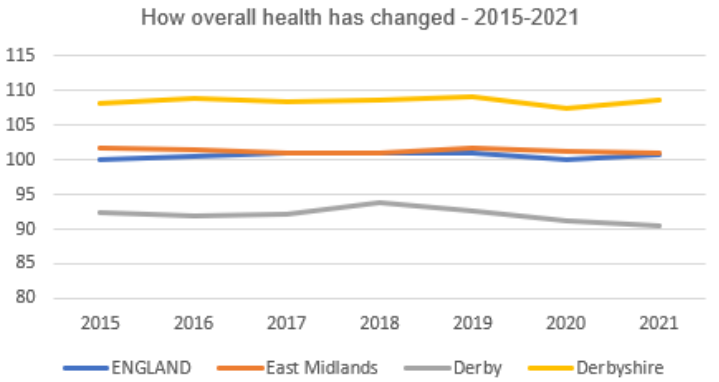


Figure 6. Health Index 2015-21. Office for National Statistics, 2023.

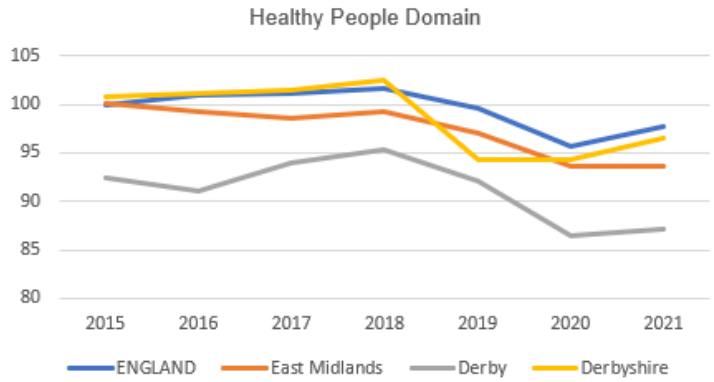


Figure 7. Healthy People Domain 2015-21. Office for National Statistics, 2023.

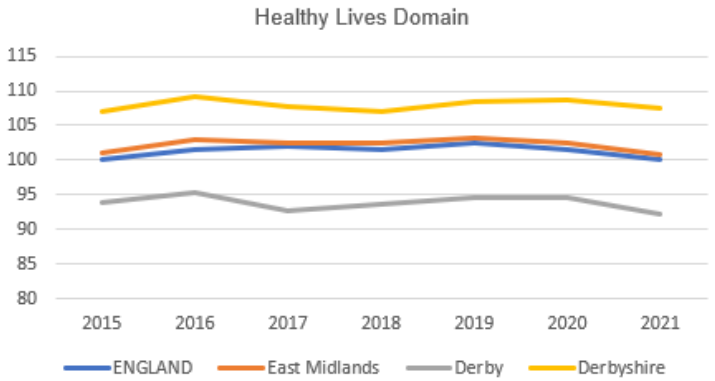


Figure 8. Healthy Lives Domain 2015-21. Office for National Statistics, 2023.

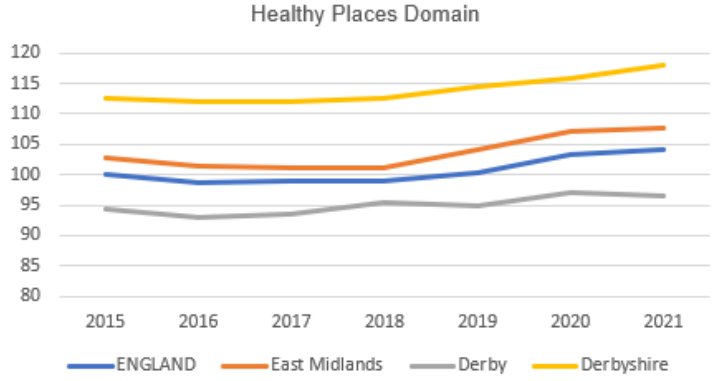
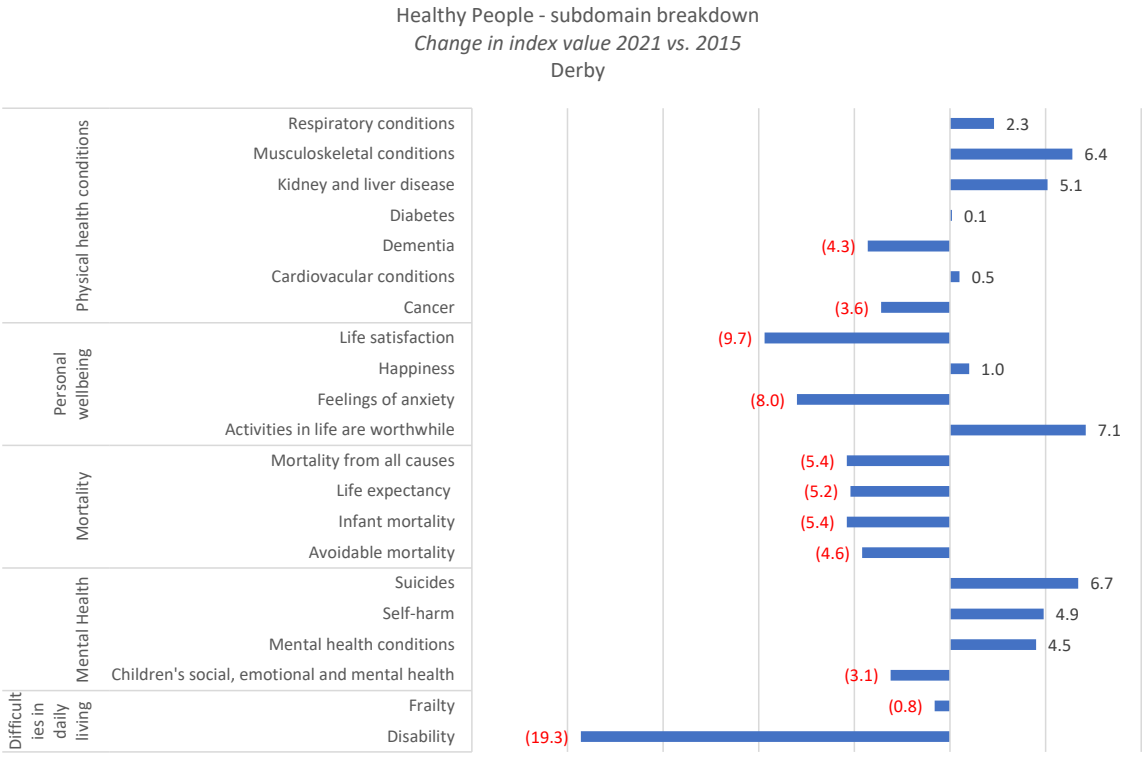
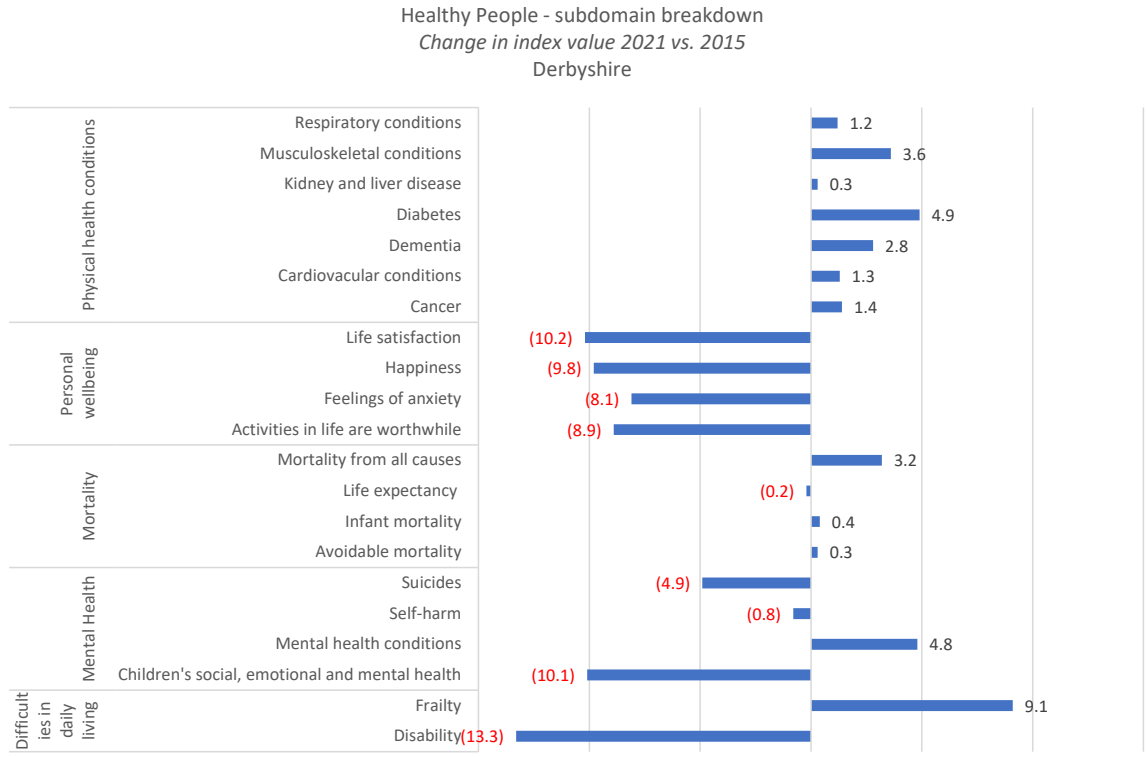


Figure 9. Healthy Places Domain 2015-21. Office for National Statistics, 2023.

The constituent elements of each sub-domain within the Healthy People Domain of the Health Index – *difference between the 2021 measure and the 2015 baseline index value*





NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

20th July 2023

Item: 050

Report Title	NHS Long Term Plan Workforce Plan							
Author	Sukhi Mahil, Assistant Director, Workforce Strategy, Planning and Transformation							
Sponsor (Executive Director)	Linda Garnett, Interim ICB Chief People Officer							
Presenter	Linda Garnett, Interim ICB Chief People Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1 – NHS Long Term Workforce Plan							
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 NHS Long Term Workforce Plan.
Purpose
The purpose of this report is to provide the ICB Board with a summary of the key points from the NHS Long Term Plan published on 30 June 2023 NHS Long Term Workforce Plan (england.nhs.uk).
Background
The Derby and Derbyshire Integrated Care System is in the very early stages of developing a 'one workforce' strategy. The ambition is that through this approach a more holistic view of our workforce will be created which includes all our partner organisations, including social care and the VCSE sector. This is considered important, as the needs of our population cannot be met through our NHS workforce in isolation and there is a need to consider the workforce across pathways. Whilst the long-term workforce plan relates specifically to our NHS partners; there is also a thread, in relation to wider one workforce approaches, such as, enabling a shift to more prevention and the role of the NHS as anchor organisations in attracting workforce from more diverse backgrounds. The implementation of this plan should therefore complement our one workforce approach as it evolves whilst also responding to any specific requirements as they become clearer.

Report Summary

The NHS Long Term Workforce Plan published on 30th June 2023 is considered nationally as a substantial step forward in the ongoing efforts to shape the future of the healthcare workforce and describes the ambition to rebuild the NHS workforce through 3 priority areas (Train, Retain and Reform).

A longer-term plan for workforce is something that has been needed for some time and whilst the plan is light on detail of what would be different in the immediate term and what this means in reality for ICBs, the fact that it is underpinned by longer term funding commitment is welcomed. The NHS Confederation has published a helpful on day briefing which can be viewed at NHS Long Term Workforce Plan: what you need to know | NHS Confederation.

The table at Appendix 1, provides an overview the 3 priority areas as set out in the national plan and aims to begin mapping out initial thoughts on what this means for the ICB; noting further guidance will be anticipated in relation to actual implementation.

In summary, we know that workforce pressures exist within our system and there is a significant amount of work needed to address these (the pressures exist in all sectors). It is hoped that the national plan and associated actions will enable the improvements needed. However, at this present time the actions set out in the plan are very high level and it is not clear how these would impact locally in the immediate to short term. It is clear that there is further work required in terms of implementation and we will continue to respond as necessary over the coming weeks and months.

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.	☐			

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?
Not applicable.

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

NHS Workforce Plan – 3 Priority Areas (Overview)	What does this mean for NHS Derby and Derbyshire? (Note these are initial thoughts which will need to develop as further national guidance emerges)
Train – Grow the workforce: By significantly expanding domestic education, training and recruitment, there will be more healthcare professionals working in the NHS. This will include more doctors and nurses alongside an expansion in a range of other professions, including more staff working in new roles: • double the number of medical school training places, particularly medical school places in areas with the greatest shortage to level up training and help address geographical inequity; • increase the number of GP training places, by increasing the number of GP specialty training places, with the first 500 new places available from September 2025; • increase adult nursing training places; • provide 22% of all training for clinical staff through apprenticeship routes by 2031/32, up from just 7% today; • apprenticeships will help widen access to opportunities for people from all backgrounds and in underserved areas to join the NHS; • introduce medical degree apprenticeships, with pilots running in 2024/25, so that by 2031/32, 2,000 medical students will train via this route; • expand dentistry training places; • train more NHS staff domestically. This will mean that we can reduce reliance on international recruitment and agency staff.	• Actively review and utilise the annual ICB-level education and activity funding statements, to manage education capacity and to support education planning. • Improve the strategic focus of education planning and investment at a system level based on medium and long-term system workforce needs; ensuring that education placement capacity is integrated into service planning within annual operational plans. • Aim to plan across settings, including primary care, in the ICB Joint Forward Plan (JFP). This will need to include all modes of education and training, including apprenticeships, peer-to-peer learning and accredited programmes and consider the development and retention of existing staff and how education capacity should be developed in key service areas, including the support required to provide high quality education such as supervision and clinical placements. • Continue working with system partners to maximise how the NHS works as an anchor institution to expand access routes into training in the NHS.

NHS Workforce Plan – 3 Priority Areas (Overview)	What does this mean for NHS Derby and Derbyshire? (Note these are initial thoughts which will need to develop as further national guidance emerges)
Retain – Embed the right culture and improve retention: By improving culture, leadership and wellbeing, ensure fewer staff leave the NHS over the next 15 years: • continue to build on what we know works and implement the actions from the NHS People Plan to ensure the NHS People Promise becomes a reality for all staff by rolling out the interventions that have proven to be successful already (e.g. ensuring staff can work flexibly, have access to health and wellbeing support, and work in a team that is well led); • implement plans to improve flexible opportunities for prospective retirees and deliver the actions needed to modernise the NHS Pension Scheme, building on changes announced by the government in the Spring Budget 2023 to pension tax arrangements, which came into effect in April 2023; • from autumn, recently retired consultant doctors will have a new option to offer their availability to trusts across England, to support delivery of outpatient care, through the NHS Emeritus Doctor Scheme; • commit to ongoing national funding for continuing professional development for nurses, midwives and allied health professionals, so NHS staff are supported to meet their full potential; • support the health and wellbeing of the NHS workforce and, working with local leaders, ensure integrated occupational health and wellbeing services are in place for all staff; • explore measures with the government such as a tie-in period to encourage dentists to spend a minimum proportion of their time delivering NHS care in the years following graduation; • support NHS staff to make use of the change announced in the Spring Budget 2023 that extended childcare support to working parents over the next three years, to help staff to stay in work.	• Refocus our one workforce approach to ensure the NHS People Promise is embedded and evident. • Ensure we have a focus on staff being safe and healthy. This includes setting out evidence-based policies, training and support for staff who experience domestic abuse and sexual violence (DASV). This should be included in the JFP. As part of this, ICBs and trusts have been asked to appoint DASV leads. • The recruitment and retention programmes are already a priority for the People Services Collaborative and we will ensure that actions are prioritised that drive recruitment and retention of their ‘one workforce’ across health and care.

Reform – Working and training differently: By enabling innovative ways of working with new roles as part of multidisciplinary teams so that staff can spend more time with patients; changing how services are delivered, including by harnessing digital and technological innovations. Training will be reformed to support education expansion: • focus on expanding enhanced, advanced and associate roles to offer modernised careers, with a stronger emphasis on the generalist and core skills needed to care for patients with multimorbidity, frailty or mental health needs; • setting out the path to grow the proportion of staff in these newer roles from around 1% to 5% by the end of the Plan by: ○ ensuring that more than 6,300 clinicians start advanced practice pathways each year by 2031/32, by having at least 3,000 clinicians start on advanced practice pathways in both 2023/24 and 2024/25, with this increasing to 5,000 by 2028/29; ○ increasing training places for nursing associates (NAs) to 10,500 by 2031/32, by training 5,000 NAs in both 2023/24 and 2024/25, increasing to 7,000 a year by 2028/29. By 2036/37, there will be over 64,000 nursing associates working in the NHS, compared to 4,600 today; ○ increasing physician associate (PA) training places to over 1,500 by 2031/32; around 1,300 physician associates (PAs) will be trained per year from 2023/24, increasing to over 1,400 a year in 2027/28 and 2028/29, establishing a workforce of 10,000 PAs by 2036/37; • 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 73% by 2036/37; • work with professions to embrace technological innovations, such as artificial intelligence and robotic assisted surgery. NHS England will convene an expert group to identify advanced technology that can be used most effectively in the NHS, building on the findings of the Topol Review; • expand existing programmes to demonstrate the benefits of generalist approaches to education and training and ensure that, at core stages of their training, doctors have access to development that broadens their generalist and core skills; • work with partners to ensure new roles are appropriately regulated to ensure they can use their full scope of practice and are freeing up the time of other clinicians as much as possible – for example, by bringing anaesthesia and physician associates in scope of General Medical Council (GMC) registration by the end of 2024 with the potential to give them prescribing rights in the future;	• ICBs should embrace volunteering as part of their overall workforce plan, giving due consideration to programmes that support volunteering as a route into the workforce, such as NHS Cadets and Volunteer to Career. As part of the one workforce approach we have committed to ensuring that the VCSE sector is included and will ensure that our approach includes broader volunteering opportunities. • We will consider how we undertake workforce planning, development and training for public health areas such as sexual and reproductive health and alcohol and drug treatment; through joint working approaches between the ICB and local authorities (this may be an area for development through the ICP). • Our ambition is to align workforce planning to improve population health which will include developing core competencies for CVD outcomes. This will include training and upskilling the local primary care workforce (through the GP Training Hub), so they have the competencies, to deliver interventions such as the NHS Health Checks • Workforce transformation approaches such as the HEE Star and the six-step workforce planning approach are the foundations of our one workforce approach; we will consider opportunities to upskill and utilise these approaches more broadly. • We will explore the opportunities which the NHS England Federated Data Platform (FDP) brings to better connect the NHS to improve insights needed to proactively plan services around people's needs and co-ordinate care across the services in the geography. We will do this in the context of the Project Derbyshire digital programme of work which is underway.

NHS Workforce Plan – 3 Priority Areas (Overview)	What does this mean for NHS Derby and Derbyshire? (Note these are initial thoughts which will need to develop as further national guidance emerges)
• support experienced doctors to work in general practice under the supervision of a fully qualified GP. We will also ensure that all foundation doctors can have at least one four-month placement in general practice, with full coverage by 2030/31; • work with regulators and others to take advantage of EU exit freedoms and capitalise on technological innovation to explore how nursing and medical students can gain the skills, knowledge and experience they need to practise safely and competently in the NHS in less time. Doctors and nurses would still have to meet the high standards and outcomes defined by their regulator; • support medical schools to move from five or six-year degree programmes to four-year degree programmes that meet the same established standards set by the GMC and pilot a medical internship programme which will shorten undergraduate training time, to bring people into the workforce more efficiently so that in future students undertaking shorter medical degrees make up a substantial proportion of the overall number of medical students; • the Plan is based on an ambitious labour productivity assumption of up to 2% (at a range of 1.5–2%). This ambition requires continued effort to achieve operational excellence, reducing the administrative burden through technological advancement and better infrastructure, care delivered in more efficient and appropriate settings (closer to home and avoiding costly admissions), and using a broader range of skilled professionals, upskilling and retaining our staff. These opportunities to boost labour productivity will require continued and sustained investment in the NHS infrastructure, a significant increase in funding for technology and innovation, and delivery of the broader proposals in this Plan.	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

20th July 2023

Item: 051

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 – Paul Lumsdon, Interim Chief Nurse Officer • Performance – Zara Jones, Executive Director of Strategy and Planning • 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
Assurance Report Signed off by Chair	Not Applicable
Which committee has the subject matter been through?	Finance and Estates Committee – 27.6. 2023 Quality and Performance Committee - 29.6.2023 System HRDs

Recommendations
The ICB Board is recommended to **NOTE** the Month 2 performance Operational Plan update against the plan commitments and targets.

Purpose
The purpose of this report is to provide an update on the Month 2 position against the 2023/24 operational plan commitments, quality, performance, 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 May 4. The improvements in the plan are planned to be achieved by using our assets more productively with minimal or no growth in workforce. The financial plan assumed a break-even position. Following submission of the operational plan, work is now underway to develop a more cohesive and integrated framework for future reporting against delivery of the plan. The ambition is to:

- create a single version of the truth with greater alignment between the various components (performance, workforce and finance).
- for performance, agree a consistent set of data sources including additional local measures and data sets, as well as adopting a more collaborative and common approach to use of data and reporting of performance against targets and commitments

The work and commitments required to achieve the integrated approach is complex and there is a significant amount of development work required to create a truly integrated and triangulated monitoring and reporting framework. This development will need to be phased in collaboration with system partners to ensure ownership. In the meantime, the respective leads are continuing to work together to ensure the position is more joined up.

Report Summary

The summary below highlights the key areas to note and additional information can be found in the supporting appendices.

Quality

- Three Year Delivery Plan – The Local Maternity and Neonatal System team are currently developing an action plan to incorporate the national recommendations by identifying responsibilities for the Trusts and the ICB.
- Infection Prevention and Control trajectories for 2023/24 have been released by NHSE. The targets will be challenging to meet based on last year's performance and first 2 month's data (item 2 on Quality Slides).
- Derbyshire Community Health Services have reported a Wrong Site Surgery Never Event (item 4 on Quality Slides).

Performance

Urgent & Emergency Care:

- Both Acute Trusts are currently meeting and exceeding the Operational Plan target for 4hr A&E wait for the period of 57%. The Chesterfield Royal Hospital (CRH) is achieving 65% while the University Hospitals of Derby and Burton (UHDB) is achieving 68%.
- There has been a slight rise in the amount of time lost due to ambulance handover delays.
- In relation to bed occupancy, both Trusts were achieving a better performance than their local Operational Plan Target with CRH achieving 96.2% and UHDB achieving 93.9% though this is still worse than the national target of 92%.
- Virtual Ward capacity for may stood at 150, against a target of 155 while utilisation in May was 17% - still facing some data quality issues which we are working through.
- The ICB is achieving an 82% success rate against a target of 70% for the 2hr for our urgent community response according to local data – published national data is showing a lower achievement due to timing differences.

Planned Care and Cancer:

- We continue to see variable performance between the two acute trusts. Both trusts are implementing targeted actions to achieve operational plan commitments.
- RTT waiting list numbers remain high
- Focus on long waiting patients has resulted in a sustainable reduction over recent months
- In relation to the Cancer 2 Week Wait target, referrals continue to exceed the pre-pandemic levels which is making it impossible to meet the target.
- GI endoscopies, Echos and MRIs still posing significant challenges to meeting the 6-week ambition for diagnostics.

Mental Health, Learning Difficulties and Autism:

- Increasing Access into Community Services: we continue to see sustained improvement in all the areas:
  - CYP Eating Disorders (Urgent & routine Access) continue to build on the Q4 performance - for urgent access performance it was 100% for both providers while for routine access it was at 100% for DHcFT and 90% for CRHFT;
  - Talking Therapies (IAPT) – achieved performance requirements in April with regards to access, recovery rates and waiting times;
  - Dementia Diagnosis Rate – Improved performance position for April 66.3% against requirement of 67%. Expect to sustain performance into May.
- Reducing Use of AMH Inpatient Out of Area Placements – significant challenges in achieving the aim to eliminate out of area MH placements in part due to the lack of PICU services within Derbyshire and capacity constraints in our AMH services currently running with occupancy level above 100%. 'Making Room for Dignity' / dormitory eradication program will enable delivery of this standard – completion expected during 24/25.
- Reducing Use of Inpatient Care: we have achieved required performance against locally agreed trajectory for all months in Q1, however we are still non-compliant against national standards require. A recovery action plan has been developed and is being closely monitored.
- Reduction in Health Inequalities for people with LD: action plan and local trajectory agreed between Primary Care and DHcFT which will support achievement of national standard 75%.

Primary Care:

- GP Appointments: In May there were 538,841 GP appointments - 19,000 appointments above the planned level. For the period.
- Agreed quarterly targets for Community Pharmacy Consultation Service

We will be working with service areas to identify additional local measures and targets (non-operational plan targets) to include in future.

Workforce

At M2, the total workforce was 459.47 Whole Time Equivalents (WTEs) below plan; this was across all areas (substantive, bank and agency). Compared to M1, there was an improvement in recruitment to substantive positions (increase of 41.70wte) and a reduction of in agency usage (-87.52wte). However, despite the position being below plan and all organisations (except CRH) being under their respective funded establishment, the pay bill for staff cost was overspent by £9.7m, and for agency cost by £2.2m.

The overall system position against the staff in post plan (as set out above) is below plan and the increase in pay costs is assumed to be as a result of the recent industrial action. In addition, the position is not fully understood due to the Agenda for Change (AfC) uplift not being in the plan and there are different approaches to efficiency phasing.

As noted last month, further work is being undertaken to fully understand the correlation between the workforce and finance positions, given the greatest proportion of costs are attributed to staff. With that in mind, the workforce actual position comparison to the funded established as shown in the appendix, is subject to further validation and scrutiny due to the known misalignment between ESR and finance ledger systems.

Finance

As of 31st May 2023, the JUCD year to date position is £11.6m deficit against a £7.5m planned deficit, factors contributing to this is industrial action by Junior Doctors, efficiency slippage and excess inflation. However, the system is confident and committed to delivering a breakeven position at year end.

Efficiency schemes continue to be developed; however, this will have to be done at pace to meet the step up in the expected delivery at month four. There has not been a sufficient increase in the development of the efficiency plans since month one. Delivery of these schemes are crucial to successfully achieving breakeven by year end.

The Provider Collaborative and Place will be required to make a significant contribution to delivering the in-year and recurrent underlying position.

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.	☐			

SR4: Risk of JUCD system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICS to move to a sustainable financial position.

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.

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?**
The papers are provided for information only and therefore have no financial impact.	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.

Integrated Assurance and Performance Report

July 2023

Dr Chris Clayton ICB Chief Executive Officer
Paul Lumsdon, Interim Chief Nurse Officer
Zara Jones, Executive Director of Strategy and Planning
Linda Garnett, Interim ICB Chief People Officer
Keith Griffiths, Executive Director of Finance

Quality

Paul Lumsdon, Interim 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 Messages

#	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/ Ockenden Review Compliance	- UHDB: stillbirth rate continues to rise to 5.15/1000 total births from a rate of 3.15/1000 in April 2022. It was identified that the neonatal death rate had previously been reported inaccurately due to the inclusion of births under 24 weeks and medical termination of pregnancy, which does not meet the MBRRACE criteria. Following recalculation, the rate is 0.94/1000 births which has decreased from 1.13/1000 births in April 2022. This is below the national rate of 1.53/1000 births. The Trust will be undertaking a further Perinatal Thematic Review and anticipate conclusion will be September 2023. Terms of reference for the extended perinatal review are due to be approved 9 June 2023. Updates on the process and findings have been recommended until the final report is completed. There are 2 quality improvement projects in place for fetal monitoring in labour and major obstetric haemorrhage as both feature prominently in incidents reported. - CRH: stillbirth rate was 1.41/1000 total births showing a consistent decrease from April 2022. The neonatal death rate was 0.35/1000 live births which has decreased over 2022/23 from 0.7/1000 live births. Both are below the ONS & MBRRACE national averages. - Saving Babies Lives - CRH had a regional review of the Saving Babies Lives Care Bundle v2 on April 28th and their updated compliance is 86%. UHDB will be assessed using the updated template following the imminent release of Saving Babies Lives Care Bundle version 3, which includes a sixth element for Diabetes in pregnancy. - Three Year Delivery Plan – The LMNS team are currently developing an action plan to incorporate the national recommendations by identifying responsibilities for the Trusts and the ICB.
2	IPC	CDiff	System	Trajectories for 23/24 released by NHSE. The targets will be challenging to meet based on last year's performance and first 2 month's data. 	- Derbyshire system CDiff summit scheduled for 5th July 2023. - Repeat NHSE visit to CRH in April found continued concerns. Both CRH and UHDB remain on enhanced monitoring and support on the NHSE Midlands IPC escalation matrix. - Work continues at both Acute trusts to implement the action plans developed to address the rise in C Diff numbers and within the Regional NHSE/I collaboratives. - AMR/IPC committee and review of community associated cases it was agreed to use the planned regional resources we can implement as a system to address some of the issues identified. - Deep dives into the HCAIs that have breached have shown no additional themes that are not already covered by the action plans that they have implemented for CDiff .
3	Safety	Primary Care	System	Previously rated by the CQC as Good following an inspection in 2018 Elmwood Medical Centre received an unannounced CQC inspection on 23rd January 2023 following concerns raised to the inspectorate from a whistle blower raising allegations of bullying within the practice. These allegations alongside some discrepancies with how the practice had been registered with the CQC resulted in the CQC examining the associated risks and determining an inspection was indicated. The outcome of the CQC inspection was the practice was given a rating of Inadequate and the practice was issued with 2 warning notices and placed in Special Measures.	- Progress review meetings held March 2023 and May involving representatives from the PCQT, GTD and Elmwood Medical centre. Revised action plans were presented by GTD and the practice is making good progress with the required actions to improve patient care. - The PCQT met with the Practice Management Team at Elmwood Medical Centre and GTD Head of Locality at the practice May to review the practice evidence in response to the warning notices issued following the inspection in preparation for the forthcoming CQC inspection. - The PCQT continue to meet with Elmwood/GTD staff monthly, the local CQC inspector will be invited to future meetings. - CQC has confirmed dates for follow up inspection

	2022/23 End of Year Position	2023/24 Target	YTD At 6.6.23
C Diff			
NHS Derby and Derbyshire ICB	367	262	**42**
Chesterfield Royal Hospital	57	30	**5**
University Hospitals of Derby and Burton	166	97	**26**
MRSA			
NHS Derby and Derbyshire ICB	16	0	**3**
Chesterfield Royal Hospital	1	0	**1**
University Hospitals of Derby and Burton	6	0	**0**

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

Derby and Derbyshire Integrated Care Board

Key Messages					
#	Concern 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
4	Never Event	Wrong Site Surgery	DCHS	Patient attended Podiatric surgery outpatient's clinic for routine 2 week post operative review following a right 2nd metatarsocuneiform joint fusion and a heel bone graft. On review of post operative x-rays, it was noted that the fixation i.e., the plate and the graft were not on the planned/consented site. In fact, it was found to be on the navicular cuneiform joint instead.	- No immediate change to postoperative care required. Follow up surgery required to remove plate once bone graft healed to prevent future complications from placement of plate – planned for 10 weeks. - Decision taken to postpone any further mid-foot fusion operations for two weeks until equipment available to utilise C-arm fluoroscopy during surgery. No impact on waiting times/operations due to no operations booked during this period. - Patient & family contacted. - Incident reported on STEiS and discussed at the May CQRG for assurance.
5	- Improvement of Category 2 Response Times	Ambulance	EMAS	Towards the end of the last financial year ambulance trusts were asked to produce a plan to demonstrate how they would each achieve an average response time of 30 minutes for Category 2 calls in 2023/24. This does not change the national standard which is a mean of 18 minutes for Category 2. There is an expectation that all ambulance trusts will achieve the national standard in 2024/25 and the 30-minute target is the first stage of this. CAT 2 (mean) response time for April 2023 was 33.38 minutes (Derbyshire 31.09 minutes) This is part of the national primary 999 triage platform moving from the Advanced Medical Priority Dispatch System (AMPDS) to NHS Pathways.	- Training for EMAS staff to use NHS Pathways will be delivered by an established training provider - 999 call taking during training periods will be handled by third party ambulance trusts. This reduces the requirement for EMAS to recruit over 100 temporary EMD staff to support call answer time performance and patient service, and provides a more flexible approach to delivery - The aspiration to achieve go-live has been brought forward to pre-winter 2023, with a target implementation date of 31 October 2023; previous implementation dates were based on a migration by April 2024.

INTELLIGENCE SHARING - horizon scanning, trends etc

There has been significant national and local media attention in relation to a Derbyshire child whose parents have now been sentenced for his murder on the 26th May 2023.
-There is another Derbyshire child case that the criminal case is due to commence in early June which is also likely to attract media attention. The Derby and Derbyshire Safeguarding Children Partnership are working with partner media representatives to be prepared for media enquires that the DDSCP or agencies may receive.

LEARNING AND SHARING - best practices, outcomes

Performance

Zara Jones, Executive Director of Strategy & Planning
Julian Corner, Non-Executive Member

*Figures in italics are **provisional** - Unavailable data is marked as n/a*
** Provisional data is unpublished by NHSE*

Planning Compliance with Operational Plan - May 23

Area	Objective	Level	Operational Plan / Local Target	Full Year OP Target Profile	M02/Q1 OP Target Profile	M1 Position	M2 Position	Comment
Primary Care	Increase General Practice appointment activity		Operational Plan	6,707,340	519,638	471,753	*538,841*	
	Increase referrals into Community Pharmacy Consultation Services (Quarterly Target)		Operational Plan	39,197	8,615	*2,274*	*n/a*	
	Recover dental activity to pre-pandemic levels (Quarterly Target)		Operational Plan	1,531,764	382,941	*n/a*	*n/a*	
Mental Health, Autism & Learning Disabilities	Increase the dementia diagnosis rate (Quarterly Target)	ICB	Operational Plan		64.0%	66.3%	*n/a*	
	Provide access for 28,294 people to receive IAPT in 23/24 (Quarterly Target)	ICB	Operational Plan	28,294	6877	*n/a*	*n/a*	
	Increase the number of women accessing specialist perinatal services in 2023/24 (Quarterly Target).	ICB	Operational Plan	2,757	270	*714*	*n/a*	
	Increase the number of children and young people accessing a mental health service (Quarterly Target).	ICB	Operational Plan	52,481	12,000	*n/a*	*n/a*	
	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	10,508	*n/a*	*n/a*	On target for qtr 1 achievement
	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%	11.9%	3.0%	*3.9%*	Target for Q1 is 11.91% therefore this is deemed on target as 3% was achieved in M1 (cumulative target)
	SMI Health Check	ICB	Local Target	60%	60.0%	56.0%		
	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	52	45	48	
	Reduce the number of children who are autistic, have a learning disability or both who are in inpatient beds	ICB	Operational Plan	3	6	7	7	
	Reduce out of area placements - Bed Days	ICB	Operational Plan	736	1,196	*571*	*634*	
	Reduce out of area placements - Actual patients at month end	ICB	Operational Plan	-	-	*12*	*8*	Month-end snapshot
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,	CRH	Operational Plan		70%	77.0%	*80.2%*	CRH reporting 75.5% at M2 internally,
		UHDB	Operational Plan		70%	66.9%	*67.5%*	
	Reduce the number of people waiting longer than 62 days for their first definitive treatment for cancer.	CRH	Operational Plan	43	51	47	*47*	CRH reporting 48 at M2 internally
		UHDB	Operational Plan	268	411	473	*456*	

Key to RAG Ratings
On Plan
Close to Plan
Off Plan

Area	Objective	Level	Operational Plan / Local Target	Full Year OP Target Profile	M02/Q1 OP Target Profile	M1 Position	M2 Position	Comment
Planned Acute Care	No person waiting longer than 65 weeks on an RTT pathway at the end March 2024.	CRH	Operational Plan	0	452	369	*353*	CRH reporting 369 at M2 internally
		UHDB	Operational Plan	0	1,935	2,260	*2,056*	
	No person waiting longer than 78 weeks on an RTT pathway.	CRH	Not OP targets	0	0	16	*13*	
		UHDB	Not OP targets	0	0	144	*130*	
	No person waiting longer than 104 weeks on an RTT pathway.	CRH	Not OP targets	0	0	0	0	There were 6 patients waiting at
		UHDB	Not OP targets	0	0	0	0	providers outside the system at May23
	At least 85% of people receive a diagnostic test within 6 weeks by March 2024.	CRH	Operational Plan	85%	85%	78.3%	*76.3%*	Endoscopies and Echoes make up most of the breaches
		UHDB	Operational Plan	85%	85%	66.0%	*66.9%*	CRH reporting 76% internally
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%	57%	67.9%	64.8%	
		UHDB	Operational Plan	76%	57%	66.7%	68.4%	
	30 minutes or less for EMAS to respond to a category 2 incident, on average.	ICB	Operational Plan	30 Mins	30 Mins	00:31:00	00:35:00	
		EMAS	Operational Plan			00:33:32	00:34:23	
	Both Acute Trusts to operate at an average general and acute occupancy rate of 92%.	CRH	Operational Plan	88.97%	99.8%	96.4%	96.2%	Planned target was not compliant with national 92% but performance is better than provider expectation.
		UHDB	Operational Plan	92.89%	95.1%	91.1%	93.9%	CRH reporting 94.4% internally at M2
	At least 70% of referrals into the Urgent Community Response Service to be responded to within 2 hours.	ICB	Operational Plan		70%	*70.0%*	*n/a*	An issue has been identified with the submission fields in CSDS not corresponding to the UCR services. The locally reported position is significantly higher (82% at may). This is being investigated with NHSE.
	Increase virtual ward capacity.	ICB	Operational Plan	255	138	140	155	
	Increase virtual ward utilisation.	ICB	Local Target	80%	41%	32.0%	17.0%	
	Reduce emergency admissions resulting from a frailty induced fall.		Local Target			*n/a*	*n/a*	

Urgent & Emergency Care

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Highlights and Issues:

- Both Acute Trusts are currently meeting and exceeding the Operational Plan target for 4hr A&E wait for the period of 57%. The Chesterfield Royal Hospital (CRH) is achieving 65% while the University Hospitals of Derby and Burton (UHDB) is achieving 68%.
- There has been a slight rise in the amount of time lost due to ambulance handover delays.
- In relation to bed occupancy, both Trusts were achieving a better performance than their local Operational Plan Target with CRH achieving 96.2% and UHDB achieving 93.9% though this is still not in line with the national target of 92%.
- Virtual Ward capacity for may stood at 150, against a target of 155 while utilisation in May was 17% - still facing some data quality issues which we are working through.
- The ICB is achieving an 82% success rate against a target of 70% for the 2hr target for our urgent community response according to local data – published national data is showing a lower achievement due to timing differences.

What are we doing ?

Ambulance:

- Ambulance Urgent and Emergency Care Centre transformation team 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.

Emergency Department (ED) Performance:

- 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
- Both acute focused on ED to SDEC flow, specifically frailty response. Recent visit to SFH SDEC facility to view good practice.
- Both acute sites and ICB reviewing our Type 1 performance/data tracking methods to ensure appropriate benchmarking with other systems.

Virtual Wards (VW);

- Focus on roll out of digital enabler, to support the step down of higher acuity patients.
- VW Summit to onboard patient and clinicians to maximise capacity of existing wards.
- Recruitment continues, with a large number of staff due in post by August.

Urgent Community Response:

- Enhanced community falls response pilots are responding to diverted 999 gateway codes across half of our ICS. Place-led plans on track for full coverage by October 23.

Planned Care & Cancer

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Highlights and Issues:

We continue to see variable performance between the two acute trusts. Both trusts are implementing targeted actions to achieve operational plan commitments.

- Referral to treatment waiting list numbers remain high
- Focus on long waiting patients has resulted in a sustainable reduction over recent months
- In relation to the Cancer 2 Week Wait target, referrals continue to exceed the pre-pandemic levels which is making it impossible to meet the target.
- GI endoscopies, Echos and MRIs still posing significant challenges to meeting the 6-week ambition for diagnostics.

What are we doing ?

Planned Care

- Capacity constraints are impacting on the long wait position at CRH and they are exploring mutual aid solutions
- CRH Theatre team continue to improve utilisation, substantive staff are now in post.
- UHDB has had a paper approved to fund further insourcing and outsourcing opportunities across a range of specialities and to incentivise staff to undertake additional activity out of hours.
- The transfer of appointment slot issues to independent sector providers has commenced this month with work ongoing to try to accelerate this.

Cancer

UHDB referrals have increased by 28% since 2019/20 a range of activities are in place to address this:

- Development of Primary Care Pathways
- Support PCNs with Cancer Directed Enhanced Service implementation.
- Development of cancer content, investment and promotion of Derbyshire Pathfinder Clinical Decision Making tool.
- Improvement of urgent (not suspected cancer) referral pathways including Direct Access Diagnostics.
- System referral optimisation group to develop options to support optimal cancer patient pathways and GP education and engagement plan.

Mental Health

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- **Increasing Access into Community Services**
  - **Children and Young People Community -** Downward trend in 1+ contacts continues. Ongoing issues with CRH data upload, work ongoing to address this. In 23/24 to increase access we have expanded our digital offer from April (Kooth), will have 3 x more Mental Health in School Teams and a focus on addressing CAMHS waiting times
  - **CYP Eating Disorders (Urgent & routine Access)** Within-quarter urgent access performance for Q4 was 100% for both providers whilst routine access was at 100% for DHcFT and 90% for CRHFT. Within-quarter data excludes earlier errors, giving a more accurate snapshot of recent performance compared with the national rolling 12 month performance data which shows Q4 urgent 75% and routine 80.6%. Recruitment to the team is ongoing.
  - **Talking Therapies (IAPT) –** achieved performance requirements in April with regards to access, recovery rates and waiting times. May data is being validated however we anticipate continued compliant performance
  - **Dementia Diagnosis Rate –** Improved performance position for April 66.3% against requirement of 67%. Expect to sustain performance into May. New service being delivered to support late stage diagnosis within care home settings
  - **Perinatal Services -** The team has now demonstrated capacity to offer the required 90 initial assessments as per long term plan across the service per month. A self referrals process has been introduced to address barriers to referral and aid work around health inequalities. Achievement of the target this month is dependent on did not attend rates
  - **Community Mental Health Teams -** achieved performance requirements in April with regards to 2+ contacts. Impact on industrial strike action is continuing to impact on ability to achieve increased access levels

- **Reducing Use of Acute Mental Health (AMH) Inpatient Out of Area Placements**
  - We continue to be non-compliant against the national requirement of eliminating out of area MH placements. This is in part due to the lack of PICU services within Derbyshire however we have also seen sustained pressure in our AMH services and are currently running with occupancy level above 100%. 'Making Room for Dignity' / dormitory eradication program will enable delivery of this standard – completion expected during 24/25

- **Progress in Transformation Areas**
  - **Reduction in health inequalities for people with a SMI –** New services developed with DHcFT to provide outreach support into primary care and utilise digital solutions. Quality and Outcomes Framework incentive for GP practices to complete all 6 checks will have positive impact. Forecast improving performance levels to 70% achievement
  - **Adult Crisis Alternative Provision –** Contracts let for new 4 bed crisis house provision in Chesterfield and new Safe Haven service both will be mobilised in Q2
  - **Mental Health Response Services (inc vehicle)** – Joint street triage service in place with Derbyshire constabulary. Business case in development re MH Urgent response service in line with 'Right Care, Right Person' policy
  - **Dormitory Eradication Program** – Building work progressing well on both new units in Derby and Chesterfield

23/24 Operating Plan Performance Requirement	Performance
CYP Increase in Access	
Talking Therapy Increase in access	
Recover dementia diagnosis rate to 66.7%	
Improve access to perinatal MH services	
Community MH Services increase in access	
Reduction in use of Out of Area Placements	

Learning Disabilities & Autism Services

Derby and Derbyshire Integrated Care Board

- **Reducing Use of Inpatient Care**

  - **Adult –** we have achieved required performance against locally agreed trajectory for all months in Q1, however we are still non-compliant against national standards required.
    - **Non-secure -**. Actual position end Q1 = 28 against trajectory of 35.
    - **Secure -** Actual position end Q1 = 17 against trajectory of 19.

  - **CYP –** We achieved required performance against locally agreed trajectory for April however was non compliant in May and finished Q1/end June with a actual performance of 4 CYP in receipt of inpatient care, 2 below trajectory. However, we are still non-compliant against national standard.

  A recovery action plan has been developed and is being closely monitored. Monthly meetings established with NHS E Midlands colleagues providing sight of improvement actions and impact. Performance forecast predicts delivery of local agreed trajectory at end of year for adults and CYP.

- **Reduction in Health Inequalities for people with Learning Difficulties (LD)**

  - **LD Annual Health Checks –** local trajectory agreed between Primary Care and DHcFT which will support achievement of national standard 75%. Action plan in place identifying GP practices where historical performance <75% and additional support is suggested. April performance is showing lower than anticipated however AHC's are usually scheduled around individuals birthdays and historical local performance peaks at Q4.

  - **Learning from Deaths Program –** the LeDeR program continues to perform well against the national standards exceeding both Midlands and England average performance for the last 6 months.

23/24 Operating Plan Performance Requirement		Performance
TCP reduction of people in inpatient care	Number of adults in ICB commissioned beds	
	Number of adults in Secure inpatient care	
	Number of CYP In Specialised/secure inpatient care	
Reducing LD Health Inequalities	Number of annual health checks	

Primary Care

Derby and Derbyshire Integrated Care Board

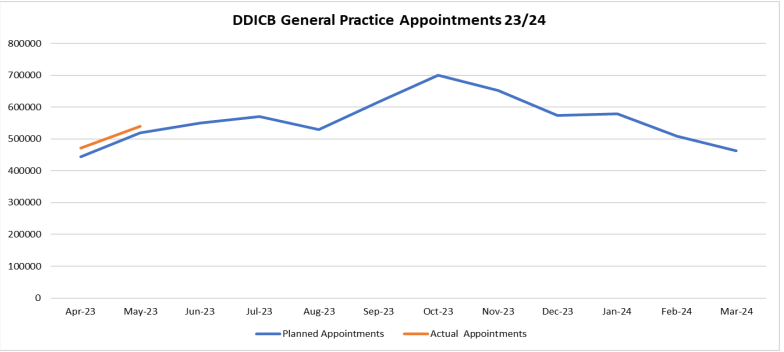
How are we doing?

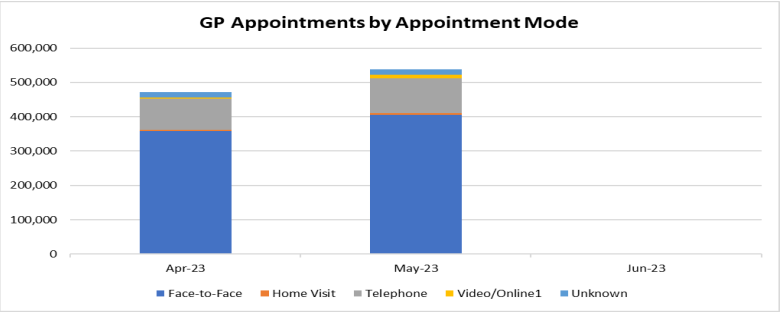
GP Appointments

- In May there were 538,841 GP appointments. This is 19,000 above the planned level.
- 75.26 of the appointments held were face to face.
- 47,985 (8.9%) of the appointments in May are recorded as did not attend or unknown.
- 39.8% of patients were seen on the same day that the GP was contacted.

Community Pharmacy Consultation Service (CPCS)

- A quarterly target is set for the CPCS service. The target for quarter 1 is 8,615. The provisional number for April is 2,274
  (428 referrals from GP / 1,846 from NHS 111)

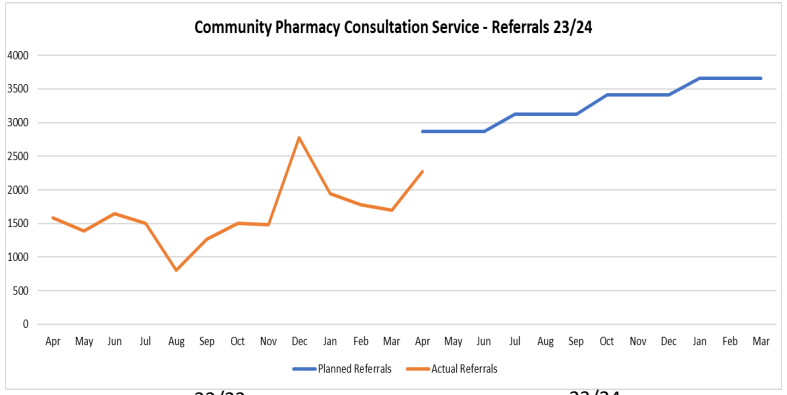




Areas of Focus:

- GP Appointments – General practice appointments data only captures appointments data that is recorded in General Practice clinical systems. Some ARRS activity would not be recorded in the GP systems and similarly Team Up data.

- CPCS – lack of engagement if practice has referred and referral bounces back they are reluctant to use again.
- CPCS referral system described as 'clunky' so kick back due to time it takes to refer (apparently) it's easier for the practice to verbally signpost to pharmacy. There is also an issue with the number of community pharmacy services now available.



What are we doing?

- Working with the regional team to allow extraction from PCN systems.
- Working with Team Up to ensure community module is able to allow extraction
- CPCS – PCNs have included in the Capacity & Access Plans that by the end of March24 CPCS will be live in all practices with increasing referrals being made.

Sources

Derby and Derbyshire Integrated Care Board

1. A&E 4hours: NHS England Statistics at https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
   Ambulance Response: NHS England Statistics at https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/
   Ambulance Handover: EMAS Iris Performance System at https://commissioners.emas.nhs.uk/Pages/home.aspx
   Community Response: Analytics Team at Derbyshire Community Health Services NHS Foundation Trust
   RTT: NHS England Statistics at https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
   Diagnostics: NHS England Statistics at https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity
   Cancer: NHS Cancer Waiting Times at https://nwwcancerwaitingtimes.sdcs.digital.nhs.uk/
2. Incompletes >18wks: RTT Performance Dashboard within the Analytics Hub at https://apps.model.nhs.uk/analyticshub
3. Diagnostics: NHS England Statistics at https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity
4. Cancer 62 days: NHS Cancer Waiting Times at https://nwwcancerwaitingtimes.sdcs.digital.nhs.uk/
5. Mental Health: Urgent and Emergency Mental Health Dashboard - Mental Health, LD&A Resource Hub - FutureNHS Collaboration Platform
6. Mental Health: Urgent and Emergency Mental Health Dashboard - Mental Health, LD&A Resource Hub - FutureNHS Collaboration Platform
7. GP Appointments: Appointments in General Practice - NHS Digital
8. CPCS: https://future.nhs.uk/connect.ti/PharmacyIntegration/view?objectId=38360112

Part A - National and Local Requirements

ICB Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire ICB: Current Month	NHS Derby & Derbyshire ICB: YTD	NHS Derby & Derbyshire ICB: consecutive months non-compliance	Chesterfield Royal Hospital FT: Current Month	Chesterfield Royal Hospital FT: YTD	Chesterfield Royal Hospital FT: consecutive months non-compliance	University Hospitals of Derby & Burton FT: Current Month	University Hospitals of Derby & Burton FT: YTD	University Hospitals of Derby & Burton FT: consecutive months non-compliance	NHS England: Current Month	NHS England: YTD	NHS England: consecutive months non-compliance
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	May-23	↓	74.2%	74.0%	49	77.2%	78.1%	92	73.2%	72.5%	21	76.3%	76.5%	92
		A&E 12 Hour Trolley Waits	0	May-23					103	257	34	573	706	14	31,494	58,393	34

EMAS Dashboard for Ambulance Performance Indicators

	Area	Indicator Name	Standard	Latest Period	Direction of Travel	East Midlands Ambulance Service Performance (NHSD&DICB only - National Performance Measure): Current Month	YTD	consecutive months non-compliance	EMAS Performance (Whole Organisation): Current Month	YTD	consecutive months non-compliance	EMAS Completed Quarterly Performance 2023/24: Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	NHS England: Current Month	YTD	consecutive months non-compliance
Urgent Care	Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	May-23	↓	00:08:23	00:08:20	35	00:08:24	00:08:27	34					00:08:17	00:08:12	25
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	May-23	↓	00:14:49	00:14:40	0	00:15:11	00:15:18	23					00:14:45	00:14:36	0
		Ambulance - Category 2 - Average Response Time	00:18:00	May-23	↓	00:35:35	00:33:22	34	00:34:23	00:34:00	35					00:32:24	00:30:30	34
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	May-23	↓	01:16:23	01:11:07	34	01:15:02	01:13:56	34					01:09:45	01:05:09	26
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	May-23	↓	05:18:18	04:53:39	34	05:18:02	05:02:06	34					04:12:34	03:52:45	26
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	May-23	→	03:58:36	04:09:27	26	04:30:03	04:31:06	26					05:35:15	05:00:05	26

111 Indicators

Area	Indicator Name	Standard	Latest Period	Direction of Travel	DHU Performance: Current Month
111 Key Indicators	Abandonment Rate	5%	Apr-23	↑	3.9%
	Average Speed of Answer	00:00:27	Apr-23	↑	00:01:19

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 ↓

Key:	
	Performance Meeting Target
	Performance Not Meeting Target
	Indicator not applicable to organisation

Performance Improved From Previous Period	↑
Performance Maintained From Previous Period	→
Performance Deteriorated From Previous Period	↓

Part A - National and Local Requirements

ICB Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire ICB Current Month	NHS Derby & Derbyshire ICB YTD	NHS Derby & Derbyshire ICB consecutive months non-compliance	Chesterfield Royal Hospital FT Current Month	Chesterfield Royal Hospital FT YTD	Chesterfield Royal Hospital FT consecutive months non-compliance	University Hospitals of Derby & Burton FT Current Month	University Hospitals of Derby & Burton FT YTD	University Hospitals of Derby & Burton FT consecutive months non-compliance	NHS England Current Month	NHS England YTD	NHS England consecutive months non-compliance
Planned Care	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Apr-23	↓	56.0%	56.0%	63	59.4%	59.4%	48	53.0%	53.0%	64	58.3%	58.3%	86
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Apr-23	↓	6,984	6,984	39	1,211	1,211	37	6,218	6,218	38	371,111	371,111	192
		Number of 78 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Apr-23	↓	195	195	25	16	16	25	144	144	25	11,477	11,477	25
		Number of 104 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Apr-23	↔	3	3	25	0	0	0	0	0	0	523	523	25
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Apr-23	↑	30.39%	30.39%	59	21.69%	21.69%	37	33.96%	33.96%	38	27.56%	27.56%	116
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Apr-23	↓	74.3%	74.3%	32	76.6%	76.6%	5	67.7%	67.7%	32	77.7%	77.7%	35
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Apr-23	↓	74.3%	74.3%	11	44.4%	44.4%	8	89.6%	89.6%	1	72.2%	72.2%	35
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Apr-23	↓	69.5%	69.5%	2	77.0%	77.0%	0	66.9%	66.9%	21	71.3%	71.3%	2
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Apr-23	↓	86.3%	86.3%	28	91.6%	91.6%	20	85.6%	85.6%	33	90.5%	90.5%	28
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Apr-23	↓	69.0%	69.0%	41	100.0%	100.0%	0	76.9%	76.9%	23	76.8%	76.8%	57
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Apr-23	↓	93.6%	93.6%	5	100.0%	100.0%	0	96.0%	96.0%	5	97.4%	97.4%	1
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Apr-23	↓	79.8%	79.8%	13				73.4%	73.4%	13	86.3%	86.3%	14
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Apr-23	↓	56.5%	56.5%	50	64.1%	64.1%	45	51.0%	51.0%	60	61.0%	61.0%	88
		First Treatment Administered - 104+ Day Waits	0	Apr-23	↓	36	36	85	6	6	60	32	32	85	1,575	1,575	88
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Apr-23	↑	65.0%	65.0%	48	80.8%	80.8%	48	50.0%	50.0%	29	67.8%	67.8%	61
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Apr-23	↓	81.1%	81.1%		100.0%	100.0%		81.8%	81.8%		74.4%	74.4%	
	Cancelled Operations	% Of Cancelled Operations Rebooked Over 28 Days	N/A	2022/23 Q4	↓				42.1%	39.8%		36.2%	19.5%		25.4%	23.4%	

Workforce

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

Workforce Summary: Month 2 (including EMAS)

NHS
Derby and Derbyshire
Integrated Care Board

Tables 1a and 1b: 2023/24 Workforce Plan Position Month 2

- The total workforce was 459.47 WTE below plan at M2; this is across all areas (substantive, bank and agency)
- Compared to M1, there was an improvement in recruitment to substantive positions (increase of 41.70wte) and a reduction in agency usage (-87.52wte).
- Note, the changes to PWR alignment to the workforce plan have resulted in some anomalies which are being resolved.

Table 2: 2023/24 Month 2: Workforce actual position (WTE) comparison to funded establishment (WTE)

- As a system work is underway to improve workforce and finance alignment. Table 2 aims to demonstrate the pay costs associated with the M2 plan staff in post actuals (note this is with the caveat that there is some misalignment between ESR and finance ledger systems and actions are being taken to resolve this).
- From this analysis, the M2 position demonstrates:
  - With the exception of CRH, all organisations are under their respective funded establishment, yet the pay bill for staff cost is overspent by £9.7m, and for agency cost is overspent by £2.2m.
  - However, the overall system position against the staff in post plan (as set out above) is below plan and the increase in pay costs is assumed to be as a result of the recent industrial action. Further analysis is being undertaken to quantify this assumption. In addition, the position is not fully understood due to Afc uplift not being in the plan and there are different approaches to efficiency phasing.

Table 1: 2023/24 Workforce Plan Position Month 2

Derby and Derbyshire Integrated Care Board

ICB Total	Reporting Period: May 2023					
	Month 2			Trend		
	Plan	Actual	Variance from plan	Previous month	Changes in actual vs previous month	Trend (Actual) previous 12 months
Workforce						
Total Workforce (WTE)	28,642.22	28,182.74	459.47	28,696.27	↓	
Substantive (WTE)	27,149.97	26,758.45	391.52	27,014.44	↓	
Bank (WTE)	1,207.78	1,162.53	45.25	1,343.58	↓	
Agency (WTE)	284.47	261.76	22.71	338.25	↓	
Cost						
Pay Cost (£'000)	122,655	128,848	-6,193	123,212	↑	

* Planned pay cost do not include the agreed AfC pay uplift.

Table 1b: 2023/24 Workforce Plan Position Month 2 - Provider Breakdown

NHS
Derby and Derbyshire
Integrated Care Board

		Plan	Actual	Variance from plan
CRH	Workforce (WTE)			
	Total Workforce	4,679.59	4,821.89	-142.30
	Substantive	4,265.13	4,421.91	-156.78
	Bank	295.20	295.45	-0.25
	Agency	119.26	104.53	14.73
	Cost (£)			
	Pay Cost (£'000)	£19,854	£21,198	-£1,344
DCHS	Workforce (WTE)			
	Total Workforce	3,799.47	3,786.41	13.06
	Substantive	3,682.25	3,701.42	-19.17
	Bank	92.61	81.06	11.55
	Agency	24.61	3.93	20.68
	Cost (£)			
	Pay Cost (£'000)	£13,018	£13,959	-£941
DHcFT	Workforce (WTE)			
	Total Workforce	3,048.63	3,013.29	35.34
	Substantive	2,828.77	2,781.51	47.26
	Bank	166.05	172.75	-6.70
	Agency	53.81	59.03	-5.22
	Cost (£)			
	Pay Cost (£'000)	£12,290	£13,134	-£844
EMAS	Workforce (WTE)			
	Total Workforce	4,051.72	3,842.91	208.81
	Substantive	3,987.06	3,781.12	205.94
	Bank	44.66	46.45	-1.79
	Agency	20.00	15.34	4.66
	Cost (£)			
	Pay Cost (£'000)	£17,367	£16,890	£477
UHDB	Workforce (WTE)			
	Total Workforce	13,058.12	12,718.24	339.89
	Substantive	12,382.07	12,072.49	309.58
	Bank	609.26	566.82	42.44
	Agency	66.79	78.93	-12.14
	Cost (£)			
	Pay Cost (£'000)	£60,126	£63,667	-£3,541

Table 2: 2023/24 Month 2 - Workforce actual position (WTE) comparison to funded establishment (WTE)

NHS
Derby and Derbyshire
Integrated Care Board

	M2 Pay Budget *	M2 Pay Actual	M2 Pay Variance	YTD Pay Budget *	YTD Pay Actual	YTD Pay Variance **	M2 Funded Establishment (as per Finance)	Staff in Post (Substantive) M2 Actual	Variance	Vacancy Rate	Bank M2 Actual	Agency M2 Actual	Net Staffing (Substantive, Bank & Agency Total) M2 Actual	Establishment V Actual Variance
	£'000	£'000	£'000	£'000	£'000	£'000	WTE	WTE	WTE	%	WTE	WTE	WTE	WTE
ICB Total	122,655	128,848	- 6,193	244,305	254,019	- 9,714	28,398	26,758	1,639	5.8%	1,163	262	28,183	215
CRH	19,854	21,198	- 1,344	39,527	41,785	- 2,258	4,680	4,422	258	5.5%	295	105	4,822	- 142
DCHS	13,018	13,959	- 941	26,013	27,644	- 1,631	3,818	3,701	117	3.1%	81	4	3,786	32
DHcFT	12,290	13,134	- 844	24,552	26,268	- 1,716	3,040	2,782	258	8.5%	173	59	3,013	27
EMAS	17,367	16,890	477	33,806	32,668	1,138	3,981	3,781	200	5.0%	46	15	3,843	138
UHDB	60,126	63,667	- 3,541	120,407	125,654	- 5,247	12,879	12,072	807	6.3%	567	79	12,718	161

Notes:
*** The planned pay costs do not included the agreed AfC pay uplift**
**** The Pay figures below include the impact of YTD efficiencies where this is planned**

Finance

Keith Griffiths, Executive Director of Finance
Jill Dentith, Non-Executive Member

Month 2 System Finance Summary – Financial Position

NHS Derby and Derbyshire Integrated Care Board

- YTD position at Month 2 (M2) is a £11.6m deficit against a £7.5m deficit plan
- Current operational challenges driving the YTD overspend are predominantly:-
- Extra staff payments to cover Junior Doctor Strikes (current estimate £3m YTD)
- Cost of living increases (current estimate £24m for 2023/24)
- The system also has a pressure as a result of the pay award (current estimate £9.88m split £5.95m 22/23 & £3.93m 23/24)
- 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 02 Position	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	Full Year Plan £m's	Full Year Forecast £m's	Forecast Variance £m's
NHS Derby and Derbyshire ICB	0.0	1.2	**1.2**	0.0	0.0	**0.0**
Chesterfield Royal Hospital	(0.8)	(1.6)	**(0.8)**	0.0	0.0	**0.0**
Derbyshire Community Health Services	0.2	(0.5)	**(0.7)**	0.0	0.0	**0.0**
Derbyshire Healthcare	0.5	(0.0)	**(0.5)**	0.0	(0.0)	**0.0**
EMAS	0.0	0.1	**0.1**	0.0	0.0	**0.0**
University Hospital of Derby and Burton	(7.3)	(10.8)	**(3.5)**	0.0	0.0	**0.0**
JUCD Total	**(7.5)**	**(11.6)**	**(4.1)**	**0.0**	**(0.0)**	**0.0**

Month 2 System Finance Summary – Risk

Derby and Derbyshire Integrated Care Board

- Risks are driving a likely and worst case forecast in the system
- The unmitigated most likely outturn position described in the table only identifies the risks that are materialising that could not have been envisaged when the Operational Plan was submitted
  - The industrial action taken in April has cost UHDB £1.7m with outpatient appointments and elective/day case procedures lost
  - Excess Inflation mainly because of contracts through the PFI and other commissioned contracts (mainly S117) are higher than the 2.8% included in the planning guidance
  - The calculation of the pay award excludes staff not directly employed by the NHS including those who pay the Agenda for Change terms, this effects UHDB PFI, CRH subsidiary and DHU seen as a non-NHS Provider
- The worst case includes risks on delivery on the financial plan including efficiency, capacity pressures and reduction of income

Month 02 Position	2023/24 Organisations Forecast		
Organisation	Best Case £m's	Likely Case £m's	Worst Case £m's
NHS Derby and Derbyshire ICB	0.0	(6.8)	(20.8)
Chesterfield Royal Hospital	0.0	0.0	(7.1)
Derbyshire Community Health Services	0.0	(2.3)	(5.0)
Derbyshire Healthcare	0.0	(1.7)	(4.2)
East Midlands Ambulance Service	0.0	0.0	(4.0)
University Hospitals of Derby And Burton	0.0	0.0	(49.3)
JUCD Total Surplus/(Deficit)	0.0	(10.8)	(90.4)

Month 2 System Finance Summary – Efficiencies

NHS Derby and Derbyshire Integrated Care Board

- Delivering cash releasing efficiencies across the system is critical to delivering the plan and moving the system to a financially sustainable position
- The plan is to deliver over 4% in cash releasing efficiency in 23/24 across the system, split into recurrent £94.3m and non recurrent of £42.5m
- JUCD have delivered £13.2m of efficiencies YTD, £1.4m under plan partially due to DCHS's flat phasing of delivery, the delivery is split into recurrent of £7.8m and non recurrent of £5.4m
- Forecast is to deliver slightly more than plan at £136.8m efficiencies
- There are still £48.2m of plans yet to be developed further than identifying the area they should be delivered
- In month three and four the expected rise in delivery in is £1.4m per month placing additional emphasis of the need to develop plans at pace
- System plans are being recorded on ePMO, a comprehensive system which will allow in-depth assessment of schemes
  - Allowing the individuals who can drive transformation a platform to initiate and follow through ideas to delivery
  - A single system version of the truth

Efficiencies by Provider Month 02 Position	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	Full Year Plan £m's	Full Year Forecast £m's	Forecast Variance £m's
NHS Derby and Derbyshire ICB	5.4	5.6	0.2	44.2	45.0	0.8
Chesterfield Royal Hospital	2.0	1.0	(1.0)	15.7	15.7	**0.0**
Derbyshire Community Health Services	1.5	1.0	(0.6)	9.2	9.2	**0.0**
Derbyshire Healthcare	1.5	0.9	(0.6)	8.8	8.8	**0.0**
EMAS	1.9	2.3	**0.5**	11.2	11.2	**0.0**
University Hospital of Derby and Burton	2.4	2.4	**0.0**	47.0	47.0	**0.0**
JUCD Total	**14.6**	**13.2**	(1.4)	**136.0**	**136.8**	**0.8**

Month 2 System Finance Summary – Capital

Derby and Derbyshire Integrated Care Board

- The system has a total capital allocation for 2023/24 of £158.1m, made up of;
- £52.5m BAU, including a 5% overplanning allowance, and an anticipated allocation from NHSE of £5.6m for the fair shares prior year revenue performance
- £101.6m of National capital allowance
- Month 2 Regional funded capital is on plan with a few variances between organisations, EMAS having incurred costs ahead of plan on the DCA vehicles. The forecast continues to be breakeven
- The national allocations are underspending year to date by £4.2m due to the delay in EMAS' PTS vehicles and UHDB projects relating to Community Diagnostic Centres and the Kings Treatment Centre

	Regional Funded Capital by Provider						National Funded Capital by Provider					
	YTD plan £'m	YTD Actual £'m	Variance £'m	Full year plan £'m	Full year forecast £'m	Variance £'m	YTD plan £'m	YTD Actual £'m	Variance £'m	Full year plan £'m	Full year forecast £'m	Variance £'m
Chesterfield Royal Hospital	1.5	1.2	0.3	8.1	8.1	0.0	0.0	0.3	(0.3)	1.7	1.7	0.0
Derbyshire Community Health Services	0.7	0.5	0.2	5.3	5.3	0.0	0.1	0.0	0.1	5.0	5.0	0.0
Derbyshire Healthcare	3.3	3.2	0.1	19.5	19.5	0.0	8.1	7.3	0.8	48.8	48.8	0.0
EMAS	0.0	0.7	(0.7)	8.9	8.9	(0.0)	2.4	0.2	2.3	6.0	6.0	0.0
University Hospital of Derby and Burton	1.0	0.8	0.2	14.7	14.7	0.0	1.3	0.0	1.3	40.1	40.1	0.0
JUCD Total	**6.4**	**6.4**	**0.0**	**56.5**	**56.5**	**0.0**	**12.0**	**7.7**	**4.2**	**101.6**	**101.6**	**0.0**

Month 2 System Finance Summary – Cash

Derby and Derbyshire Integrated Care Board

- Chesterfield Royal Hospital have submitted a cash request of £5.4m to NHSE to cover them for the next 3 months
- This is a mixture of revenue and capital, with the revenue being classed at PDC and attracting an unplanned 3.5% dividend charge
- The reduction in the cash balance at Derbyshire Healthcare from the 1st April relates to the payment of several large value capital invoices
- Cash releasing efficiencies must be identified and start to deliver early in 2023/24

Provider Cash Month 02 Position	Opening Balance 01/04/2023 £m's	Cash Balance 31/05/2023 £m's	Plan year ending 31/03/2024 £m's
Chesterfield Royal Hospital	20.2	20.5	19.9
Derbyshire Community Health Services	37.3	35.2	34.1
Derbyshire Healthcare	53.9	35.1	23.7
EMAS	18.2	19.4	13.7
University Hospital of Derby and Burton	48.4	39.2	35.6
JUCD Total	178.0	149.4	127.0

JUCD System Finance Report to 31st May 2023 (M02)

1. Introduction

This report details the JUCD System Financial Position as at 31st May 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

Pressures continue into the second month of the financial year, the year to date overspend includes pressures from industrial action, capacity issues, efficiency slippage and high cost patients. However JUCD is committed to ensuring the system delivers a breakeven position by the 31st March 2024.

The first draft activity data indicates that Derbyshire system providers are performing below the 103% of 2019/20 elective activity level target, however this is being offset by overperformance in the other NHS trusts we contract with. As the funding arrangements for the ERF allocation has not yet been agreed, the guidance at month 2 was to ensure the ERF position did not favourably or adversely affect the systems forecast position and until final guidance and more robust activity data is received it is difficult to determine the impact.

Table 2.1 JUCD I&E Position Summary as at 31st May 2023

I&E Position by Provider Type Month 2 Position	Month 2 Planned Variance £m's	Month 2 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	(0.8)	(1.6)	(0.8)	0.0	0.0	0.0
Derbyshire Community Health Services	0.2	(0.5)	(0.7)	0.0	0.0	0.0
Derbyshire Healthcare	0.5	(0.0)	(0.5)	0.0	0.0	0.0
EMAS	0.0	0.1	0.1	0.0	(0.0)	0.0
University Hospital of Derby and Burton	(7.3)	(10.8)	(3.5)	0.0	0.0	0.0
Other NHS Acute	0.0	(0.0)	0.0	0.0	(0.0)	(0.0)
Other NHS Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
Other NHS Community Services	0.0	(0.1)	(0.1)	0.0	(0.0)	(0.0)
Acute Independent Sector	0.0	0.1	0.1	0.0	0.1	0.1
Mental Health Independent Sector	0.0	(0.7)	(0.7)	0.0	(1.5)	(1.5)
Community Services Non NHS	0.0	(0.1)	(0.1)	0.0	0.0	0.0
Continuing Health Care	0.0	1.5	1.5	0.0	0.0	0.0
Primary Care Prescribing	0.0	0.0	0.0	0.0	(0.0)	(0.0)
GP Co-Commissioning	0.0	(0.2)	(0.2)	0.0	(1.2)	(1.2)
Other GP Primary Care	0.0	0.1	0.1	0.0	(0.2)	(0.2)
Pharmacy	0.0	0.0	0.0	0.0	0.0	0.0
Optometry	0.0	0.0	0.0	0.0	0.0	0.0
Dental	0.0	0.0	0.0	0.0	0.0	0.0
Other Programmed Services	0.0	(0.0)	(0.0)	0.0	0.1	0.1
ICB Running Costs	0.0	0.3	0.3	0.0	1.7	1.7
ICB Operational Costs Other Programme	0.0	0.2	0.2	0.0	1.0	1.0
Grand Total	**(7.5)**	**(11.6)**	**(4.1)**	**0.0**	**0.0**	**0.0**

Capital

The system has received £52.5m of capital from the Regional team and £101.6m from the National team to date for the financial year, there is also an anticipated £5.6m in relation to achieving a breakeven capital position at year end 2022/23. The JUCD plan includes a tolerance to ensure all capital is spent and currently that is being assumed to be part of the £5.6m. Further details on the Capital plan are set out below.

Cash

The JUCD organisations cashflow forecasts for the year reflect the planned delivery of cash releasing efficiencies. However, if these do not materialise it will significantly impact on in-year cashflow and we have already had one of the JUCD Providers request cash support from NHSE/DoHSC.

3. Income and Expenditure Performance

As at 31st May 2023, the year to date system position is a £11.6m deficit against a £7.5m planned deficit, including pressures from industrial action, capacity issues, efficiency slippage and high cost patients.

Demonstrating the emerging risks, the table below gives the range of forecasts for the system outturn positions, if these risks materialise each organisation will be responsible for finding covering mitigations.

The likely case reflects the cost pressures outside of our plan, which were unforeseen at the time of planning, this includes pay award pressures, excess inflation and the costs relating to industrial action. The worst case includes risks on delivery of the financial plan including achievement of efficiency, capacity pressures and reduction in income. There is still work ongoing to ensure a consistent approach from all organisations.

Table 3.1 *JUCD I&E position best, most likely and worst case forecast position.*

Month 02 Position	2023/24 Organisations Forecast		
Organisation	Best Case £m's	Likely Case £m's	Worst Case £m's
NHS Derby and Derbyshire ICB	0.0	(6.8)	(20.8)
Chesterfield Royal Hospital	0.0	0.0	(7.1)
Derbyshire Community Health Services	0.0	(2.3)	(5.0)
Derbyshire Healthcare	0.0	(1.7)	(4.2)
East Midlands Ambulance Service	0.0	0.0	(4.0)
University Hospitals of Derby And Burton	0.0	0.0	(49.3)
JUCD Total Surplus/(Deficit)	**0.0**	**(10.8)**	**(90.4)**

Risks

As all JUCD organisations remain committed to delivering a breakeven position, the unmitigated most likely outturn position described in table 3.1 only identifies the risks that are materialising that could not have been envisaged when the Operational Plan was submitted on 4th May 2023.

Table 3.2 *System Identified Risks*

Month 02 Position Area of Risk	2023/24 Risks £m's
Efficiency delivery	(30.9)
UHDB Baseline and non-recurrent Income	(16.4)
Excess inflation	(16.3)
UHDB Quality and Safety	(5.0)
Better Care Funding for Local Authority	(5.0)
EMAS Income Risk	(4.3)
UHDB Industrial Action	(3.4)
Capacity Pressures	(3.2)
Pay award	(2.2)
UHDB Increasing pathway to 103/107%	(2.3)
UHDB Cost of cash support	(1.8)
Drugs costs	(1.0)
Other	(1.6)
	(93.4)

The risks identified in this table 3.2 also include the risks associated with the delivery of the efficiency plans and other risks within the plan. A consistent approach to assessing risk has been agreed across all organisations, with risks being rated on the standard 5 x 5 matrix.

The total value of the risk is then subject to a risk confidence level based on the rating above to give a final value, where:

5x5 Risk Matrix

Impact						
	5	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	2	3	4	5
	Probability					

Red	=	100%
Amber	=	75%
Yellow	=	50%
Green	=	25%

In the submitted plan much of the mitigations to these risks were described as either unidentified or as additional efficiency, which are at this time remain unidentified. As risks continue to materialise, possible mitigations need to be identified and in many instances these mitigations can only be described as additional efficiencies. Assurance cannot be provided that these mitigations will be found as the level of identified efficiencies is already behind where it needs to be to deliver the level recognised in the submitted plan.

The risk associated with the delivery of efficiency plans is significant and covered in detail in the Efficiencies section of this report. The other significant risks are described in detail below:

Industrial Action

The continued industrial action being taken across the NHS workforce is a key risk for the system that is outside of the plan submitted on the 4th May 2023. This is having an impact across all different aspects of NHS services and is created financial pressures across the system that, at this stage, cannot be mitigated, this is reflected in table 3.1 above.

For UHDB, the action taken in April has cost £1.7m (almost half of the £3.5m they are off plan at M2) with just over 12,000 outpatient appointments and 1,100 elective/day case procedures lost. To recover this lost activity, its estimated that this could cost another £2.5m. At the time of writing the report, that information from CRH hasn't been received.

Whilst the impact that this is having on the ERF performance is still being worked through at a national, regional and local level, this will compound the risk. Work is ongoing and a more detailed assessment of ERF will be provided at month 3 (Q1).

Excess Inflation

Another key risk that the system is subject to is inflationary pressures over and above those funded and therefore planned. At the time of planning, the system had £45m of excess inflation pressures, split £22m in the plan and a further £23m in risks.

At month 2, the system is already seeing some of those risks coming through which is driving a variance to plan of £2m, £1.1m of which is at UHDB. This mainly because of contracts through the PFI and other commissioned contracts (mainly S117) are higher than the 2.8% included in the planning guidance

This will continue to be tracked over the coming months and work is underway to forecast what the pressure might look like at 31st March 2024 and this forecast will be included in the month 3 report.

Pay Award

The 2023/24 pay award, for all staff directly employed on the NHS Terms & Conditions of service, included 2 parts.

2022/23 - Two one off non-consolidated awards on top of the 2022/23 pay award.

2023/24 - The award is worth a 5% increase in basic pay for all pay points, with the lowest paid staff seeing their pay brought up to the top of band 2.

As with previous years, the system has been given funding for these payments, however, due to the national methodology used to calculate the impact and funding provided, this is short of the estimated cost impact of the pay uplift. This is mainly because it excludes:

- UHDB PFI – There are approximately 700 whole time equivalents (WTE) who are not on their payroll but fall under the services received on the PFI
- CRH Subsidiary - Staff employed by the subsidiary. There is approximately 1,200 WTEs working directly for DSFS
- DHU – Although these can be seen as a 'non-NHS provider' and therefore outside the scope of the pay award, this payment is not seen as optional for recruitment, retention and parity purposes

The estimated impact of this and therefore risk to the systems financial position is £9.88m, split £5.95m for the 2022/23 element and £3.93m for the 2023/24 element. This has been raised with the National team. It should be noted that these are current estimates, and we are working to provide a final figure by month three reporting. It should also be noted that this includes the ICB increasing contracts with non-NHS providers and a decision is needed as to whether to go ahead with this or not, noting the operational, quality and patient safety risks this might create. The financial risk of this is not included in table 3.2. A list of these are:

Table 3.3 *Pay award costs on Non NHS Commissioned Services*

ICB - Other commissioned services	2022/23 estimate £'m	2023/24 estimate £'m
DHU	(3.2)	(1.9)
CSUs	0.0	(0.3)
Hospices	0.0	(0.1)
Other Community Non NHS	0.0	(0.9)
Other Mental Health Non NHS	0.0	(1.6)
Total	**(3.2)**	**(4.8)**

Primary Care

Since the risk position has been reported it has become increasing likely that the ICB will need to step in and support some failing General Practices as they continue to manage the developing workload and financial pressures. The ICB has a legal responsibility to ensure continuity of care for the patients registered with any of the GPs on Derbyshire. This would involve either the ICB to directly manage the practice for a short interim period or find an interim provider at short notice, both of which have come at considerable additional cost when this has happened in the past. An estimate for a 6 month interim provider could be an additional cost of £1m. The GP Provider Board should be asked for a view on what they can do by way of support to this Practice and any other Practice that is having difficulty maintaining services for their registered patient list.

Efficiencies

Delivery of efficiencies is crucial to JUCD being able to deliver a balanced financial position on 31st March 2024. £136.1m of efficiencies is required to deliver the breakeven forecast but it

should be noted that if any cost pressures and risks emerge during the year, this value will need to increase to compensate.

The below table tracks the development of these plans from the planning stage to the current position

Table 3.4 *System Efficiency Plan Development*

Month 02 Position	Fully Developed £m's	Plans in Progress £m's	Opportunity £m's	Unidentified £m's	Total £m's
ICB - Plan	17.7	14.1	12.4	0.0	44.2
ICB - at Month 2	24.5	8.1	12.4	0.0	45.0
ICB - Movement	6.8	(6.0)	0.0	0.0	0.8
CRH - Plan	5.4	3.0	7.3	0.0	15.7
CRH - at Month 2	4.1	3.0	8.4	0.2	15.7
CRH - Movement	(1.3)	(0.0)	1.1	0.2	0.0
DCHS - Plan	1.5	2.6	2.8	2.3	9.2
DCHS - at Month 2	1.5	2.6	2.8	2.3	9.2
DCHS - Movement	0.0	0.0	0.0	0.0	0.0
DHcFT - Plan	2.5	6.2	0.0	0.0	8.8
DHcFT - at Month 2	6.1	2.7	0.0	0.0	8.8
DHcFT - Movement	3.6	(3.6)	0.0	0.0	(0.0)
EMAS - Plan	6.5	4.6	0.0	0.0	11.2
EMAS - at Month 2	6.5	4.6	0.0	0.0	11.2
EMAS - Movement	0.0	0.0	0.0	0.0	0.0
UHDB - Plan	7.7	11.3	20.6	7.4	47.0
UHDB - at Month 2	10.0	14.8	14.7	7.4	47.0
UHDB - Movement	2.3	3.5	(5.8)	0.0	0.0
Total - Plan	41.4	41.9	43.0	9.7	136.0
Total - at Month 2	52.8	35.8	38.3	9.9	136.8
Total - Movement	**11.4**	**(6.1)**	**(4.7)**	**0.2**	**0.8**

The above shows that progress has been made from the time of submitting the plan as the system has a higher value of plans fully developed but it should also be noted that there are still £48.2m of plans yet to move further than an opportunity, an opportunity being described as we have identified an area to make the saving but have no plans developed. This will be tracked over the next few months to provide assurance around the deliverability of the efficiency target.

The table below sets out the month two efficiencies by organisation and the actual delivery against those plans. The year to date has already fallen behind plan partially due to DCHS's flat phasing of delivery, however, it is also necessary to point out the expected rise in delivery in month three and four is an increase of £1.4m per month placing additional emphasis of the need to develop plans at pace.

Table 3.5 *System Efficiency Delivery*

Efficiencies by Provider Month 02 Position	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	Full Year Plan £m's	Full Year Forecast £m's	Forecast Variance £m's
NHS Derby and Derbyshire ICB	5.4	5.6	0.2	44.2	45.0	0.8
Chesterfield Royal Hospital	2.0	1.0	(1.0)	15.7	15.7	0.0
Derbyshire Community Health Services	1.5	1.0	(0.6)	9.2	9.2	0.0
Derbyshire Healthcare	1.5	0.9	(0.6)	8.8	8.8	0.0
EMAS	1.9	2.3	0.5	11.2	11.2	0.0
University Hospital of Derby and Burton	2.4	2.4	0.0	47.0	47.0	0.0
JUCD Total	14.6	13.2	(1.4)	136.0	136.8	0.8

The ePMO system will become the single point for efficiency reporting from month three onwards. Whilst recognising some of the issues and delays on getting efficiency schemes onto the system, there is a commitment to ensure that this will be done. There is a process being developed to produce reports that tracks delivery against the plan and the development of those plans with set cut off dates for the monthly reporting process established. It is fundamental to support the delivery of efficiencies, and by implication a breakeven 2023/24 position, that the ePMO system is up to date and a monthly update completed in a timely manner.

The table below shows the value of the schemes currently in ePMO (as at 16th June 2023) by Organisation

Table 3.6 *Efficiencies in ePMO*

Activity Type (Fin Year 2023-24) 16th June	Target Value Totals £'m	12 Months Plan Value Totals £'m	12 Months Forecast Value Totals £'m	Actuals Value Current Totals £'m
NHS Derby and Derbyshire ICB	44.2	19.6	19.4	4.2
Chesterfield Royal Hospital	15.7	4.4	3.7	0.8
Derbyshire Community Health Services	9.2	2.4	2.9	0.7
Derbyshire Healthcare	8.8	5.8	5.7	0.9
East Midlands Ambulance Service	11.2	11.2	11.2	2.3
University Hospitals of Derby And Burton	47.0	0.0	6.4	2.1
JUCD Totals	**136.0**	**43.3**	**49.2**	**11.0**

4. Activity, Workforce and Finance Triangulation

Work is progressing on a local productivity tool / model to bring the three elements of the plan together which has been reviewed and validated by all system partners. This builds on the regional productivity tool but tailors this to our local requirements. This local tailored approach will enable other sectors beyond the two Acute Trusts to be incorporated into the model more easily and quickly. This revised model needs to be validated by system partners in advance of including in the report.

Workforce

Workforce date for month two is available from the Provider Workforce Return (PWR) and Provider Finance Return (PFR) but these give a very different picture. The PWR data suggests our System Providers are between them about on plan for month two, but individual Providers have significant variances.

Table 4.2 *Workforce Plan for 2023/24 WTE*

Workforce WTE Plan	May Planned WTE	May Actual WTE	May WTE Variance
Chesterfield Royal Hospital	4,679.6	5,271.7	(592.1)
Derbyshire Community Health Services	3,799.5	3,786.4	13.1
Derbyshire Healthcare	3,048.6	3,013.3	35.3
EMAS	4,051.7	3,842.9	208.8
University Hospital of Derby and Burton	13,058.1	12,718.2	339.9
JUCD Total	28,637.5	28,632.5	5.0

The PFR data shows a significant cost pressure across our System Providers with the exception of EMAS and their PWR is broadly in line with their PFR. For other Providers, notably UHDB, their PWR and PFR data initially appear at odds with each other, as they have 340 WTE less than planned at M2 but are overspending by £5.2m. This could be explained by the impact of the Junior Doctors industrial action creating the need for additional non-contractual pay. DCHS and Derbyshire Healthcare also have small variances less than plan against their WTE, but again are overspending at month 2 by £1.6m and £1.7m, respectively. DCHS overspend is in relation to the pay award where a 5% increase in expenditure has not yet been matched by the plan, the pressures if any will be clearer in month three after the pay award has been transacted.

HR colleagues need to work with Finance as a matter of urgency to fully understand this situation.

Table 4.3 *Workforce Cost*

Staff Costs by Provider Month 02 Position	2022/23 M12 £m's	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	39.5	41.8	(2.3)	232.5	232.5	0.0
Derbyshire Community Health Services	170.8	26.0	27.6	(1.6)	157.3	163.2	(5.9)
Derbyshire Healthcare	155.6	24.6	26.3	(1.7)	149.9	157.8	(7.9)
EMAS	198.0	33.8	32.7	1.1	207.6	201.8	5.7
University Hospital of Derby and Burton	750.5	120.4	125.7	(5.2)	696.7	698.3	(1.6)
JUCD Total	1,528.3	244.3	254.0	(9.7)	1,443.9	1,453.6	(9.7)

The added concern with this lack of understanding of the data is there seems to be an inconsistency in assumptions between the workforce plan and the efficiency plans we have. The whole time equivalent (WTE) staff in post at 31st March 2023 was 28,495, with the planned WTE in April 2024 set at 29,111, an increase of 616. It is acknowledged that in year there are staff transferring into EMAS under TUPE arrangements that will not be an extra cost to the system, as additional resource will come with those staff. There are also additional staff that will be employed throughout the year where the system will either receive additional funding or the additional cost is within the Plan.

Our Providers have planned Efficiencies of c£92m and around 70% of their costs are pay cost, meaning all things being equal, £64m of efficiencies would be pay related. This is completely at odds with a workforce plan that remains relatively stable. If we assume the average cost of employing one WTE is £50,000 this would require a workforce reduction in the region of 1,300 WTE to deliver £64m of efficiencies. It is recognised that the full extent of workforce efficiency savings will not just come from reducing the workforce and savings on reducing overtime and agency expenditure could contribute, but the efficiency and workforce plans appear incompatible. The work underway with HR colleagues will look to explain this apparent difference and will be shared at the earliest opportunity.

Table 4.4 *2023/24 Agency Staff Plan*

Agency by Provider Month 02 Position	2021/22 M12 £m's	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	1.6	2.2	(0.6)	9.1	9.1	0.0
Derbyshire Community Health Services	1.4	0.2	0.1	0.1	1.3	1.3	0.0
Derbyshire Healthcare	7.6	0.9	1.7	(0.8)	5.3	7.8	(2.5)
EMAS	0.7	0.1	0.1	0.0	0.8	0.8	0.0
University Hospital of Derby and Burton	14.5	1.8	2.7	(0.9)	10.7	10.7	0.0
JUCD Total	39.7	4.6	6.8	(2.2)	27.2	29.7	(2.5)

In total JUCD spent £39.7m on Agency staff in 2022/23 and the plan is to reduce this to a maximum of £27.2m in 2023/24. As can be seen from the table above JUCD is already spending more than planned at M2 but all providers with the exception of Derbyshire Healthcare are assuming they will not spend more than planned by year end. Derbyshire Healthcare's agency spend is partly being impacted by additional agency expenditure to support a complex Eating Disorder patient on one of their wards whilst a specialist Eating Disorder in-patient bed is being sourced.

5. Pharmacy, Optometry and Dentist

On 1st April 2023, NHSE delegated the responsibility for £106m of Pharmacy, Ophthalmic and Dental services to ICBs across the country. Similar to Primary Care Medical Services, these contracts are still held by NHSE and the terms of the contract and prices paid to these providers is determined at national level.

Management of these contracts is undertaken on an East Midlands footprint and the services is operated by Nottingham and Nottinghamshire ICB. For 2023/24 a Risk Share Agreement is in place and NHSE have informed ICBs that they will determine how any underspends will be utilised but overspends will be covered by the Risk Share Agreement, which may or may not be sufficient.

In Summary the services are:

Pharmacy

- Payment for dispensing of prescriptions
- Advanced Services directed nationally
- Local Enhanced Services based on patient and geographical need

Optometry

- National contract which is for the provision of an NHS sight test to an eligible person, funded on an activity basis

Primary Care Dental inc. Orthodontics

- High street dentists who are contracted to deliver a certain amount of activity
- Contracts are either GDS (General Dental Services) which are in perpetuity or PDS (Personal Dental Services) and are time limited.

Secondary care dental

- Contracted via the NHS Standard Contract

IMOS (Intermediate Minor Oral Surgery)

- Specialised dental service within high street dental practices.

(CDS) Community Dental Services

- Specialist dental services which provide dental services to special needs patients and vulnerable groups and who would have difficulty accessing high street dental practices

The risks associated with activity based contracts is that activity is based on patient need and patients meeting criteria, therefore expenditure can vary significantly. This in effect means the ICB has all the financial risks but little or no autonomy to determine how care is provided and resources are used.

6. Capital

Table 6.1 *Regional funded Capital plan for the system*

Regional 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	1.5	1.2	0.3	8.1	8.1	0.0
Derbyshire Community Health Services	0.7	0.5	0.2	5.3	5.3	0.0
Derbyshire Healthcare	3.3	3.2	0.1	19.5	19.5	0.0
EMAS	0.0	0.7	(0.7)	8.9	8.9	(0.0)
University Hospital of Derby and Burton	1.0	0.8	0.2	14.7	14.7	0.0
Additional Capital less planning tolerance				1.6	1.6	0.0
JUCD Total	6.4	6.4	0.0	58.1	58.1	0.0

The system has received a capital allocation of £52.5m and is expecting an additional £5.6m for achieving the target position in 2022/23. The plan per organisation has an additional allowed tolerance on top of the initial allocation to ensure all the capital is fully utilised, therefore the difference of £1.6m is shown as unallocated. Agreement is yet to be made on where the additional funding will be committed in 2023/24.

Overall the month 2 system position is on plan with a few variances between organisations. EMAS have incurred costs ahead of plan the DCA vehicles, however this is not expected to impact the breakeven forecast.

Table 6.2 *National funded Capital plan and actuals for the system*

National 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	0.0	0.3	(0.3)	1.7	1.7	0.0
Derbyshire Community Health Services	0.1	0.0	0.1	5.0	5.0	0.0
Derbyshire Healthcare	8.1	7.3	0.8	48.8	48.8	0.0
EMAS	2.4	0.2	2.3	6.0	6.0	0.0
University Hospital of Derby and Burton	1.3	0.0	1.3	40.1	40.1	0.0
JUCD Total	12.0	7.7	4.2	101.6	101.6	0.0

The national allocations are underspending year to date by £4.2m due to the delay in EMAS' PTS vehicles and UHDB projects relating to Community Diagnostic Centres and the Kings Treatment Centre.

7. Cash

Some JUCD Provider organisations have raised concerns regarding their diminishing levels of cash in recent years. One of the ways breakeven positions were achieved in 2022/23 was the use of all possible balance sheet benefits, to fund expenditure above the levels of income received, but this has eaten into cash reserves that were built up over many years. The reduction in the cash balance at Derbyshire Healthcare from the 1st April relates to the payment of several large value capital invoices.

Chesterfield Royal Hospital have already had to submit a cash request of £5.4m to NHSE to cover them for the next 3 months. This is a mixture of revenue and capital, with the revenue being classed at PDC and attracting an unplanned 3.5% dividend charge. Therefore, it is vitally important that cash releasing efficiencies are identified and start to deliver early in 2023/24.

Table 7.1 *Cash Balances*

Provider Cash Month 02 Position	Opening Balance 01/04/2023 £m's	Cash Balance 31/05/2023 £m's	Plan year ending 31/03/2024 £m's
Chesterfield Royal Hospital	20.2	20.5	19.9
Derbyshire Community Health Services	37.3	35.2	34.1
Derbyshire Healthcare	53.9	35.1	23.7
EMAS	18.2	19.4	13.7
University Hospital of Derby and Burton	48.4	39.2	35.6
JUCD Total	**178.0**	**149.4**	**127.0**

A way of traditionally measuring an organisations cash risk is to look at their Cash Ratio, comparing their available cash to their current liabilities, those liabilities that are payable in one year or less. The table below shows the ratios of liabilities which can be covered by existing cash balances showing possible impending cash difficulties.

Table 7.2 *Cash Ratio*

Cash Ratio Month 02 Position	Cash Balance 31/05/2023 £m's	Current Liabilities 31/05/2023 £m's	Cash Ratio
Chesterfield Royal Hospital	20.5	(54.8)	0.4
Derbyshire Community Health Services	35.2	(41.0)	0.9
Derbyshire Healthcare	35.1	(48.9)	0.7
EMAS	19.4	(52.4)	0.4
University Hospital of Derby and Burton	39.2	(180.9)	0.2
JUCD Total	**149.4**	**(378.0)**	**0.2**

Guidance has recently been received that describes how providers with available cash can support those providers within the system where required. This guidance is being reviewed to understand the opportunities in taking this approach.

8. Recommendations

The Committee are asked to **NOTE**:

- The increasing level of unmitigated risk outside the submitted plan
- The increasing level of risk in delivering the submitted plan
- The lack of assurance in identifying mitigations for the above risks
- There is an upcoming risk on ERF due to guidance asking us not to report any impact of under delivery of targets
- The lack of progress in developing efficiencies in conjunction with the increase in the planned delivery in month three and four
- The responsibility for £106m of POD services, but there is a lack of decision making power in how these services will be delivered

And **DISCUSS**:

- The impact of paying the pay award to non-NHS providers taking into consideration the risks to the operational, quality and patient safety risks
- The role of the GP Provider Board in supporting failing practices

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

20th July 2023

Item: 052

Report Title	Hewitt Review – Government response							
Author	Chrissy Tucker, Director of Corporate Delivery							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1 – Hewitt Review and Health and Social Care Select Committee report on ICS autonomy and accountability							
Assurance Report Signed off by Chair	N/A							
Which committee has the subject matter been through?	N/A							

Recommendations
The ICB Board is recommended to **NOTE** the key recommendations from the Hewitt Review and the Government response to the Review and the Health and Social Care Select Committee report on ICS autonomy and accountability referred to in the attached letter (Appendix 1) from the NHS Chief Delivery Officer.
Purpose
The purpose of this paper is to set out the key points from the Hewitt Review together with the outline plan as to how these will be addressed by NHS England.
Background
The Hewitt Review was commissioned to consider how the oversight and governance of Integrated Care Systems (ICSs) can best enable them to succeed, balancing greater autonomy and robust accountability with a particular focus on real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement. It was agreed to cover ICSs in England and the NHS targets and priorities for which Integrated Care Boards (ICBs) are accountable, including those set out in the government's mandate to NHS England, timetabled to report by no later than 15th March 2023.
Report Summary
The Review made a number of recommendations; the most significant of these are set out below, together with the Government's response *(in italics):*

1. Fewer central targets to be set, to enable ICBs to prioritise resources, with no more than ten national policies.
   DHCSC and NHS England acknowledge the importance of outcomes-based targets in driving improvements in health and social care services and agree that other measures and targets may be needed alongside outcomes to demonstrate progress or to address key issues of public concern. There are clearly areas of particular national importance where we will set both a future target and a trajectory towards it, but there will also be areas where it is appropriate for local systems to set their own targets or areas where there may be a future national target where it makes sense for local systems to determine their trajectory of delivery against it.

2. Enabling a shift towards upstream investment in prevention to ensure longer-term sustainability of the health and care system
   The government agrees that in line with the ambitions of the NHS Long Term Plan, over time the focus for the NHS should increasingly shift towards implementing evidence-based interventions to help improve prevention and support healthier life expectancy. To support investment in prevention, NHS England and DHSC will work closely with ICSs, local government partners and NICE to develop practical information and evidence to support local investment decisions.

3. Multi-year funding to enable systems to plan more effectively, with the ultimate aim of a ten-year capital plan for the NHS
   The allocation of funding to ICBs to support them in commissioning services for their local population is one of the key duties of NHS England. NHS allocations, which are published during the NHS planning process, are distributed using an independent 'fair shares' formula. NHS England published allocations for 2023 to 2024 to 2024 to 2025 on 27 January 2023. However, funding may be required outside this standard process where certain priorities require in-year funding that is accompanied with reporting requirements. For example, between December 2022 and March 2023, DHSC provided £500 million of discharge funding to reduce the number of people delayed in hospital waiting social care. In addition to the multi-year funding announced at the Autumn Statement, we published the details of the £600 million 2023 to 2024 Discharge Fund on 4 April 2023, to give local systems the maximum time to prepare ahead of winter 2023 to 2024. We have also confirmed that we will provide £1 billion of additional funding to reduce delayed discharges in 2024 to 2025.

4. Payment mechanism flexibility to allow ICSs to determine allocations for services and appropriate payment mechanisms within system boundaries
   DHSC agrees in principle that systems should be provided with sufficient flexibility to determine allocations for services and appropriate payment mechanisms, particularly to meet the needs of their local population. However, we believe that there are circumstances that warrant payment system incentives to encourage a particular activity; elective care, promoting value for money, and patient choice are all supported by common payment mechanisms.

5. Defining accountabilities for ICBs together with NHSE and defining a clear pathway and criteria towards ICB maturity
   The new NHS England operating framework sets out a commitment to working collaboratively with systems to support effective system working. NHS England will work with ICB leaders to consider how to best support ICBs to mature, building on the co-design approach that has been used to support the development of ICSs so far.

6. Data available to ICSs – NHSE to share data they hold about ICSs with ICSs together with benchmarking data
   DHSC supports the spirit of this recommendation and is already making progress in several ways. We are reducing the burden on services which provide information for these different uses, through better strategic co-operation between the key stakeholders, and through judicious use of the latest technology. The central organisations which oversee health and

social care delivery are increasingly working together to remove any duplication in data collections. The Data Alliance Partnership brings together key organisations to maximise the benefits of sharing data already held in health and care systems and to minimise the burden of collecting more from frontline services. The philosophy is to collect once and use for multiple purposes. It is important that NHS England, DHSC, ICSs and CQC - and other key stakeholders responsible for the oversight of health and social care - should have equitable access to high-quality information, in its broadest sense, to ensure the accountability of services, and to support their continuous improvement.

7. An enhanced role for the CQC in systems in supporting ICSs, approach to be co-developed
ICBs are accountable to NHS England, which will undertake annual performance reviews to assess how well each ICB has discharged its statutory duties. CQC's assessments of ICSs will look at the whole system. CQC is continuing to work with NHS England in developing its approach to ICS assessment, to ensure alignment with NHS England's annual assessments of ICBs, including sharing evidence and information. CQC will test working arrangements with NHS England during its pilot assessments.

8. Reconsider Running Cost Allowance cut of the additional 10% to be achieved in 25/26, prior to the 2024 budget.
The 10% cut in ICB RCA planned in 2025 to 2026 forms part of the 30% real-terms reduction per ICB by 2025 to 2026, which has been agreed with government and which forms part of NHS financial plans. NHS England's requested reforms within the Health and Care Act 2022 aimed to ensure that resource could be most effectively focused on the front line.

The full Government response can be found at the below link:

https://www.gov.uk/government/publications/government-response-to-the-hscc-report-and-the-hewitt-review-on-integrated-care-systems/government-response-to-the-house-of-commons-health-and-social-care-committees-seventh-report-of-session-2022-to-2023-on-integrated-care-systems-aut#theme-3-ics-governance-accountability-and-oversight

The Board were briefed on the review at the Development Session of 18th May where a number of recommendations were considered to have potential for the ICB/ICS to move forward:

- Autonomy linked to maturity - what does this mean for us
- Take advantage of the fewer national asks to enable the ICB to focus on key issues
- Better use of data and information to underpin decision making and planning
- Demonstrate accountability to local people
- Preparing for CQC new role within ICSs
- Reductions in system overhead costs including those in providers

It is noted that our strategy already fits with the direction of travel that the Hewitt Review we will continue to plan on that basis.

Identification of Key Risks

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

No further risks identified.

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?

Not applicable.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable.

Appendix 1

Classification: Official

Publication reference: PR00557

To:
- ICB:
  - Chief executives
  - Chairs
- ICP chairs

cc.
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

14 June 2023

Dear colleagues

Hewitt Review and Health and Social Care Select Committee report on ICS autonomy and accountability

The Government has today published its joint response to the Hewitt Review and the Health and Social Care Select Committee's report on integrated care system (ICS) autonomy and accountability. I want to thank you, and all partners across the health and care sector, for dedicating your time, energy and views to these important reports.

Almost a year on from their establishment, support for ICSs as the right arrangements to address the shared challenges being faced across the health and care system remains strong. Up and down the country ICSs are embedding their local partnerships and working to improve the way that health and care is delivered and experienced in communities. Together, they are tackling the critical challenges we face including improving population health for local communities, urgent and emergency care transformation, recovery of elective services, access to primary care and building the resilience of the health and social care workforce.

The Hewitt Review emphasises the work already happening locally and nationally to capitalise on these new arrangements, acknowledging some of the significant progress that both systems and NHS England have started to make and highlighting where we need to do more to ensure our approach across the NHS and with partners enables local leaders to succeed.

Our Operating Framework sets out how we are starting to work differently, and we are changing to become a smaller organisation that is focussed on supporting leaders and their teams in local organisations and enabling them to deliver our collective core priorities.

We now want to work collaboratively with systems and national partners to drive that change forward through a clear roadmap for the future changes we will make together. This will pick up how we set direction for the NHS, how we assure delivery and support improvement, and how we align ways of working to build a collaborative culture that enables success – all oriented to align behind local leaders.

As part of this we will consider how we can:

- embed co-creation and co-ownership into our ways of working as part of demonstrating our commitment to collaborative leadership by, for example,

building on this year's approach to co-produce the next round of planning guidance to ensure the way that we develop national priorities and set direction will be genuinely informed by local ambition.

- streamline how we interact with systems as we devolve decision-making to give systems the space to lead locally, seeking to minimise reporting requirements so that capacity and energy can be focused on developing tomorrow's services rather than describing today's services.

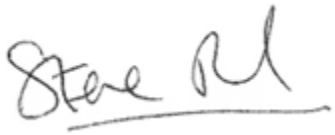
- develop the 'one team' approach we are embedding across the NHS and with our partners, working collaboratively and empowering each other but also being clear about who is accountable for what within systems. This will mean a shift in our oversight framework and our approach to performance management to place a stronger emphasis on improvement and transformation.

- better listen to local leaders in systems to inform how we reorganise our ways of working. Our behaviours and culture need to reinforce these ambitions as we seek to create a simpler and more enabling NHS England to lead the NHS more effectively.

Achieving the ambitions reiterated in the Hewitt Review, and creating the conditions for ICS success, will require sustained commitment from all partners across the health and care system and we at NHS England are committed to playing our part.

We look forward to working in collaboration with colleagues to take this important work forward.

Yours sincerely,



Steve Russell
Chief Delivery Officer and National
Director for Vaccinations and Screening
NHS England

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

20th July 2023

Item: 053

Report Title	People and Culture Committee Assurance Report – June 2023							
Author	Linda Garnett, Interim ICB Chief People Officer							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Margaret Gildea, Non-Executive Member and Chair of People & Culture Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Margaret Gildea, Non-Executive Member and Chair of People & Culture Committee							
Which committee has the subject matter been through?	People and Culture Committee – 7th June 2023							

Recommendations
The ICB Board is recommended to **NOTE** the People and Culture Committee Assurance Report.
Items to escalate to the ICB Board
No items to escalate.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the People and Culture Committee on the 7th June 2023.
Background
The People and Culture Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The People and Culture Committee's Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made; • major actions commissioned or work underway; • positive assurances received; and • comments on the effectiveness of the meeting.

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

Any risks highlighted and assigned to the People & 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?			
Not applicable.			
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?			

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable.

Board Assurance Report

People and Culture Committee on 7th June 2023

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	No items for decision were presented.
Major actions commissioned or work underway	**Positive assurances received**
The Committee requested a deep dive into the supporting People and Culture Governance structures at the next meeting. The Committee noted the importance of creating the One Workforce Strategy, which has two elements, the NHS Family and the wider ICP integrated care plan.	• Report from the People Services Collaborative Delivery Board on the three priority areas agreed for 23/24 • System WRES Report – has some areas of good practice to build on
Comments on the effectiveness of the meeting	
The meeting was well attended and generated some helpful and insightful challenge and insight. It is recognised that the BAF approach is still relatively immature and needs further development.	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

20th July 2023

Item: 054

Report Title	Audit & Governance Committee Assurance Report – May and June 2023							
Author	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							
Assurance Report agreed by:	Sue Sunderland, Non-Executive Member (Audit & Governance)							
Which committee has the subject matter been through?	Audit and Governance Committee – 4th May 2023 and 8th June 2023							

Recommendations
The ICB Board is recommended to **NOTE** the Audit and Governance Committee Assurance Report.
Items to escalate to the ICB Board
No matters of concern or key risks to escalate.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Audit & Governance Committee on the 4th May 2023 and 8th June 2023. .
Background
The Audit & Governance Committee ensures that the ICB complies with the principles of good governance whilst effectively delivering the statutory functions of the ICB.
Report Summary
The ICB Audit & Governance Committee's Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate • decisions made • major actions commissioned or work underway • positive assurances received • 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.	☐			

Any risks highlighted and assigned to the Audit & 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 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?			
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.			

Board Assurance Report

Audit & Governance Committee on 4th May 2023 and 8th June 2023

Matters of concern or key risks to escalate	Decisions made
1. The External Auditors will need to make a Section 30 referral to the Secretary of State highlighting the deficit positions on both the CCG (£12k) and ICB (£14.8m) as this represents a breach of the Revenue Resource Limits (RRL). The ICB deficit is the consequence of the last minute additional funding from the Region that is not reflected in the ICB's RRL. 2. The action log is still showing the issue raised in March around the ImpACT+ (Specialist Respiratory Services) contract which expired on 31 March 2023 as outstanding. A verbal update stated that a decision to extend had been taken by Executives since the June Audit Committee but the committee remain concerned about how this process has been managed.	1. We received the External Auditor's ISA 260 reports for both the 3 month CCG and 9 month ICB financial statements audits and agreed a final approval process including delegation to the DoF and Audit Chair unless any significant changes are identified as part of the final audit stages in which case the Committee members will be involved via virtual sign off or extraordinary committee depending on the issues raised. **No significant changes subsequently identified, and final approval completed on 27 June as per process outlined.** 2. Approved the final annual reports for both the CCG and ICB subject to any final amendments required as a result of the ongoing external audit work. Amendments to be approved as per the financial statements process outlined above. **No significant changes subsequently identified and final approval completed on 27 June as per process outlined.** 3. The following policies were approved: a. Procurement policy b. Learning & development policy c. Dignity, civility & respect policy d. Freedom to speak up policy e. Disclosure & barring policy.
Major actions commissioned or work underway	**Positive assurances received**
1. Internal Audit are in the process of starting discussions around the cross systems work on discharge management and length of stay. 2. The first Executive risk conversation on strategic risk 8 raised a query as to whether the two sub-elements (1 – data access and use 2 – digital transformation) needed to be separated. This has been passed back to the two Executive Directors responsible for the sub risks to reassess and bring back to the Finance & Estate Committee.	1. The External Audit ISA260 reports for both the CCG and the ICB are forecasting unqualified opinions on the financial statements and no significant weaknesses identified in relation to the use of resources. 2. The changes that have been required to be made to the draft financial statements were explained and it was confirmed that none were material, and most are presentational.

	3. Substantial assurance received from Internal Audit review of the General Ledger and Financial Reporting 4. Final Head of Internal Audit Opinions both remain as significant assurance 5. The Executive risk conversation around IT provided reassurance that the lead Executive has clear insight into emerging matters and the potential risks that are likely to arise. 6. Assurance was taken from the following regular reports: a. Digital & cyber assurance b. Information governance c. Procurement highlight d. Complaints e. Freedom of information requests f. Conflicts of interest g. Month 1 financial position
Comments on the effectiveness of the meeting	
We covered a lot of ground at both meetings with several key items including the external audit of the financial statements and completion of the annual reports for both the CCG and ICB as well as our first Executive risk conversation. There was a good level of engagement from all participants and a good level of constructive challenge as well as appreciation for the hard work that had gone into preparing and auditing the statutory documents and submissions.	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

20th July 2023

Item: 055

Report Title	Derbyshire Public Partnership Committee Assurance Report – June 2023							
Author	Sean Thornton, Deputy Director Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Julian Corner, Non-Executive Member (Population Health and Strategic Commissioning)							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Julian Corner, Non-Executive Member (Population Health and Strategic Commissioning)							
Which committee has the subject matter been through?	Public Partnership Committee, 27th June 2023							

Recommendations
The ICB Board is recommended to **NOTE** the Public Partnership Committee Assurance Report.
Items to escalate to the ICB Board
No matters of concern or key risks to escalate.
Purpose
This report provides the ICB Board with highlights from the development meeting of the Public Partnership Committee on the 27th June 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. Consideration is being given to adjusting this rhythm now that the committee has completed its establishment phase. This report provides a summary of the items transacted for assurance.
Background
The Public Partnership Committee ensures that the ICB effectively delivers the statutory functions of the ICB in relation to patient and public involvement. The committee also seeks, through its terms of reference, to drive citizen engagement in all aspects of the ICB's work to ensure that local people are central to planning and decision-making processes.

Report Summary
The Derbyshire Public Partnership Committee Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate • decisions made • major actions commissioned or work underway • positive assurances received • 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.	☐			

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.					

Board Assurance Report

Public Partnership Committee on 27th June 2023

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	Board Assurance Framework The committee approved a detailed action plan that set out milestones to mitigate the risk identified relating to patient, public and stakeholder engagement. Additional actions arising from the discussion included the need to clarify the engagement approach being taken by NHS providers and the promotion of future discussion about the assessment we make on the effectiveness and impact of engagement. Phase 2 Development of Committee The committee approved the proposed approach to recruitment for committee lay members. This would seek recruitment of representatives from place partnerships, the PPG Network, the public partners peer group and the to-be-established Lay Reference Group. Of particular important was the need to improve the diversity across membership for each constituent part and provide opportunities for progression in supporting engagement across our system. It was also decided to formally invite the Executive Director of Strategy & Planning to become a member of the committee to strengthen the links between public involvement and our commissioning processes. The terms of reference would be amended accordingly.
Major actions commissioned or work underway	**Positive assurances received**
• Board Assurance Framework action plan – ongoing delivery of mitigating actions • Recruitment to committee lay member vacancies • Review of approach to committee/sub-group diversity. • Ongoing development of engagement frameworks ○ Insight Framework	None received at this development meeting.

○ Governance Framework ○ Evaluation Framework ○ Co-production Framework ○ Engagement Framework	

Comments on the effectiveness of the meeting
The committee reviewed a series of assurance questions and agreed that the meeting had been effective.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

20th July 2023

Item: 056

Report Title	Quality and Performance Committee Assurance Report – April/May/June 2023							
Author	Jo Hunter, Director of Quality							
Sponsor (Executive Director)	Paul Lumsdon, Interim Chief Nurse Officer							
Presenter	Dr Adedeji Okubadejo, Non-Executive Member and Chair of Quality and Performance Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – April Committee Assurance Report Appendix 2 – May Committee Assurance Report Appendix 3 – June Committee Assurance Report							
Assurance Report agreed by:	Dr Adedeji Okubadejo, Non-Executive Member and Chair of Quality and Performance Committee							
Which committee has the subject matter been through?	Quality and Performance Committee – 27.4.2023, 25.5.2023 and 29.06.2023							

Recommendations
The ICB Board is recommended to **NOTE** the Quality and Performance Committee Assurance Report.
Items to escalate to the ICB Board
The ICB is currently not compliant with any statutory operational targets relating to the urgent care and planned care and cancer programme.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Quality and Performance Committee on 27.4.2023, 25.5.2023 and 29.06.2023. The ICB Quality and Performance Committee agreed to escalate the above issue to the ICB Board.
Background
The Quality and Performance Committee ensures that the ICB effectively delivers the statutory functions of the ICB.

Report Summary
The System Quality and Performance Committee Assurance Report (Appendices 1, 2 and 3) 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 £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.	☐			

Any risks highlighted and assigned to the Quality and Performance 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 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?
None noted.

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

Details/Findings
Not applicable.

ICB Board Assurance Report

ICB Quality and Performance Committee on 27th April 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 following items were approved by the Group: • Board Assurance Framework (BAF) – It was agreed to set up an Operational BAF Review Group to allow scrutiny in advance of the Committee. First Group meeting 05/06/23. • NOF Q4 Templates - The Committee supported the NOF Q4 segmentation. For confirmation at ICB Board.
Major actions commissioned or work underway	**Positive assurances received**
It was agreed to develop a schedule of deep dives for presentation at the System Quality and Performance Committee on a month-by-month basis to allow members to focus on areas of concern and good practice/celebration. The schedule will be constantly refreshed based on discussions at the Committee regarding performance and quality. Prior to presentation at the Committee the detail of the deep dive will have been shared at the preceding System Quality Group to ensure system oversight. The first deep dives presented through this schedule will be at the June Committee meeting.	The following papers were presented for assurance: • Deep Dive - Childrens and Young Peoples Eating Disorders • Integrated Performance Report • Current Position Safeguarding Adults and Children • System Quality Group Assurance Report • Board Assurance Framework (BAF)
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.	

ICB Board Assurance Report

ICB Quality and Performance Committee on 25th May 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.	Schedule Of Proposed Deep Dives - The Committee supported the process for the presentation of Deep Dives into SQG and Quality and Performance Committee.
Major actions commissioned or work underway	**Positive assurances received**
Nothing to note.	The following papers were presented for assurance: • Integrated Performance Report • POD Update – The Governance arrangements were confirmed. • System Quality Group Assurance Report • Board Assurance Framework (BAF)
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.	

ICB Board Assurance Report

ICB Quality and Performance Committee on 29th June 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 NOF Q1 Submissions was approved.
Major actions commissioned or work underway	**Positive assurances received**
The following pieces of work will be regularly presented to the Group: • Deep Dive – LeDeR Review Process • Deep Dive – Role of the LMNS: An update will be brought back to Quality and Performance committee in November which will link the work with the thematic review on perinatal mortality.	The following papers were presented for assurance: • Integrated Performance Report • System Quality Group Assurance Report • Board Assurance Framework (BAF) • Risk stratification and harm: It was noted that the harm reviews do not include psychological impact on people waiting. The Team will explore to see how this could be captured as part of the process.
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.	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

20th July 2023

Item: 057

Report Title	Population Health & Strategic Commissioning Committee Assurance Report – May/June/July 2023							
Author	Julian Corner, (Chair) Non-Executive Member for Population Health and Strategic Commissioning and Public Partnerships							
Sponsor (Executive Director)	Zara Jones, Executive Director of Strategy & Planning							
Presenter	Julian Corner, (Chair) Non-Executive Member for Population Health and Strategic Commissioning and Public Partnerships							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☒
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Julian Corner, (Chair) Non-Executive Member for Population Health and Strategic Commissioning and Public Partnerships							
Which committee has the subject matter been through?	Population Health & Strategic Commissioning Committee – 11th May, 8th June and 13th July 2023							

Recommendations
The ICB Board is recommended to **NOTE** the Population Health & Strategic Commissioning Committee Assurance Report.
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 & Strategic Commissioning Committee on 11th May, 8th June and 13th July 2023.
Background
The Population Health & Strategic Commissioning Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The Population Health & 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.

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.	☐			

Any risks highlighted and assigned to the Population Health & 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?
Not applicable.

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

Details/Findings
Not applicable.

Board Assurance Report

Population Health & Strategic Commissioning Committee on 11 May, 8 June and 13th July 2023

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	All decisions were confidential.
Major actions commissioned or work underway	**Positive assurances received**
None to note.	11th May meeting The Committee approved the following: 1. Risk Register: • approved the decrease in score for risk 18; • approved the decrease in risk score for risk 04C. Glossop alignment of policies. It was agreed to keep this risk under close watch while it is worked through. 2. BAF, Quarter 1 2023/24 Assurance Framework Strategic Risks 7 and 9. It was agreed to discuss the BAF in more in detail in July. The following items were received for information: • Derbyshire Prescribing Group report/minutes • Clinical & Professional Leadership Group minutes • Derbyshire Joint Area Prescribing Committee Bulletin • CPAG Bulletin • Tomorrow's NUH Programme - Letter from Nottingham and Nottinghamshire ICB • Management of infertility for East Midlands ICBs • Options paper for Children's Vision Screening in Derbyshire The PHSCC 8th June meeting was a development session and so no business items were approved.

	13th July The Committee approved the Risk Register reports and the closure of risk 03C relating to optometry provision for children's vision screening. The following items were received and noted for information: • Derby and Derbyshire NHS' Five Year Plan – 2023/24 to 2027/28 • CPAG Updates • Derbyshire Prescribing Group report/minutes for April & May • JAPC April Minutes & Bulletin & May Bulletin • CPLG minutes for April, May & June
Comments on the effectiveness of the meeting	
It was agreed that there had been some really good examples of collaboration and team work.	

MINUTES OF THE AUDIT AND GOVERNANCE COMMITTEE

HELD ON 23 MARCH 2023 VIA MS TEAMS AT 2.00PM

Present:		
Sue Sunderland	SS	Non-Executive Director/Audit Chair
Richard Wright	RW	Non-Executive Director
In Attendance:		
Andrew Cardoza	AC	Audit Director, KPMG
Joanna Clarke	JC	Principal Anti-Crime Specialist, 360 Assurance
Helen Dillistone	HD	Executive Director of Corporate Affairs (part)
Debbie Donaldson	DD	EA to Chief Finance Officer (note taker)
Darran Green	DG	Acting Operational Director of Finance
Keith Griffiths	KG	Chief Finance Officer
Claire Haynes	CH	Senior Public Equality and Diversity Manager (part)
Richard Heaton	RH	Business Resilience Manager (part)
Donna Johnson	DJ	Acting Assistant Chief Finance Officer
Martin Ndoro	MN	Audit Manager, KPMG
Usman Niazi	UN	Client Manager, 360 Assurance
Glynis Onley	GO	Assistant Director, 360 Assurance
Suzanne Pickering	SP	Head of Governance
Craig Stephens	CS	Senior Procurement Manager (part)
Chrissy Tucker	CT	Director of Corporate Delivery
Kevin Watkins	KW	Business Associate, 360 Assurance
Rosalie Whitehead	RH	Risk Management & Legal Assurance Manager
Apologies:		
Chris Leach	CL	Head of EPRR
Ged Connolly-Thompson	GCT	Head of Digital Development & Digital Health Skills Development Network Lead

Item No.	Item	Action
AG/2223/151	**Welcome, introductions and apologies** Sue Sunderland as Chair welcomed all members to the meeting. Apologies were received from Chris Leach and Ged Connolly-Thompson.	
AG/2223/152	**Confirmation of quoracy** The Chair declared the meeting quorate.	
AG/2223/153	**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.	
FOR DECISION		
AG/2223/154	**Audit and Governance Policies** **Procurement Policy**: Chrissy Tucker reported that the Procurement Policy had been drafted for the ICB as a 'lift and shift' from the CCG, with the following changes: • On the 21st December 2022, the Public Contracts (Amendment) Regulations 2022 came into force and references to the Public Contracts Regulations 2015 had been replaced to show this; and • The excerpt at Section 2, paragraph 4 from the ICB's Scheme of Reservation and Delegations had been updated to reflect recent changes approved by the Finance and Estates Committee around approvals related to direct award of contracts and monitoring of associated STWs and delegations around procurements. The Chair referred to item 9.2.1 decommissioning services and various tests (page 18); one of the tests was support from GP Commissioners, she asked whether this was a tie over from the CCG or whether there was something specific still relevant to GPs? Chrissy Tucker reported that this was a tie over and agreed to update this section. The Chair then referred to Section 2.1.4 (page 21) which referred to Monitor; she thought Monitor now ceased to exist. Chrissy Tucker agreed to amend this section. The Chair referred to item 23 (page 40) regarding sustainable procurement. She reported that she was surprised this section had not been expanded in line with NHS net zero ambitions. It was noted that there was nothing in the policy regarding what the requirements were nor the requirements of suppliers to comply. There was also nothing about sustainability in the checklist that had been attached to the policy. Suzanne Pickering confirmed that the Governance Team would further engage with the procurement team to make sure that the	

	above was reflected and the policy would be brought back to Committee for reapproval. It was confirmed that the financial limits in the delegation section were set centrally and were in line with all other NHS organisations. **The Audit and Governance Committee AGREED that the Procurement Policy would be brought back for Committee approval once the above amendments had been reflected.** **Ethical Framework for Decision Making Policy**: Suzanne Pickering reported that the Ethical Framework for Decision Making Policy was a new policy and was identified as a requirement through mandatory IFR training. The policy aimed to underpin all ICB decision making made at a population level, which would include IFR requests. Work had previously been undertaken on an Ethical framework prior to the Covid-19 pandemic by the CCG. However, it was unclear how widely this document had been circulated, so it was agreed that a refresh/review of the policy was required to reflect the ICB's approach. The ICB's Clinical Policies, Corporate Delivery and Communications and Engagement Teams had all worked together to finalise this policy. It was noted that the policy had been approved by the Clinical Policy Advisory Group (CPAG) and had been presented to the Population Health and Strategic Commissioning for information. Richard Wright referred to Section 3.3; he felt the approach to decision making had to be a balance between short and long term. He felt the policy concentrated on the short term; it was noted that sometimes decisions were made on contracts that may not benefit in the short term, but focused more on benefits in 3-5 years. It was noted that the principles of decision making would remain the same. Suzanne Pickering agreed to reflect this slight change in the policy. **The Audit and Governance Committee APPROVED the Ethical Framework for Decision Making Policy subject to this minor amendment.** **Digital - Network, Internet, and Email Acceptable Use Policy:** Chrissy Tucker reported that on March 2nd, 2023, NHS England issued a bulletin, and circulated it to all local administrators of NHS Mail nationally. The bulletin indicated that, from the end of June 2023, multi-factor authentication would be mandatory across all NHS Mail accounts across all NHS organisations – this would affect both ICB and Primary Care colleagues.	

	The policy had been changed to take into account the mandatory activation of multi-factor authentication and steps that colleagues would need to take to enable them to receive the necessary secondary code to access NHS Mail and services which use NHS Mail as an authentication mechanism. It was noted that an engagement programme for staff informing them of the changes would be carried out. **The Audit and Governance Committee APPROVED the Network, Internet, and Email Acceptable Use Policy.**	
FOR CORPORATE ASSURANCE		
AG/2223/155	**Internal Audit: Progress Report** **Draft 2023-26 Internal Audit Strategic Plan** Kevin Watkins highlighted the following key points of the Plan: • Approval for the 2023-26 Internal Audit Strategic Plan would not be sought from Committee today as further work was required. It would be presented to the May meeting of this Committee for approval. • Since discussing and the developing the plan with Executive Management and agreeing the cost envelope (which had been based on what the ICBs former organisation had purchased in terms of number of days), the ICB had received a notification instructing it to cut running costs by 30%. It was noted that internal audit was included within that. • 360 Assurance had engaged with Darran Green and Keith Griffiths regarding how this might be reflected within the Plan. The areas being reviewed were the System wide pieces of work that were originally being planned for next year; it was hoped that the amount of resources required could be reduced and therefore the cost envelope. • Appendix A1 detailed the Internal Audit Plan and indicative phasing for 2023/24. • It was noted that discussions regarding the Plan had been held with Executive Team, System Audit Chairs and System DoFs. • Richard Wright referred to item No 7 on the Plan, Operational Planning, he felt we needed to do a lot of work on System wide workforce. He felt focus on this should extend beyond 2023-24 Plan and probably for the next 5 years. Kevin Watkins reported that he was happy to reflect this comment within the Terms of Reference for that piece of work. • The Audit Chair welcomed 360 Assurance trying to get the Derbyshire System to contribute more to some of the tasks contained within the Plan to reduce ICB costs. If we needed to potentially take out a review, she felt that Policy Management Framework would be the top of her list; this could be deferred, bearing in mind that we had reviewed all the policies since we had come into being as an ICB.	

	• Richard Wright referred the Transformation and Efficiency review in year 1; he felt this needed to be more than 1 year as this should become part of our culture going forwards. • The Chair reported that we were currently awaiting a report on Transformation and Efficiency which was still in draft. This would be a key area to follow up, as the progress report was projecting that this review was going to be of limited assurance. • The Chair referred to PPV, and asked how we were going to manage it, as this was something we had not really been sighted on so far. • It was noted that 360 Assurance's intention was at the beginning of this financial year to start to bring PPV into the planning and the audit assurance process. • PPV had been put on hold everywhere during the pandemic and Primary Care was left to get on with the very important business of trying to care for people. Prior to that it was seen as a management function that was provided for the CCG and therefore did not really come through audit. It was noted that a line had been put into the Plan for this year for PPV totalling 40 days. • It was noted that 360 Assurance should have engaged with Audit Committee regarding this much more than they had. • Moving forward 360 Assurance agreed to speak with Primary Care management on how they would like them to use the time for PPV and then engage with Audit Committee about bringing that into the planning process for next year. • At the last Audit Committee meeting, members were informed that the PPV work was taking longer than anticipated and a request for additional time was made to complete the review. Audit Committee had not agreed to this request as the Audit Chair needed to understand the value of transferring more time in for this work. • The Chair reported that this was an outstanding action from the last Committee meeting. It was noted that in reality that time had already been spent and she was more concerned about getting things sorted out for the future. She was reassured by the change in approach by 360 Assurance to the PPV work. • It was noted that Darran Green was happy with the findings coming out of the PPV review work he had seen so far. • The Audit Chair proposed that Audit Committee retrospectively approve the transfer of the spare time in the Audit Plan to cover the work that had already been used. • The Audit Chair agreed that the 2023-26 Internal Audit Strategic Plan should come back to Audit Committee on 4 May 2023 for approval. It was noted that she welcomed the dialogue regarding any reductions to the Plan to help with the running cost pressures. • It was reported that 360 Assurance would commence the DSPT work in the first quarter.	

	Progress Report Kevin Watkins presented the progress report and highlighted the following: • Issued the final report resulting from our Governance and Risk Management review – significant assurance • Completed the PPV work, and a draft report had been shared with the ICB's Assistant Director GP Commissioning and Development. 360 Assurance were currently undertaking the following exercises from the 2022/23 Internal Audit Plan: • Transformation & Efficiency Review – Fieldwork for this review had been completed and a draft report prepared. The report was updated following the receipt of comments from operational management and reissued. It was currently being considered by ICB executive management. • General Ledger and Financial Reporting – Fieldwork for this review was complete. 360 Assurance were currently in the process of drafting the report. • Committee Effectiveness Review – 360 Assurance were scheduled to commence the fieldwork for this review in late March 2023. Terms of Reference for the review were currently being prepared. The Chair highlighted the Transformation and Efficiency review and reported that the indicative assessment on that was limited, which was not surprising, and asked whether there was a timeframe to get the report finalised. The Chair asked if we could receive the report back by 4th May 2023 and whether it would influence the HOIAO? Kevin Watkins reported that it would influence the Head of Internal Audit Opinion but would not change the overall opinion. It was noted that the Opinion currently had several high-risk recommendations contained within it. Darran Green reported that he Keith Griffiths would be reviewing the draft Transformation and Efficiency report tomorrow with a view to it going the Executive Team as soon as possible for further discussion. **Interim Head of Internal Audit Opinion Stage 2** Usman Niazi presented the Interim Head of Internal Audit Opinion Stage 2 and highlighted the following: • 360 Assurance had issued their Interim Head of Internal Audit Opinion before the NSHE submission deadline of midday on 10 March 2023. A copy was included as a separate item within the papers.	

	• 360 Assurance would publish a revised interim Head of Internal Audit Opinion for submission to NHSE by 27 April 2023 and the Final Head of Internal Audit Opinion and Annual Report for the submission of the annual report and accounts. • It was noted that 360 Assurance had tried to reflect in this Opinion the fact that the ICB had done a considerable amount of work to develop a System wide Board Assurance Framework (BAF), which was reflected in the fact that there were only two recommendations in the report. The first of these related to the introduction of several referencing mechanisms to try and more clearly link the actions that were within the BAF with the gaps in control and assurance. The second action related to the presentation of the BAF and the Risk Register. 360 Assurance had proposed for the BAF and Risk Register to be considered for presentation at a sufficiently early stage within the business that was considered at Board meetings to allow for sufficient time and consideration of these agenda items. • 360 Assurance were expecting to provide significant assurance on the BAF and the follow up elements of the Head of Internal Audit Opinion work. It was noted that there were a couple of medium risk actions from the financial sustainability report and they both had a due date of the 31st of March. • The final position for the whole year would be reflected within the revised interim Opinion. 360 Assurance were not yet able to provide an Opinion on the individual assignment outturn as they had not concluded sufficient work at this stage. It was noted that there were a couple of reviews that were at draft report stage, the General Ledger and Financial Reporting, and Transformation and Efficiency. Once these had been concluded, they would be reflected within the revised interim Opinion. **The Audit and Governance Committee:** • **APPROVED the draft 2023-26 Internal Audit Strategic Plan** • **NOTED the Internal Audit Progress Report; and** • **NOTED the Interim Head of Internal Audit Opinion – 1st July 2022 to 31st March 2023.**	
AG/2223/156	**External Audit** **Progress Report:** Andrew Cardoza introduced the KPMG progress report and highlighted the following: • KPMG had commenced planning for the 2022/23 external audit, including initial meetings with the finance team, to discuss current and emerging risks. A summary of KPMG's initial consideration of audit risks was provided on page 5 as draft. • KPMG would complete its detailed risk assessment procedures over the next few weeks and update the External Audit Plan if	

	there were any changes for presentation to the Committee at the 4 May 2023 meeting. • This report outlined KPMG's draft risk assessment and planned audit approach. At page 16 KPMG included its VFM risk assessment as required by the Code of Audit practice, which, at this stage, highlighted a potential significant risk of a weakness in the ICB's arrangements regarding medium term financial sustainability. • KPMG's audit plan incorporated key changes required because of changes to both International Auditing Standard (ISA) UK 315: Identifying and assessing the risks of material misstatement and ISA 240: The auditor's responsibilities relating to Fraud. Martin Ndoro highlighted the following: • KPMG had done an initial risk assessment and the audit risks had remained broadly the same as those previous audited for its predecessor CCG. • Two significant risks were brought to Committee's attention, namely Fraud Risk-Expenditure Recognition (detailed on page 6 of the report) and Management Override of Controls (detailed on page 7 of the report.) • There was one other audit risk: Regularity (detailed on page 9 of the report). • KPMG's planned responses to the above risks were also detailed in the report. The Chair referred to revenue recognition and reported that as well as the individual organisations targets, we now had System targets. We were managing the System position in terms of working together to get balance across the System, which was allowable now. It was noted that we had more flexibility for helping partners in the system. Andrew Cardoza reported that KPMG was aware that the ICB had that flexibility, and it was more about making sure that the money that was passed over to other partners was rightly spent in the right year for the right things. He added that in terms of helping other organisations, previously it had been very clear that the money had been spent in the year for things that the System was required to spend money on to improve the health and welfare of individuals across the region. He reported that he was able to take comfort from the information and evidence provided, but KPMG would always look at that in the round. **Value for Money:** Andrew Cardoza highlighted the following three areas that would be reviewed, 70% of the VFM work was this risk assessment: • Financial Sustainability • Governance	

	• Improving Economy, Efficiency, and Effectiveness (three E's) It was noted that there were no significant risks from KPMG's risk assessment of Governance and Improving Economy, Efficiency and Effectiveness. Regarding Financial Sustainability, one significant risk had been identified; this did not mean that it was a significant weakness. It was reported that KPMG had heard rumours that money would be pushed out into ICBs from the Centre. If this happened at a late stage then chaos would ensue, and KPMG as Auditors would be looking to see how the ICB would handle that; in the past the ICB and formerly CCG had handled this robustly and professionally. Andrew Cardoza highlighted the section of the report regarding KPMG's independence confirmation on page 28-29. This section disclosed matters relating to KPMG's independence and objectivity including integrity and objectivity of the audit engagement partner and audit staff. Andrew Cardoza highlighted KPMG's fees, there had been a decrease due to the tender from the previous year. It was, noted that the ICB would also have to pay for the 3-month CCG audit. Andrew Cardoza explained that this audit although called Value for Money (VFM), was essentially to check whether VFM arrangements were in place to deliver. KPMG were not making a judgement of whether the ICB were delivering value for money or delivering efficiencies, it was whether the ICB had arrangements in place to ensure financial sustainability. Whether the ICB had arrangements in place to ensure the right governance was in place to deliver the objectives that the ICB had, and whether the ICB had arrangements in place to deliver the efficiencies through the three 'E's' Richard Wright felt that this limited the value of the audit. The Chair reported that this audit was set nationally and as such was not something the ICB had a lot of choice over. She explained that was why we needed all the internal audit work which looked in more detail at some of these key areas to give us a more granular review. Andrew Cardoza reported that KPMG did review whether the ICB was a going concern. But unlike a private sector organisation, if it went out of business and the service was gone, a public sector service would continue under a new organisation and continue to deliver. KPMG would also look at cash flow that the ICB had for the next 18 months, but it would never be as rigorous as would be done for shareholders.	

	Audit and Governance Committee members approved the plan as it stood, noting the scope of the audit was out of our control and set nationally. The key was to try and make sure we got as much value out of it as we could. **The Audit and Governance Committee APPROVED the Draft External Audit Plan for the period ended 31st March 2023.**	
	FINANCE	
AG/2223/157	**M11 ICB Financial Position Review** Keith Griffiths reported that this paper presented the financial position of NHS Derby and Derbyshire ICB for period end 28th February 2023. It highlighted the key areas where we had particular I&E challenges, as well as summarising the efficiencies position for the ICB. It was noted that as of 28th February 2023, the ICB had reported a forecast surplus position in its return to NHS England, which was shown in the statutory duties table, the improvement of £5.4m in the position to £12.3m surplus was due to funding received from NHSE against the No Cheaper Stock Available (NCSO) prescribing costs. Forecasting a surplus result was in line with the road map agreed by the System to achieve the now improved £13.6m deficit. Work continued to address the underlying issues to achieve additional savings. The savings challenge required to meet the FOT position of £12.3m had decreased by £2.2m in month to £1.2m**.** There was a high level of confidence the savings challenge could be met within the ICB's final position. The mitigated FOT position of £12.3m, in table 3.1 helped to offset overspends within the System. **The Audit and Governance Committee NOTED the M11 ICB Financial Position.**	
AG/2223/158	**2023/24 ICB Financial Position** Keith Griffiths gave a verbal update regarding 2023-24 Financial Position and highlighted the following: • It was noted that the ICB had to submit flash reports weekly to show improvements in closing the gap. • The first flash report described a gap of £149.5m two weeks ago. • The flash report submitted on Monday reduced the gap to £98m. • Julian Kelly had a conversation yesterday with every FD across England and Wales (Provider FTs and ICBs). He talked generally about the national position, which he felt was not a	

	credible position to have for the NHS. He reflected on the fact that there should be no growth in the workforce next year and the funding that had gone in for this year was sufficient to normalise the capacity that we had last year, and we should not be going beyond that by going out to recruit more. • Julian Kelly had reported that there was probably only 25% of Trusts in England and Wales that had got a plan that he felt was credible, 75% by association had not. He went on to add that those that had a credible plan were going for at least 4- 5% CIP efficiency next year. Keith Griffiths reported that our plans had been predicated so far on 3%. • Alongside those reflections, he then went on to talk about our legal duty to deliver financial balance and if we were unable to do so, then the formalities around the regulatory regime may well be enacted. • Keith Griffiths reported that it had been a completely different tone from Julian Kelly than had previously been experienced. We could take from that, the gravitas, and the concern he had, and particularly where that left the central team in conversations with Treasury. • It was reported that the finance community currently met three times a week to get planned sign off. • At the planned finance meeting yesterday afternoon, DoFs had reflected on what they had heard from Julian Kelly. There had been a consensus on the back of yesterday's call that we would remove any growth in the workforce from our plans and we would consider the CIP position that we were using now. • We needed to sign up to something that we could deliver. Alongside that, we already had a list of other things that we were continuing to work through as a local finance community to improve the position. • The £98m submitted on Monday was not the end point, it was just the stage we had got to as of the end of last week. • It was noted that there were several other things that were being reviewed, for example, consistency of approach on things like inflation, plans across all organisations etc, to ensure we were all taking a similar line. • Regarding investments, it was noted that there were still some parts of the System that had costs built into their plans such as new investments over and above the workforce growth that were referenced before. • These were two key areas that we were continuing to work through, and obviously alongside the usual things, around understanding balance sheets and run rates and any other personal variations; personal in the sense that they were bespoke to each organisation. • It was important to recognise that over the next week we needed to get everything on the table and see what level of risk the System should take into next year. There would be some big challenges in delivering 4% (if that was where we end up) CIP efficiency. We needed to make sure that we could deliver what we commit to, rather than just come up with a plan that we know was a lost cause.	

	• Professional judgments and reflections needed to be made once we had done the analytical work described; this would continue next week. • Keith Griffiths reported on the appetite for the Statutory Bodies that were part of our System to sign up to these principles. It was noted that he had seen some reticence on an earlier call yesterday morning. (This had been before we had listened to the call with Julian Kelly). It had been reticence about the risk of sharing the £98m from one Chief Executive, with a clear message that that Board would probably be unlikely to be able to sign up to their share of the £98m. • It was unclear whether it was a comment from a moment in time, but nonetheless, we needed to respect what sits behind it, which was the challenge financially alongside the operation on quality and safety issues that we were all juggling with. • Keith Griffiths raised this point because he felt the concept was important around where we end up next week. We could not dictate what other Boards signed up to. He added that we may have a set of principles that we were all trying to work to, but Statutory Bodies had a right to go to their Boards and make a decision that they felt was right for them. Ideally, we wanted everybody to navigate to the same place, but the scale of this and the importance of it was exercising people well outside of finance community, and that was before we started looking at higher CIP and workforce growth. • Keith Griffiths was to meet with the FD's tomorrow afternoon to reflect on what had done since yesterday and would also be meeting again next week. • It was noted that an Extraordinary Board Meeting had been called for next week to hopefully sign off the final plans. • John MacDonald was looking to organise another meeting with Chairs, Chief Executives, and FD's next week, hopefully, to get agreement. • It was noted that Julian Kelly had reported yesterday that he was of the mindset, given the size of the gap, and the fact that 30th of March was only a week away, he would probably end up interpreting the plans as draft. He reported that if he was not happy, then there would be formal meetings of escalation with the Centre and engaging with Systems to get them to work differently to improve the position. • It was a balance of managing the financial challenges alongside the operational recovery. • The Chair realised that it was quite a fast-moving situation and that there was a lot of pressure on Keith Griffiths and the whole of the System to continue to move that trajectory downwards. • It was noted that there were some difficult decisions to be made along the way. The dialogue that was happening was positive, that there were arrangements in place to keep that dialogue going and to keep working on this until the end of the month, which was the deadline for getting the Plan in. • This update had given Committee an indication of the scale of the problem. It was noted that we had queried the growth in the workforce already, but it was whether we had got the right	

	workforce in the right place, and what we could do to encourage productivity increases, which presented individual organisations with huge challenges. • Keith Griffiths reported that he wanted to be reassured that DDICB was being judged on an equal footing with other ICBs; it was about fairness and equity and not about lack of ownership of the problem. • Keith Griffiths wanted to discuss this in more detail at the next Finance and Estates Committee. It was noted that he had opened discussions with region regarding our £3bn turnover as a System. Our allocation from the Centre was based on our population, which was £2bn, but half of our business sits across the boundary in another ICB (Burton and the two community hospitals in Stafford), we also had EMAS. When the statistics were pumped out from the national and regional team about deficit in relation to upper percentage of deficit, they used the allocation based on population as their denominator. It could be seen straight away that our deficit at £98m on £2bn was a bigger percentage of £98m on £3bn. Every time, regardless of what we do, we were going to be in the upper echelons of the poorest performing ICBs by virtue of that calculation. • There were other ICBs that had Provider hospitals across their borders, but Keith Griffiths did not know of any of the scale that we had here where 50% of our business sits in another geographical patch. • Keith Griffiths was trying to make sure that reputationally the Derbyshire System was given a fair hearing or packaged correctly on the national metrics. • It was noted that we needed to work with regional colleagues to understand the extent of that materiality. We were not running with a deficit that was 5% of our turnover, we were running with a deficit that was about 5% of our allocation, and those two things were materially different. • Keith Griffiths reported that he was starting to look at what we would have received if the calculation was based on what we were managing, as opposed to what our allocation was because of that boundary issue. This would have a real impact on our I&E position, both where we were now, in the past, and then unless the rules changed where we were likely to be in the future. • There was a connected issue around what they used as the criteria for demonstrating performance on CIP and for allocating money out. Keith Griffiths reported that it felt that we are being hampered on both fronts and therefore an unduly big financial challenge on our hands that we were trying to close, which was disproportionate to other Systems. • Keith Griffiths reported that he knew of a similar issue around the Black Country; but did not know the scale of it. There were also probably two ICBs in the Midlands, but he felt we may be the biggest in the country that had this proportion of business sitting outside our geographical patch. • Keith Griffiths reported that we needed to provide the financials to back this up and work was ongoing to do that. If this was	

	found to be correct, we needed to be clear about how we would like region to reflect on what was really going on in the Derby and Derbyshire System. It was noted that this would have a bearing on our System oversight position at Level 3, as all these things were connected and were all about reputation. • The Chair felt that this was a point well-made and was something to keep at the back of our minds so that we understand that context. • It was noted that convergence also needed to come into the equation. **The Audit and Governance Committee thanked Keith Griffiths for this update.**	
	GOVERNANCE	
AG/2223/159	**Update on Delegated Functions** Helen Dillistone reported that the papers regarding Delegated Functions, that Committee reviewed as its last meeting, went to the Public Board last Thursday; all of which were approved. The Chief Executive, Dr Chris Clayton, had signed the Joint Working Agreement, and this had now gone back to NHS England. Helen Dillistone reported that the Delegation Agreement, which was due for signature also (she understood), would have one or two minor changes made to it. **Audit and Governance Committee thanked Helen Dillistone for her update on Delegated Functions.**	
AG/2223/160	**Draft Annual Governance Statement** Suzanne Pickering reported that NHS England annual reporting guidance required Integrated Care Boards to prepare an Annual Report, Annual Governance Statement and Accounts in accordance with the NHS Act 2006 (as amended). The draft Annual Governance Statement covers the period 1st July 2022 to 31st March 2023. The draft Annual Governance Statement was found within the Accountability Report section of the Annual Report. It had been produced in accordance with the guidance and template as directed by NHS England. The Committee were asked to provide feedback and comments to the Corporate Governance Team via email. For assurance purposes, the interim Head of Internal Opinion had been received from our internal auditors and was uploaded to the NHS England Sharepoint ahead of the deadline of noon on the 10th March 2023.	All

	The deadline for the draft Annual Report to be submitted to NHS England and our External Auditors was by 9am on the 27th April 2023. The Chair referred to the Quality and Performance section, under the part regarding maternity, there had been no mention of the maternal deaths reported at Board last week. Suzanne Pickering agreed to include these in the Annual Report. The Chair then referred to the limited draft report on Transformation and Efficiency, and asked when we came to finalise this, she felt it would be beneficial to have a short paragraph/comment about the limited assurance report and how it was being dealt with. **The Audit and Governance Committee:** • **RECEIVED the initial draft of the NHS Derby and Derbyshire ICB Annual Governance Statement; and** • **AGREED to provide comments and feedback to the Corporate Governance Team via email.**	SP SP
AG/2223/161	**ICB Risk Register Report** Chrissy Tucker reported that as at 28th February 2023, the Audit and Governance Committee were responsible for five ICB Corporate risks, 3 of which were scored high: **Risk 11:** *If the CCG 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* **Update:** • MOU Funding commitments approved at the ICS Greener Group Feb 2023. • Liftshare Scheme Project underway and Proposed launch in Quarter 1 2023/24. Air Quality Project with two Derbyshire schools is in process. • ICS Dashboard was in development • Q4 - January Highlight Reports had been reported to NHSE. • SRO Review Meeting with NHSE took place on 1st March 2023. • The current risk score was reasonable. This could not be reduced until the ICS started to achieve its targets through the action plan for 2022-23. • The risk did not require an escalation in risk score. **Risk 15:** *The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI*	

Update:

- Meetings were taking place to discuss how ICB's in the region would work with the host ICB and this would help clarify the role of each individual ICB and the resource required to fulfil our obligations.
- Risk score to remain unchanged.

Risk 16:
Risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.

Update:

- Continued promotion of wellbeing offers and access to our employee assistance provider - Confidential Care.
- Sickness absence levels had reduced in January.
- Risk score to remain unchanged.

The following risk score decrease was approved virtually and was detailed for ratification. The virtual approval process was conducted in order to enable the risk to be included in the ICB Board risk report for the 16 March 2023 meeting.

Risk 05:
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.

Update:

- The recruitment process continued for the Band 7 EPRR Manager post.
- Further plans continued to be signed off with IRP, Adverse Weather now completed, and Business Continuity was ready for submission at the Audit and Governance Committee and the emerging infectious disease group would commence in March 2023.
- System planning was now in place to commence in March also in relation to mass casualty, evacuation, and shelter.
- Further reduction in risk score impact recommended due to the plans and processes outlined.

The risk score was recommended to be decreased from a high score of 8 (probability 2 x impact 4) to a moderate score of 6 (probability 2 x impact 3).

Risk 07 Safe Storage of Staff Files

It was noted that this was currently scored at a 6, and there was no proposed change to this score this month.

	Richard Wright referred to the Climate Change Risk, he reported that there were huge risks here and he felt that the ICB had a lot of work to do to mitigate this risk. Helen Dillistone agreed that the size of the challenge was immense; the biggest gains by far would be through our Providers regarding their estate and use of various aesthetic gases. It was noted that the ICB's carbon footprint was quite tiny in comparison. The Chair highlighted the fact that this report still referred to itself as the CCG rather than the ICB. Chrissy Tucker agreed to correct this. The Chair referred to Risk 16: impact of running cost reductions. She felt we needed to be mindful of this on staff morale and the uncertainty it could create. It was noted that we may need to increase the score of this Risk until we were able to provide some more reassurance as to how this was going to be managed. Helen Dillistone reported that staff were clearly aware of the challenge that ICBs had going into 2024-25 and 2025-26 and the planning that would take place this coming year. Helen Dillistone agreed to review the scoring 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 05 relating to the ICB sufficiently resourcing EPRR and Business Continuity functions and strengthening emergency preparedness policies and processes, as a Category 1 Responder** • **NOTED Appendix 2 which detailed the full ICB Corporate Risk Register as reported to the ICB Board on the 16th March 2023.**	CT HD/SP
AG/2223/162	**Counter Fraud Progress Report and DDICB Risk Assessment** Joanna Clarke presented the Counter Fraud Progress Report and highlighted the following: • Component 10 Undertake Detection Activity (amber score): It was noted that 360 Assurance were undertaking a conflicts of interest review, it was hoped that this would be completed and moved to agreeing prior to the submission's deadline at the end of May. It was noted that we were on target for a full green for submissions this year. • It was noted that the comparative referrals report had been attached to the report. • This report would go into 360 Assurance's planning process for next year and the risks that had been identified across the whole of the comparative piece of work would be added onto the risk work for next year.	

	• It was noted that the full detailed risk assessment document had been shared for information, which the Chair had found very helpful. It was noted that we now had sight of the full risk assessment spreadsheet and the discussion about how that was managed, which had provided a good picture. It was noted that a lot of the fraud risks, whilst important and needed to be managed, did not cross the threshold to get into our wider risk register as they were scored differently. • Richard Wright reported that no referrals was actually bad news. Joanna Clarke reported that CFMG had been trying to address this nationally as to why people were not reporting fraud like they had in previous years. Richard Wright reported that we wanted people to feel comfortable raising concerns to Counter Fraud. It was noted that there was a lot to do regarding fraud awareness work for next year. **The Audit and Governance Committee:** • **NOTED the key messages and progress made against the Counter Fraud Plan.** • **RECEIVED the information contained within this paper and supporting Appendices' and gained assurance that sufficient controls and management mechanisms were in place within the ICB to mitigate fraud, bribery, and corruption risks.** • **SUPPORTED the work of 360 Assurance by challenging ICB officers to ensure that identified risks and system weaknesses were adequately mitigated in line with recommendations made by 360 Assurance and/or the NHS Counter Fraud Authority (NHSCFA).**	
AG/2223/163	**Health and Safety Report** Suzanne Pickering presented the Health and Safety Report. It was noted that under the Workplace (Health, Safety and Welfare) Regulations 1992 the ICB has a legal duty to ensure, so far as reasonably practicable, the health, safety, and welfare at work of its employees. The Management of Health and Safety at Work Regulations 1999 (The Management Regulations) requires the ICB to assess and control risks to protect its employees. 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 as a consequence of moving to a hybrid model. Suzanne Pickering reported that our first Health and Safety audit would be held at Scarsdale tomorrow, which would inform the action plan. This would then be reported to Audit and Governance	

	Committee and then across the three sites eg Cardinal Square, Scarsdale and Ilkeston Health Centre. **The Audit and Governance Committee NOTED the Health and Safety Report.**	
AG/2223/164	**Internal Audit Recommendations Report** Suzanne Pickering reported that as part of Public Sector Internal Audit Standards, Internal Audit were required to consider the appropriateness of the organisation's response to internal audit recommendations and actions subsequently agreed. As part of an established process, 360 Assurance regularly liaises with nominated officers within the organisation in relation to actions due using an online tracker. The Internal Audit Recommendations Tracker detailed the recommendations required from the outcome of the individual audit reports. Responsible leads were required to upload evidence to demonstrate the completion of the required recommendations and actions. The online tracker also identified those that were outstanding, and the Corporate Delivery Team were required to monitor and request updates on these to ensure that the ICB meets its aim of a 100% completion on all actions. This percentage was a key area of the Head of Internal Audit Opinion. It was noted that failure to implement robust arrangements for the recommendations made by 360 Assurance may lead the organisation open to further challenge and risk. Richard Wright referred to Assurance Audit Tracker and asked whether we had the Terms of Reference (TOR) right for the People and Culture Committee reflecting some of the issues that we were exposing regarding workforce, plans and forward views? Suzanne Pickering reported that as part of governance arrangements, we would be reviewing all TORs to ensure roles and responsibilities were reflected correctly. Kevin Watkins reported that 360 Assurance were carrying out a committee effectiveness review, which was due to commence soon. This would focus on the five System wide committees, and it was noted that Helen Dillistone and he would be meeting tomorrow to discuss the Terms of Reference for that in more detail. Kevin Watkins reported that there would be an opportunity to have reflections and discussions with each of the Chairs of the Committees. **The Audit and Governance Committee REVIEWED and NOTED the Internal Audit Recommendations Tracker.**	

AG/2223/165	**Mandatory Statutory Training Report** Chrissy Tucker reported that the purpose of this paper was to provide assurance to the Audit and Governance Committee of the ICB's compliance regarding mandatory training. ICB employees were expected to complete mandatory training through the ICB's electronic staff record. The areas of training listed below are key to an employee's role, create a safe working environment and ensure effective service delivery. Compliance levels as at the 14 March 2023 were presented in the report. There were currently no concerns regarding compliance with training, which continued to be encouraged through line managers, our appraisal processes and reminders generated by our online system. It was noted, however, that the Managing Conflicts of Interest Training was no longer included within the table in the report, as this has been removed from the online training system. The training was retired by NHSE on the 23 December 2022. This decision was made following engagement with designate ICB Chairs, who agreed that the NHSE Conflicts of Interest guidance would not be replicated for ICBs. The ICB would continue to have a Managing Conflicts of Interest Policy in place and expect ICB employees to adhere to this. The Chair referred to Safeguarding Adults Level 2 and 3 training (it was noted that this tended to be for clinically based members of staff) but had indicated a level of 60% compliance level. She asked whether this was an issue or a timing thing? Chrissy Tucker reported that it was not an issue and only affected 2-3 members of staff. It was noted that it may be helpful going forwards that this report indicated the number of staff that were required to undertake each training module. **The Audit and Governance Committee RECEIVED the Mandatory Training Compliance Report.**	
AG2223/166	**Conflicts of Interest Report (COI)** Chrissy Tucker presented the COI report which summarised the activity that the ICB had undertaken since December 2022 to fulfil its obligations regarding managing its conflicts of interest. It was noted that following the dissolution of CCGs, the online training module for staff on Conflicts of Interest was retired by NHSE on the 23rd December 2022. This decision was made following engagement with designate ICB Chairs, who agreed that the NHSE Conflicts of Interest guidance would not be replicated for ICBs. The ICB would continue to have a Managing Conflicts of Interest Policy in place and expect ICB employees to adhere to this.	

	It was noted that Conflicts of Interest awareness for all employees was a key part of the conflicts of interest forward planner. **The Audit and Governance Committee NOTED and RECEIVED assurance from the Conflicts of Interest Report.**	
AG2223/167	**EPRR and Business Continuity Update** Richard Heaton provided an update to Committee on the progress of the Integrated Care Board (ICB) in relation to Emergency Preparedness, Resilience and Response and Business Continuity processes internally and for the system. It was noted that the primary purpose of the report was to seek approval of the Business Continuity Plan, the Business Continuity Management System which sits separate to the Business Continuity Plan. **Industrial Action**: It was noted that Junior Doctors had announced a 96-hour walkout over the period 11-14 April. Other disputes had been suspended or were on hold pending unions going out to members with an offer from the Government. **Business Continuity:** Business Continuity was a key part of preparedness for the ICB in relation to any incidents that it may face internally and was a key part of the ICBs own EPRR core standards return. The team had reviewed the standing arrangements and had generated the ICB Business Continuity Plan (Appendix 1) and the Business Continuity Management System (Appendix 2) which detailed the planning arrangements and process for ensuring compliance against ISO 22301, but also the response arrangements for the variety of threats that could cause a business continuity incident to affect the ICB. **EPRR Core Standards reassessment for 2022/23:** Since the previous report the Head of EPRR had met with providers to reassess against the work plan progress of the core standards open actions since the 2022/23 submission. The update/closure percentages for each organisation were indicated in the report. It was noted that the percentage completion was lower than anticipated. Several causes were generating this lower attainment against these targets: • EPRR teams were all involved in industrial action preparedness and response. • Several actions required System planning support eg Mass Casualty, this was being managed through LHRP with several systems working groups commencing in March 2023.	

	• A number of organisations were having changes to their EPRR teams leading to the requirement to employ or re-employ to posts. **Training** was a key element of EPRR and the ICB had a duty to ensure that staff were appropriately trained, this covered the below key staff as a minimum: • ICB Chief Executive and Deputy • ICB AEO and Deputy • ICB Strategic Commanders (2nd on call) • ICB Tactical Commanders (1st on call) • ICB Incident Manager (OCC Commander) • Loggists • Support roles to the Incident Management Team (IMT) The Head of EPRR had ensured a training programme was available to ensure compliance against this standard. In addition, the roles in command-and-control (Strategic Commander, Tactical Commander, and Incident Manager) were expected to complete an annual PDP, this would capture the learning against the national occupational standards for EPRR. **Major Incident Response:** The ICB was part of the response with System partners to a Major Incident in Derbyshire on 10th March 2023 for the heavy snowfall that was experienced. Richard Wright referred to the recent industrial action by some of our partners (eg Civil Service/Local Government) and asked whether this had affected the NHS. Richard Heaton reported that the recent teachers strike had impacted people's ability to provide childcare and as a result had affected our employees being able to attend work. The Chair felt this report had reflected the development that had gone on within the ICB since we had picked up our Category 1 responder role; she felt this had been well reflected in the documents attached to this report. **The Audit and Governance Committee NOTED the EPRR and Business Continuity Update and APPROVED the Business Continuity Plan and Business Continuity Management System.**	
AG/2223/168	**Equality Delivery System 2022/23** Claire Haynes presented the Equality Delivery System 2022-23 report and highlighted the following: • It was noted that every year we were asked to undergo and complete a report, as part of the Public Sector Equality Duty, on how we considered equality as an organisation.	

	• The pandemic had brought about some changes in this area and had led to a review of how we were delivering the Equality Delivery System and looking at the changes in the NHS with the Integrated Care Systems. • There had been a pilot programme to look at System approach rather than organisationally based. This was just for Domain 1 which was patients and the public. This year we had not been required to deliver on elements 2 and 3, which were much more functional management system areas. • The paper outlined our process. Claire Haynes had led a programme of work to collate all the information from our Providers and we had held a joint scoring programme. • Organisations invited were detailed within the report; the event had been a positive experience and good feedback was received from the Providers. • Actions for next year included improving our relationships with the community. We had a lot less involvement from non-members of staff than we had expected. It was noted that colleagues in the Voluntary and Community Sector had been busy doing other work. • We needed to spend the next year developing relationships, which we were very keen to do as a System and spread that work and ensure that people understood what we were doing. • It was noted that we were keen to work with DCHS, who had been very integral in the pilot programme and had been very involved in the development of the piece of work going forward. • It was hoped to hold a learning session with DCHS. • Claire Haynes was looking forward to next year when we had two areas of work that we needed to reference per provider plus a third one that was system wide. Richard Wright reported that he was pleased to see that we were becoming more proactive. He had noted that some Trusts were doing better than others. He added that we were getting to the point where everybody across the System had started to value diversity; this, he felt, was a massive cultural shift. **The Audit and Governance Committee NOTED the Equality Delivery System update for 2022/23.**	
AG/2223/169	**Procurement Highlight Report** Craig Stephens presented a highlight report which provided a monthly overview of the status of each project from the workplan and their progress to date. Key factors considered included the undertaking of a due process, that was compliant under the regulations and ensured contracts were renewed/in place for contract commencement date. Craig Stephens highlighted the following:	

	• The report was in two parts; the first part being the highlight report and the second part being the expansion of pipeline projects to include contracts coming up for expiry. • The highlight part of the report (as at February 2023) focused on the following: **Minor Eye Conditions Service**: the amber rating in compliance was due to ongoing discussions around value and the legislation that applied to that value. The value had since been confirmed as £418k and the ICB had produced a report to evidence compliance with the PPCC had been attached to the STW that would go through the appropriate governance process. For the March highlight report this had now turned to green as we were confident this would comply with legislation. **Triage Service:** the amber rating in compliance was due to ongoing discussions regarding value. The Commissioner had confirmed the spend figure for next 12 months was £736k and therefore exceeded the PCR threshold. Procurement had advised regarding the need to comply with Reg.32. When evidence of perceived compliance was provided, the RAG rating would be changed to green. **Smart Messaging Service:** the red rating in contracting was due to the contract having expired. The procurement process had been completed and was in the process of award. The contract was currently being submitted for signature, and once this was in place it would move to green. **Clinical Advice & Guidance (currently provided by Consultant Connect):** the amber rating in compliance was due to the existing contract having to be extended to facilitate a procurement process. That extension had not been built into the existing contract but was needed due to delays encountered including the need to undertake the procurement process itself. It was noted that there was a risk of challenge by providers as this market was quite litigious. **Living Well Derbyshire:** the amber rating in contracting was due to the unknown contract start date. This was because the provider had experienced significant unforeseen staffing issues during their mobilisation phase. The Commissioner was working with the provider to overcome those issues and agree a new service start date. Once that was agreed that would change the rating to green – discussions were ongoing. **ImpACT+:** There were several issues here and the red rating for process was because no procurement process had been undertaken or was currently planned within the next 12 months. The amber rating for contract was due to the contract expiring on 31st March. Craig Stephens had recently met with the Commissioner and Contracting, and they had confirmed that it was in the process of being renewed and the contract would be in place for 1st of April. This therefore would move to green rating going forwards. The red rating for compliance was due to a breach of regulations including the extension from the 1st April onwards. When Craig Stephens met with the Commissioner, they had confirmed that the service had been hit heavily by	

	Covid which had resulted in a lack of sufficient data to help refine the model, and that was to get them to a place where they could undertake a procurement. Therefore a 12-month extension had been requested to support the redesign work of these services and no further procurement support was required at this time. Whether that redesign was achievable within the 12-month period was unknown. The Chair felt this was quite a concern and asked whether it was a significant value? She then asked whether this was going to committee for sign off? Craig Stephens reported that it would go through the normal governance process as it was over the threshold; the threshold being £663k. It was noted that Craig Stephens had been informed by Contracting that this was currently going through Governance for approval. The Chair asked Chrissy Tucker to pick this issue up outside of this meeting with Craig Stephens and Contracting to find out the exact position. It was noted that we did not have a Strategic Commissioning Committee meeting before the end of this month for them to review this contract. **Occupational Therapies:** the red rating for process was because the procurement had not been undertaken. The red for compliance was because the process had not been undertaken. The Commissioners had confirmed they were proceeding at risk. **GP Streaming**: the red rating for contract was due to the contract having expired in June 2021. However, we had acknowledged this was being varied into the Acute Contract. The Commissioner had since confirmed that Executives had agreed last week that the funding would now sit within the Acutes, and this was now being actioned as a contract variation and would be amended to a green rag rating and removed to the completed section of the report. Richard Wright reported that at the end of the month the ICB was to take on responsibility from NHSEI for Pharmacy, Ophthalmology and Dental and asked whether there was any procurement required for this? Darran Green reported that technically the contracts were still being held by NHSEI and they were delegating the responsibility of the management of the contracts to us. The contracts would still be held by NHSEI and negotiated nationally. The Chair thanked Craig Stephens for his detailed report. Chrissy Tucker reported that Craig Stephens had been doing some work with the Contracting Commissioning Teams and he now had access to the contract registers that we hold together with the contract expiry tracker.	CT

	The Audit and Governance Committee: • **NOTED the highlight report for Derby and Derbyshire ICB.** • **NOTED the status of projects – future projects, in-progress and completed.** • **REVIEWED key issues and activities over the current period.**	
FOR INFORMATION		
AG/2223/170	**Non-Clinical Adverse Incidents** Chrissy Tucker reported that there had been no non-clinical adverse incidents. **Audit and Governance Committee thanked Chrissy Tucker for this update.**	
MINUTES AND MATTERS ARISING		
AG/2223/171	**Minutes from the Audit and Governance Committee Meeting held on 9 February 2023** Usman Niazi referred to the section re Changes to the 2022-23 Internal Audit Plan, and requested that Page 8, second bullet point of the minutes re PPV be amended to read: *"It was noted that the aim of the PPV work was to provide a report to the ICB of practices that had either over or under claimed during the first two quarters of the current financial year".* **The minutes from the meeting held on 9 February 2023 were agreed as a true and accurate record, subject to the above amendment, of the meeting.**	
AG/2223/172	**Action Log from the Audit Committee meeting held on 9 February 2023** The action log was reviewed and updated during the meeting.	
CLOSING ITEMS		
AG/2223/173	**Forward Planner** Helen Dillistone reported that we needed to schedule in further discussions around the Strategic Risks. The Audit and Governance Committee ACCEPTED the Forward Planner.	SP
AG/2223/174	**Any Other Business** **Quarter 3 Oversight Framework Letter** Helen Dillistone asked Audit and Governance Committee to note the letter and highlighted the following:	

	• This review was undertaken quarterly. This letter related to Quarter 3 position of the ICS and the individual organisations. • As part of that, the ICB was required to assess based on the data and information that we had available to us, the various national oversight framework segment levels, and make a recommendation to NHSE on those. • This was governed through Quality and Performance Committee as most of the issues related to performance. • The letter was here for noting and oversight. • We were now in the process of working through Quarter 4; Quarter 3 had been delayed by NHSE because of the volume of critical incidents underway during the Christmas period. • The Quarter 4 letter would be brought back to this Committee to note any changes. • In terms of our own System assurance, we had a monthly NHS Executive Meeting, where all the Chief Executives of each of the organisations plus ICB Executives and SROs across the System met. It was noted that this meeting also had oversight of this letter. • Richard Wright reported that he was surprised by the section in the letter regarding emerging concerns about UHDB maternity services; they were hardly emerging. • Helen Dillistone reported that the letter had been written at a point in time, so was misleading because the information that drove this letter went back to October/November; it was not only really late but also out of date. **The Audit and Governance Committee NOTED the Q3 Oversight Framework letter.** There was no further business.	
AG/2223/175	**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.** • Were papers that have already been reported on at another committee presented to you in a summary form? **Yes**. • 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.**	

DATE AND TIME OF NEXT MEETING
Date: Thursday 4 May 2023
Time: 2.00PM
Venue: MS Teams

Signed: …… Dated: ……..
(Chair)

MINUTES OF THE AUDIT AND GOVERNANCE COMMITTEE

HELD ON 4 MAY 2023 VIA MS TEAMS AT 2.00PM

Present:		
Sue Sunderland	SS	Non-Executive Director/Audit Chair
Richard Wright	RW	Non-Executive Director
In Attendance:		
Andrew Cardoza	AC	Audit Director, KPMG
Liam Daley	LD	Finance Manager
Helen Dillistone	HD	Executive Director of Corporate Affairs
Debbie Donaldson	DD	EA to Chief Finance Officer (note taker)
Darran Green	DG	Acting Operational Director of Finance
Keith Griffiths	KG	Chief Finance Officer
Donna Johnson	DJ	Acting Assistant Chief Finance Officer
James Lunn	JL	Head of Human Resources and Organisational Development
Martin Ndoro	MN	Audit Manager, KPMG
Usman Niazi	UN	Client Manager, 360 Assurance
Frances Palmer	FP	Corporate Governance Manager
Suzanne Pickering	SP	Head of Governance
Kevin Watkins	KW	Business Associate, 360 Assurance
Apologies:		
Chrissy Tucker	CT	Director of Corporate Delivery

Item No.	Item	Action
AG/2324/176	**Welcome, introductions and apologies** Sue Sunderland as Chair welcomed all members to the meeting. Apologies were received from Chrissy Tucker.	
AG/2324/177	**Confirmation of quoracy** The Chair declared the meeting quorate.	
AG/2324/178	**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.	

FOR DECISION		
AG/2324/179	**Draft ICB Annual Report and Annual Accounts – 1 July 2022-31 March 2023** The NHSE Annual Reporting Guidance required ICBs to prepare Annual Accounts and an Annual Report in accordance with the NHS Act 2006 (as amended). The draft Annual Accounts and Annual Report cover Quarters 2-4 of the 2022/23 financial year. **Annual Accounts** The ICB submitted its Annual Accounts to NHSE within the agreed timescales. These were reviewed in detail by Donna Johnson, Acting Assistant CFO and Darran Green, Operational Director of Finance, and subsequently signed off by Keith Griffiths, Executive Director of Finance. The presentation included as part of this paper highlighted the key elements of the ICB's Annual Accounts to the Committee. Alongside this were the detailed updates to the accounting policies for both the CCG and ICB, following the final release of the 'parent's' policies by NHSE. Donna Johnson reported that a detailed analytical review had been carried out to explain the key movements in the position from the prior year. She explained that because the ICB accounts were just a short period of 9 months, that she had tried to help committee members to understand the numbers, by providing in grey alongside the prior years or the 21/22 numbers, and then the annual result for 22/23 (the CCG and ICB numbers together). It was noted that the accounts, analytical review, and associated documents were all submitted to NHSE by the agreed timelines. **Accounting policies** Donna Johnson highlighted the following: • **Going concern** – It was noted that there had been a slight updating of the wording around the Health and Social Care Bill, more specifically regarding the cessation of the CCG. Both the CCG and ICB continued to be considered a going concern on the basis that the function of the ICB must continue as a public sector organisation for the next 12 months. The Chair explained that the ICB was a public sector body, and even if the ICB as an organisation were to be dissolved, the functions would continue to be picked up by another body. She added that whilst the ICB still had a financial deficit, we were planning (in terms of our 5-year plan) on how that would be addressed, and how we could get to a point of being financially sustainable. It was noted that all our financial plans were agreed/signed off by region and nationally. Members were happy on that basis to approve that the ICB was a going concern for the next 12 months.	

- **Grants payable** – this policy had previously removed but was now reinstated as the ICB had paid grant monies over to organisations during the ICB's 9 months. This policy stated that grants were recognised when paid.
- **Leases** – The context had not particularly changed. But the introduction of the policy and the expedients followed had been moved to the 'Adoption of New Standards Policy'. The new paragraphs had focused more on recognition and measurement, which aligned to the Property, Plant and Equipment policies. The changing of the policy had not impacted the way the assets and leases were calculated.
- **Adoption of New Standards** – this impacted the CCG only. This incorporated some of the previous leases policy, but also now demonstrated the impact of IFRS16. Which was quite minimal for an organisation of this size.
- **Accounting Standards not yet adopted** – introduction of IFRS 14, which did not apply to the ICB but was disclosed for completeness.

Note 23 – Financial Performance

The ICB reported a £15m deficit for 2022/23. This was a movement from the expected position and was discussed at Board yesterday. Whilst this was a breach of our statutory financial duties, this had been discussed and agreed with NHSE.

It was noted that our ring-fenced revenue did not exceed ring fenced allocations. Running cost expenditure did not exceed our running cost allocation.

Donna Johnson reported that the ICB directions were issued after submission, and some of these disclosures may change for the final draft. It was noted that we had received a specific direction surrounding the ring-fenced pay award, which may need to be disclosed in the Accounts.

BPPC

Due to the Financial Control Teams continued efforts and hard work, we had once again far surpassed the BPPC target to pay 95% invoices within 30 days of receipt. Over 99% of both Non-NHS and NHS invoices were paid within 30 days of receipt by the team.

SoCNE

Details were provided under Notes 2, 4 and 5.

Note 2 – Income

1. Education – had increased by £900k. The ICB had taken on System Transformation Programme responsibilities. This was income from Health Education England for workforce development across the System.

2. Non-patient care – had decreased by £1.2m, this was a re-categorisation in the ICB relating to capital recharges from NHSE, that had now been included as Other Contract income
3. Other Contract income – an increase of £3.3m, which included the recategorization of £1.6m:
   - £0.9m balance transferred from DHcFT for outstanding STP projects linked with health education.
   - £0.5m of NECS transformation funds.
   - £0.3m Crisis Alternative support from Derbyshire Police and Crime Commissioner.

Note 4 Employee Benefits

Permanent Staff costs and staff numbers had both increased in the year:

1. Permanent staff numbers had increased reflecting the increased staffing TUPE'd into the ICB.
2. Other staff numbers had decreased in contrast to the increase in expenditure. However, there had been several secondments into the organisation this year, which included prominent figures such as the Chief People Officer and Chief Information Officer.
3. Termination benefits – one case had been provided for in the CCG. This had not been disclosed in the ICB's exit packages as it had already been disclosed in the CCG Accounts.

Note 5 – Operating expenses

FTs – increase of £86m:

- Acute block contracts had increased by £36m.
- £29m Elective recovery fund payments.
- £37m NR allocations for cancer, virtual wards, CDC, and discharge funding.
- (£39m) reduced covid funding.
- £21.6m impact of Glossop patients.

1. Purchase of Non-NHS Healthcare – an increase of £21m:
   a. £11.8m CHC costs due to increased unit costs and caseload, including the length of stay on certain packages and fast track.
   b. £7m ophthalmology clearing waiting list backlogs and increased patient choice.
   c. £3.3m similarly independent sector clearing waiting lists and patient choice.
   d. £1.8m increase in 111 call services.
   e. (£2.5m) reduced covid funding.
2. Purchase of Social Care – a decrease of £6.5m:
   a. 21/22 saw a £10m non-recurrent contribution to Derbyshire County BCF due to the change in BCF agreement.
   b. In 22/23, there has been an increase in BCF spend as a result of national Adult Social Care Discharge funds - £1m for Derby City and £3m for Derbyshire County.

3. Prescribing costs – an increase of £17.4m:
    a. £7.9m due to volumes coupled with huge price cost pressures.
    b. £1.2m increase in the category M drug tariff from Jan 23.
    c. £4.6m of Glossop patient costs.
    d. £3.7m DOAC – previously recharged, but now we received resource rather than income, hence expenditure increase.
4. GPMS etc – increased by £10.4m:
    a. £6.5m due to 3% increase in rate per weighted population as per national GP contract
    b. £4.0m for Additional Roles Reimbursement Scheme due to increased funding in 22/23:
5. Supplies and Services – increased by £1.4m
    a. £2.2m Community due to the development and increase in activity of Ageing Well and long Covid service
    b. The ICB was now a System hub; we now had the spend associated with the HEE funding as seen in the change in income £1.7m
    c. Offset by a:
        i. £1.2m reduction in NHS 111 due to 21/22 allocations received on behalf of East Midlands commissioning
        ii. £0.5m transition preparation costs in 21/22
        iii. £0.5m reduction in long-term conditions
6. Premises – an increase of £1.0m:
    a. In the main this related to the Primary Care hub transferred over to the ICB from Glossop.
7. Other Professional Fees – had increased by 1/3:
    a. Small number, but was in relation to ICB set-up costs

Operating Expenses – 2

It was noted that these were all small numbers.

Statement of Financial Position

Note 8 Transfer by Absorption

As a new organisation, the ICB had the CCG's closing balances transferred to it, and these were recognised through a 'Transfer by Absorption'.

Donna Johnson highlighted the following:

- The right-hand side of the slide represented each of those closing balances from the CCG. Each of these balances would be seen as we moved through the notes supporting the SOFP.
- The middle column was NHSE balances transferred to the ICB. This was in relation to 'PUPoC' (Previously Unassessed Periods of Care) up to 31st March 2013. Claims had been closed, and paid over several years, and so at this stage, NHSE transferred the estimated closing balance for expected claims.

Note 9 PPE

An addition of £90k of corporate IT equipment related to the purchase of laptops and accessories. Note 9 also showed the balances transferred from the CCG.

Note 10 Leases

1) Right of Use Asset Note:
   a. Balances transferred from the CCG – in relation to our HQ buildings
   b. There had been a lease modification as part of the ICB, due to giving notice on the East Wing of Cardinal Square and departing end of May 2023. Therefore, we had formally changed the lease term and hence the value of the asset.
2) Lease liability note:
   a. As noted on the previous slide we had a modification due to giving notice on the lease, and the transfer from the CCG
   b. Other smaller movements were interest, remeasurement for a review of the liability, and cash repayments of the liability during the period.
   c. The note at the bottom of the slide splits the maturity of the liability between one year and over one year. Alongside detailing where leases were owed to the DHSC group.

Note 11 Trade and other receivables

It was noted that this slide had been changed slightly from the version issued in the agenda pack. This was to incorporate a prior year comparator (as M12 v M12 was a better comparison because of the year end processes followed nationally).

Donna Johnson explained that there were three columns – the ICB's closing balance, the balance transferred from the CCG, and then the closing balances at 31st March 2022 for comparison.

Trade and other receivables had increased by £2.5m overall:

1. NHS Receivables – an increase of £630k:
   a. Increase in invoices raised in March 23 to NHSE of £1.3m for Primary Care capital charges and prescribing.
   b. 21/22 saw a one-off invoice of £500k to CRH for MSK Digital Innovation Project (late capital allocation), and an invoice to DCHS for covid recharge, which were not required in 22/23.
2. Non-NHS Receivables increase of £960k:
   a. Mainly related to an £868k invoice to DCoC for Adult Care
   b. £94k invoice to HEE
3. Non-NHS prepayments increased by £300k:
   a. Generally relating to premises charges for Primary Care and corporate.

Note 13 – Trade and other payables

Overall, trade payables had increased by £21m, which represented a 21% increase on prior year compared with an 6.3% increase in our expenditure.

1) NHS revenue payables increased by £9.8m variance:
   a. Mainly related to invoices issued by UHDB and CRH totalling £12m. This related to hospital discharge and other cost pressures faced by the Acutes during 22/23.
   b. Offset by the fact the 21/22 had some larger invoices, one being for £1m from CRH.
2) NHS accruals increased by £3.2m relating to non-recurrent items:
   a. £576k for 78wk wait to 6-week challenge for UHDB.
   b. £660k revenue support for cost of capital.
   c. £196k to Tameside & Glossop Primary Care hub.
   d. £500k grant monies to be returned to NHSE.
   e. £689k to for missing invoices from UHDB.
   f. £542k for growth to Stockport and South Yorkshire Trusts.
3) Non-NHS payables decreased by £3.7m:
   a. There was cash availability at the end of the year, therefore Council invoices were paid, whereas in 21/22 these were outstanding for £2.5m and £1m.
4) Non-NHS accruals increased by £7.7m:
   a. £1.3m increase for Home Oxygen.
   b. £2.9m increase for prescribing.
   c. £0.7m for s117s, reflecting the increased activity in year.
   d. £0.4m for claims practices are eligible to make for the last 6 years against funding received.
   e. £0.3m for orthotic backlog payments.
   f. £0.5m for IS activity, reflecting the clearing of waiting lists and patient choice.
   g. £0.8m increase in CHC Fast Track caseload.
5) Other payables increased by £4.1m:
   a. £1.0m internal pay award relating to 2022/23.
   b. £0.4m increase in QOF *(*Quality & Outcomes Framework*)* accruals.
   c. £1.5m increase in Investment and Impact Fund (incentive to support PCNs in delivering quality care) accruals.
   d. £1.0m for Covid therapeutics in 2022/23.

Note 14 – Provisions

Donna Johnson reported that this slide was how the note was presented in the Annual Accounts. It was noted that we could clearly see the transfer by absorption balances coming into this note from the CCG.

The key movements of this note were detailed below:

	1) Redundancy – one colleague had received a redundancy payment in early January 2023, fully utilised. 2) Legal – this was one claim, which the Committee were made aware of in November 2022. The case had now been settled and so was now fully utilised. 3) CHC – related to retrospective claims. Some cases had closed resulting in utilisation and reversal, with further claims in year increasing the provision. 4) Dilapidation – small unwinding in calculating the present value of money. 5) Estates and Technology Transformation, and Digital Transformation - had all been made in relation to legal obligations but had been largely delayed. These had been reviewed against updated data and forecasts and remeasured where deemed appropriate by the relevant team. 6) Primary Care Network roles and Acute Services Improvement Post provisions – these were legal obligations, which had been largely delayed, but would no longer be committed. Fully reversed. 7) Corporate Education – continued pressures left a backlog of training needs, and therefore this provision remained. 8) EMAS Pension shortfall – no longer deemed a liability and had been fully reversed during the period. 9) Minor surgery backlog – some clearing of backlog was demonstrated during the period, and therefore utilised. A reassessment of the need resulted in £600k being reversed. 10) Acute IS waiting list – as seen in previous areas of the Accounts, there had been an increase in the IS to clear patient waiting lists, and through patient choice. Therefore, the provision had been fully utilised during the period. 11) EMAS PTS – new provision in the year. The contract with NEPTS was uplifted to secure an additional 3 vehicles. The leases of these vehicles run beyond the healthcare provision contract, and hence the ICB would have a liability to fulfil/terminate the vehicle leases. **<u>Related Party Transactions</u>** Related parties were based on declarations made by Board members as to related parties with whom the ICB had transactions during the 9-month period. These included payments made; what was owed to the Related Parties as at 31 March, what the ICB had received and what the ICB was owed as at 31 March. The Chair asked whether this included organisation members sitting on Committees other than the ICB Board. Donna Johnson believed this related to members sitting on the ICB Board only but agreed to check the definition of 'members' with the Governance Team and Audit colleagues. The Chair felt the payments stated here were very low and asked whether they excluded contract payments. Donna Johnson agreed to review this section again.	DJ DJ

Senior Manager Remuneration

Remuneration of senior managers (those in a position of influence) must be disclosed in salary bands of £5k, alongside taxable expenses, bonuses, and pension related benefits. This had been compiled using payroll data and pension data from the Business Services Authority.

All pension related benefits = assumption a lump sum would be paid on retirement and pension for 20 yrs. Therefore, all pension related benefits were calculated as (real increase in pension x 20 years) + (real increase in lump sum) over the 2020-21 year (less employee's personal contributions).

Senior Manager Pension Benefits

It was noted that pension benefits were presented in the (Annual Report) – with data from the Pensions Agency (BSA). It included an accrued pension, lump sum accrued and cash equivalent transfer value, and the real increases of such during the period.

Fair pay multiples

These ratios compared staff salaries to the highest paid Director. It was noted that if we list the full-time equivalent salary of all staff, and cut it into 4 sections:

- Top of the first section is the 25th percentile. The highest paid Director earned 7 times that salary.
- The top of the second section is the median. The highest paid Director earned 4 times that salary.
- The top of the third section is the 75th percentile. The highest paid Director earned 4 times that salary.

The salary at the median point and the 75th percentile were very similar hence the outcomes of those ratios.

Next Steps

The final slide outlined the next steps, so that the Committee could understand how we moved forward from the draft Accounts to the final published Accounts, which was expected to be in September.

Donna Johnson took the opportunity to thank Liam Daley and Natalie Breeze for leading the Accounts and Analysis, and the wider finance team for their support in delivering what was needed to get to this end result. It was noted that it had been a challenging year end with the 9-month period bringing its own complexities, with the continued review of the CCG Accounts and Annual Report bringing additional pressures, and the System consideration as part of the timetabling.

	Donna Johnson reported that the team would regroup to learn lessons from the 2022/23 Annual Accounts. Keith Griffiths asked that his personal thanks be given to Donna Johnson and her team for preparing the Annual Accounts. The Chair reported that she had asked to see the financial statements submission and asked whether Richard Wright also wanted sight of these. Richard Wright declined this offer. **<u>Annual Report</u>** Suzanne Pickering reported that the draft Annual Report had been reviewed and approved by Dr Chris Clayton, Chief Executive Officer, prior to the submission to NHSE. It was noted that alongside the ICB Annual Report, it was also a requirement for the ICB to resubmit a complete draft CCG Annual Report and Accounts for Months 1 to 3 of 2022/23. These were approved by the Audit & Governance Committee in September 2022. The following was highlighted: • The draft Annual Report had been produced in accordance with the NHS England guidance and on the template provided by NHS England. • It included the Performance Report, Accountability Report, Governance Statement, Remuneration and Staff Report. • Dr Clayton signed off the draft on 24 April and it was submitted to NHSE on the evening of 26th April via Sharepoint before the deadline. • The documents submitted were shared with Internal Auditors, 360 Assurance. • Feedback had been received from NHSE yesterday. They were confident on first impressions that it was a neat and well-structured document which befitted the size of the Derby and Derbyshire ICB. NHSE had reviewed the full checklist and National Audit Office checklist against the signposting to ensure that everything had been covered and were happy and confident that it did. • Alongside the ICB Annual Report, it was also a requirement for the ICB to resubmit a complete draft CCG Annual Report and Accounts for Months 1 to 3 of 2022/23. These were approved by the Audit & Governance Committee in September 2022. • Helen Dillistone thanked both Suzanne Pickering and Frances Palmer for their work in producing the Annual Report. • Kevin Watkins reported that in his Committee Effectiveness Review, he would pick up the question about what the difference between the System Quality Performance Committee and the System Quality Group was; he currently did not understand the answer to that. It was noted that in the AGS both appeared to be formal subcommittees of the Board.	

	• It was noted that the System Quality Group (SQG) was a statutory committee of the ICB as were Audit and Governance and Remuneration Committees. Suzanne Pickering agreed that we needed to have a conversation with Brigid Stacey to understand the differences/responsibilities of both committees. • The Chair highlighted that we appeared to have a statutory committee (SQG) with no Non-Executive Directors on it. • Kevin Watkins agreed to report back and to compare their other client base ICBs to see how they were operating. • The Chair referred to the missing remuneration data required for the report. It was noted that the Finance Team were working on this and would be reflected in the final report; guidance had indicated that this was not required as part of the draft report. **The Audit and Governance Committee:** • **APPROVED the Draft Annual Accounts 2022/23.** • **APPROVED the draft NHS Derby and Derbyshire ICB Annual Report for the 1st July 2022 to 31st March 2023 reporting period.**	SP KW
FOR CORPORATE ASSURANCE		
AG/2324/180	**Internal Audit** **Updated Interim Head of Internal Audit Opinion** Usman Niazi presented the updated Interim Head of Internal Audit Opinion (HOIAO) and highlighted the following: • The updated Interim Opinion was issued on 27 April, and the plan was to publish the final HOIAO plus the Annual Report for submission of the Annual Report and Accounts. • Within the Interim Opinion, 360 Assurance had provided a Significant Assurance (currently an indicative Opinion). • The three main areas that had been considered in providing this Opinion were the individual audit assignments outturn, the BAF, Strategic Risk Management and the follow up of agreed actions. • In relation to the outturn from 22/23 Plan (P243 of the pack) there were still a couple of reviews that were at final draft report stage and one that was in progress, namely the Committee Effectiveness Review. • 360 Assurance were at a sufficiently advanced stage to be able to anticipate providing a Significant Assurance Opinion in respect of the Plan outturn and the only review that they had provided Limited Assurance on was in respect of the Transformation and Efficiency Review. • Significant Assurance was provided in respect of the BAF element of the Opinion, as 360 Assurance had seen sufficient evidence throughout the year to demonstrate good progress had been made in developing a System focused BAF.	

	• The BAF was regularly reviewed as part of a reporting cycle to the subcommittees of the Board as well as being subject to regular review by the Board itself. • Significant Assurance had been given regarding the follow up of agreed actions; the follow up rate and overall implementation rate both currently stood at 67%. • There were no outstanding actions from assignments reported during previous financial years. • It was noted that the Chair and Richard Wright felt that this was a pleasing report. **The Audit and Governance Committee NOTED the updated Interim Head of Internal Audit Opinion – 1st July 2022 to 31st March 2023.** **Transformation and Efficiency Final Report** Kevin Watkins presented the Transformation and Efficiency Final Report and highlighted the following: • It was noted that Keith Griffiths had originally asked for this piece of work to go into the Audit Plan. • Kevin Watkins reported that this showed a level of maturity of the ICBs assurance systems to look at this area and want an independent view as early as possible. • Kevin Watkins reported that Auditing ICBs, being new organisations, who were implementing and developing new processes had been challenging; it was noted that the Audit was undertaken at a point in time; the work was completed by end of November last year. • The summary of findings in the report picked up where the Derbyshire System was at that point. It was noted that Tamsin Hooton, who was playing a key role in implementing transformation for the System, had only been in post a couple of weeks when the work commenced. • It was noted that Tamsin Hooton had been involved in seeing the draft report and in preparing the detailed management response. Kevin Watkins thanked her for that. • Kevin Watkins reported that one of the areas that came out in the report was whether as a System we had enough resource to devote to transformation; this was very similar to other Systems. • It was noted that all Systems had to respond to the pandemic and PMO staff had been reassigned. • Kevin Watkins reported that the Derbyshire System had put the ePMO in, which was a good system, but the ICB needed to ensure that this was supported well in its implementation. • It was noted that Keith Griffiths, Tamsin Hooton, Helen Dillistone and Maria Riley were eager for 360 Assurance to continue to	

	keep a view on this area. It had been agreed that a formal follow up would be undertaken early in June. • Kevin Watkins reported that some of the recommendations and actions in the report may take some time to do, with some scheduled for August. The work in June would give a good opportunity to see how the organisation was getting on and how things had progressed since November. • It was noted that this would be the third consecutive year that the ICB and its predecessor organisation had had a piece of work from 360 Assurance on Transformation and Efficiency. • The Chair felt this had been a very comprehensive and useful report. She felt it important to acknowledge that this review had been undertaken by request from the ICB, as we knew this was an area that we needed to improve on. • The Chair reported that the fact that the review came out as being Limited Assurance rather than anything higher had confirmed the ICBs suspicions; this had been a very positive piece of work and had given us comprehensive feedback and suggestions for improvement. • The Chair reported that Tamsin Hooton's response had been very helpful and had flagged up areas where she acknowledged more work needed to be done across the System. • The Chair thanked 360 Assurance for this piece of work and reported that this review was probably one of the most value adding pieces of work that had been done for us by Internal Audit this year. She added that she felt a follow up review would be very helpful and a useful check that we were going in the right direction and would be fundamental if we were going to transform services and ensure that we had this area properly resourced. • Richard Wright reported that this was one of the areas that gave him the greatest concern; he too thanked 360 Assurance for this review. The ICB was very much the coordinator for this area, and it was hoped this would help focus the messaging across the Derbyshire System. • Keith Griffiths reported that this review had been undertaken with the willingness and cooperation from other organisations across the System who were statutorily independent. This was a good signal that organisations had been willing to participate in this review. • This report had implications for the Provider Collaborative, Primary Care Provider Collaborative and had also been a useful focus for conversations at ICB Executive level about whether we needed a financial efficiency programme board to be set up to have an overarching view around efficiency and transformation across the System, rather than relying on the Programme Delivery Boards and the Provider Collaborative and the reports that came out of individual organisations.	

	• Keith Griffiths acknowledged that the review had highlighted that we needed to be sharper on the reporting. Currently it felt like we had got a lot of data which was too much to digest at this kind of level, and we needed to simplify what was going on and get assurance that things were being mobilised to deliver what we needed to do in the future. • Keith Griffiths reported that there had been a lot of high-level conversations since this report had been received. He welcomed the fact that 360 Assurance had agreed to come back and do a follow up review in the next few weeks. **The Audit and Governance Committee NOTED the Transformation and Efficiency Final Report.**	
AG/2324/181	**External Audit: 2022/23 Audit Plan** Andrew Cardoza thanked Donna Johnson for taking Committee through the draft Annual Accounts earlier in the meeting. It was noted that there had been an urgent meeting with Keith Griffiths, Donna Johnson, Darran Green, Andrew Cardoza and Martin Ndoro last Friday to update on an instruction from the Centre. This had resulted in KPMG being delayed receiving the Accounts due to the changes. Andrew Cardoza reported that KPMG had received most of the information required for their Audit from the finance team, apart from a few things still awaited from Donna Johnson and Liam Daley. KPMG reported that they hoped to make up time lost at the beginning of the Audit and finish on time. It was noted that KPMG had worked very well with the finance team in the past and with Donna Johnson and Darran Green in particular. Andrew Cardoza reported there had been the added complexity this year of doing two Audits, one for the CCG and one for the ICB. It was noted that VFM would always be a challenge in terms of where the System and ICB was. As stated earlier, there was a deficit in the Accounts; there was question as to how that would that sit with KPMGs assessment of financial sustainability. Regarding 'going concern', as stated earlier, an organisation was always going to provide this service, but at the end of the day it was noted that KPMG still had to give that opinion in terms of VFM. Martin Ndoro reported the final version of KPMGs Audit Plan was broadly the same as the draft version presented to this Committee last month. The following was highlighted: • Attention was drawn to changes made to Expenditure Significant Risk description on P279 of the pack.	

	• The NHS national position was underspent, so the ICB had received an additional allocation. This had slightly changed the risk from what was stated in the draft version from accruals existence to expenditure existence around year end. KPMG were concerned that expenditure could be overstated in year by being pushed to Providers in the System, while this did not relate to the financial year, all was not actually spent in year. KPMG had made a minor amendment in the Plan to reflect this; this was the only change made. • Keith Griffiths thanked KPMG for meeting with him and the finance team at short notice last week. He appreciated their counsel regarding this last-minute issue. It was noted that the ICB had clearance/permission from the national team for a 24-hour postponement on the submission of the Accounts to allow conversations with KPMG and others. He acknowledged the difficulties and consequences of this for KPMG. • The Chair reported that the ICB Board appreciated being informed that KPMG had been involved in those late conversations with Keith Griffiths. She thanked KPMG for being flexible around this. • Andrew Cardoza reported that he appreciated the openness shared by the ICB. **The Audit and Governance Committee NOTED the Final Draft External Audit Plan for the period ended 31st March 2023.**	
FINANCE		
AG/2324/182	**Month 12 ICB Financial Position Review** Keith Griffiths explained that this report had been produced prior to the conversations with NHSE last week. Prior to those conversations described in the previous item, the ICB had a breakeven position for 2022/23, and that was a part of the Derby and Derbyshire System's reported £13m deficit for 2022/23. As described earlier in the meeting and shown in the Accounts, the reported position was now £15m deficit. **Audit and Governance Committee NOTED this verbal update.**	

FOR INFORMATION		
AG/2324/183	**POD Financial Delegations** Donna Johnson reported that from the 1st April 2023, the ICB had taken on delegated responsibility for dental (primary, secondary and community), general ophthalmic services and pharmaceutical services (including dispensing doctors and dispensing appliance contractors). These additional delegated services were classified as "POD". The authority and accountability for POD was enshrined in the Delegation Agreement between NHS England and the ICB. The changes enacted were to ensure that the transactions, financial delegations, and decisions the ICB made in relation to POD business remain intra vires while the governance documents/ instruments associated with the working arrangements of the Joint Committee of ICBs (which considers PODs business) were being developed. Matters of substance included: • Varying ICB finance limits in the SoRD to allow senior hosted staff for POD to approve contract variations, where the financial impact was nil. • Widening the scope of authorisation of invoices/POs in the SoRD to include hosted officers, employed elsewhere. • Proposing a variation to the relevant sections of the joint working arrangements between ICBs, to address several finance related aspects that either remain silent or required explanation when compared with the equivalent documents for Specialised Services Commissioning. **Appendix 1** – outlined the changes in the SoRD **Appendix 2** - outlined the section to be included within the Joint Working Agreement. **The Audit and Governance Committee NOTED:** • **Variations to the SoRD as set out in Appendix 1, including the accompanying table, in relation to the ICB's Financial Limits, the scope of officer authorisation, Schedule 5 of the Delegation Agreement and any other activities that may be undertaken as part of the business of POD; and** • **The proposal put forward to the Joint Committee to vary the wording of the existing joint working arrangements (POD Business) as set out in Appendix 2.**	
AG/2324/184	**ICB Annual Assessment** Helen Dillistone reported that the purpose of this paper was to set out the regional approach and process for the ICB Annual Assessment to the Audit and Governance Committee. In accordance with the final guidance (Appendix 2) the ICB Annual Assessment would consider whether the ICB had met the 8 statutory requirements across 5 domains, using several Key Lines	

	of Enquiry (KLOEs). This was the first year of ICB assessment and unlike the CCG Annual Assessment there would be no rating for the 2022/23 Annual Assessment. An annual summary of segmentation ratings under NHSE's national oversight framework and the ICB annual assessment would be provided to inform the NHSE annual report due for publication in July or early August 2023. A recent letter from Mark Cubbon set out some delays to the annual report publication due to potential changes because of the Hewitt Review recommendations. This would not change the timelines for the regional team to conduct and conclude its annual assessment of the ICB for 2022-23. The ICB annual report, any other relevant documents and intelligence from routine interactions with the ICB during the year would inform NHSE's assessment of ICB effectiveness in delivering against the statutory duties and KLOEs. NHSE would also seek feedback from key stakeholders as in previous years. NHSE would use the engagement we had with the ICB during May (at the System Review Meeting (SRM) or alternative) to explore the emerging conclusions from the assessment. Supporting evidence of signposting to the ICB Annual Report and other related documents not covered by the draft Annual Report would be submitted to NHSE by the 5th May 2023. **The Audit and Governance Committee NOTED the ICB Annual Assessment documents for information and awareness of the process.**	
MINUTES AND MATTERS ARISING		
AG/2324/185	**Minutes from the Audit and Governance Committee Meeting held on 23 March 2023** The minutes from the meeting held on 23 March 2023 were agreed as a true and accurate record of the meeting.	
AG/2324/186	**Action Log from the Audit Committee meeting held on 23 March 2023** The action log was reviewed and updated during the meeting.	
CLOSING ITEMS		
AG/2324/187	**Forward Planner** The Audit and Governance Committee ACCEPTED the Forward Planner.	
AG/2324/188	**Any Other Business** There was no further business.	

AG/2324/189	**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.** • Were papers that have already been reported on at another committee presented to you in a summary form? **Yes**. • 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.**	

DATE AND TIME OF NEXT MEETING
Date: Thursday 8 June 2023
Time: 2.00PM
Venue: MS Teams

Signed: …… Dated: ……..
(Chair)

MINUTES OF THE ICB PEOPLE & CULTURE COMMITTEE (ICB PCC)

HELD ON WEDNESDAY 08 MARCH 2023, VIA MICROSOFT TEAMS, 0900-1100

Present:		
Gildea, Margaret	MG	ICB Non-Executive Member and Chair of ICB PCC
Dawson, Janet	JD	DCHS NED and Chair of PCC
Garnett, Linda	LG	JUCD Programme Director, People Services Collaborative
Gulliver, Kerry	KG	EMAS, Director of Human Resources & Organisational Development
Knibbs, Ralph	RK	DHFT Non-Executive Director and Chair of PCC
Leggatt, Zahra	ZL	Derby Health United Director of People and OD
Moore, Liz	LM	Derby City Council, Head of HR
Rawlings, Amanda	AR	ICB and UHDB Chief People Officer
Skila, Jen	JS	Assistant Director HR, Derbyshire County Council
Tidmarsh, Darren	DT	DCHS Chief People Officer / Deputy Chief Executive
Wade, Caroline	CW	CRH Director of HR & OD
Wight, Jeremy	JW	CRH Non-Executive Director and Chair of PCC
In Attendance:		
Bryan, Petra	PB	UHDB Director of Culture
Jackson, Jo	JJ	UHDB Director of People Services
Mahil, Sukhi	SM	JUCD Assistant Director Workforce Strategy, Planning and Transformation
Oakley, Rebecca	RO	DHFT Deputy Director of People & Inclusion
Shelton, Lynne	LS	JUCD Project Lead, People Digital: Project Derbyshire
Smith, Beverley	BS	NHS Derby and Derbyshire CCG, Director of People Transformation, People Services Collaborative
Smith, Jen	JS	CRH Deputy Director of HR & OD
Thompson, Helen	HT	Executive Assistant to Amanda Rawlings
Apologies:		
Bayley, Susie	SB	General Practice Taskforce Derbyshire – Medical Director
Blackwell, Penelope	PB	Place Board Chair and NHS Derby and Derbyshire CCG Governing Body GP
Lowe, Jaki	JL	DHFT Director of People & Inclusion
Sharma, Vijay	VS	EMAS, Non-Executive Director
Street, Joy	JS	UHDB Non-Executive Director and Chair of PCC

Item No.	Item	Action
PCC/2223/39	**Welcome, introductions and apologies** Attendees were welcomed to the meeting, introductions were made and apologies were noted as above.	
PCC/2223/40	**Confirmation of quoracy** The meeting was confirmed as quorate.	
PCC/2223/41	**Declarations of Interest** MG 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.	

	No declarations were made at this meeting.	
ADMINISTRATION		
PCC/2223/42	**ICB People & Culture Committee - Minutes of Meeting held on 07 December 2022** The minutes of the meeting held on 07 December 2022 were accepted as a true record. **ICB PCC ACCEPTED the minutes as a true record.**	
PCC/2223/43	**ICB People & Culture Committee - Action Log** The action log was noted. **ICB PCC NOTED the action log.**	
ITEMS FOR APPROVAL		
PCC/2223/44	**Board Assurance Framework** ICB PCC received the report which provided the final Quarter 4 BAF Strategic Risks for agreement by the committee. LG advised that following discussion at the last meeting, the template had been populated in relation to the two risks for agreement and also agreement of the proposed risk appetite risk scores. The two strategic risks were noted as :- • 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. JW fed back that it would be helpful to provide information on how scoring for risk are reached and also would be worth considering in reviewing the target score, whether are aiming to reduce the likelihood, impact or both. LG advised that this had been included on earlier versions of the template, but appears to have been removed. LG agreed to ask for it to be reinstated. SM noted in the meeting chat that with regards to Strategic Risk 6, having a draft one workforce strategy by 30/04/23 will not be possible and SM agreed to liaise with LG with regards to a more realistic time scale. In response to a query from RK regarding whether the overall risks are a combination of all the different organisations, LG confirmed that she did not believe that is how the risk had been built up. Discussions had taken place around system risks in particular and have not been built from reviewing individual trust risk registers. AR advised that trust secretaries across the system have been working with each other to look at, read across the BAFs, and the way they are developed. The aim is to ultimately try and get system wide alignment, but this is still in early days.	LG SM/LG

	MG observed that would not want to indicate that the system is just an aggregation of all scores from individuals trusts, as would not be meaningful. The risks are ultimately the big system risks and is where the People Services Collaborative Delivery Board will work, as they are collaborative risks at system level. ICB PCC members provided feedback around gaps, risk mitigations and risk score reduction. LG agreed to take back to the System HRD group for further discussion and thought. MG suggested that the ICB PCC have LIMITED ASSURANCE on this item which was agreed by committee members. **ICB PCC noted and AGREED the BAF as presented..**	
ITEMS FOR ASSURANCE		
PCC/2223/45	**2023/24 Annual Workforce Plan Progress with the Five-Year Workforce Plan** ICB PCC received the report which provided a summary of the draft Derby and Derbyshire ICB provider workforce plans. The draft plans were submitted on 23/02/23 and the paper provides assurance of the activities to finalise the system workforce plan which is due for submission on 30/03/23. SM highlighted that it has been an extremely challenging process. SM also noted that all of the trusts workforce planners have been working extremely hard to try and get something meaningful with the recognition that the templates did not work, and the numbers had to be manually added. SM advised that each NHS provider had been required to submit a workforce plan on an annual basis; including monthly data for year one (2023/24) and annual data thereafter to March 2028. Each provider was required to complete numerical returns made up of the following components parts; whole time equivalents (WTE); KPIs including sickness absence rate and turnover rate; hosted services and supply bridges. In addition, there were specific returns for; primary care and mental health (to include non-NHS Providers to reflect LTP delivery). SM outlined that on the 22/02/23 there was recognition that the portal and templates did not work and instead the submission was to be made via email to the regional leads. The requirements were also adjusted to take into account the difficulties all systems had experienced with the process and the following were requested; WTE, Primary Care. Mental Health. KPI (if completed) and Hosted (if completed). The draft aggregate system position and provider WTE plans, primary care and mental health were then submitted on 23/02/23. SM highlighted key messages from the plan as follows:- • Overall workforce plans indicate an increase in WTE March23 to March 2024 of 1,204 WTE or 4.33% growth. This includes Substantive, Bank and Agency.	

	• 5% in total substantive positions from the current baseline of 26,364 to 28,682 by March 2024 (equates to 2,318 WTE). For each provider this growth reflects; 4% CRH, 3% DCHS, 4% DHcFT, 13% EMAS and 3% UHDB. • Whilst there is growth in substantive workforce planned, this does not reflect a corresponding reduction in temporary supply. • Overall slight improvement in sickness, absence and turnover. • Focus on nursing workforce (commitment to recruit more nurses nationally) - 6% growth in substantive WTE. Of which; 9% growth in Midwives (Ockenden), 7% growth in Community Nursing (supports more care in the community) and 8% Growth in Primary care workforce (269 WTE). SM advised that the draft plans require further work ahead of the final submission on 30 March, in relation to the workforce supply as the returns do not currently show how the workforce growth will be achieved (e.g., numbers of newly qualified WTEs) which impacts deliverability and potential use of agency. Work is also underway to triangulate the workforce plans alongside activity and finance and ascertain whether the growth would support the increased levels of activity required and understand the affordability aspects. SM confirmed that each organisation is now reviewing any anomalies and clarifying / confirming underpinning assumptions made. Month 9 data is being used to base the plan, however each organisation is reviewing top level areas against Month 10 to sense check that there is no significant difference in the position that could adversely affect the baseline planned position for 2023/24. SM also confirmed that have been working closely with Finance and Planning leads, to review the plans and progressing triangulation actions. This review will then inform agreement and completion of further work required ahead of the final plan submission on 30 March. SM noted that over the coming year, need to get to a position where the accuracy of ESR is better and there is better alignment with finance. **ICB PCC NOTED the report.**	
PCC/2223/46	**One Workforce Strategy Plan Update** ICB PCC received a verbal update on the progress with the One Workforce Strategy Plan. SM advised that the work that is needed to launch the one workforce strategy in earnest has been quite tricky. All of the work that is happening with the operational plan, is a component part of starting to get to the position of understanding our baseline information. SM confirmed that a workforce conference workshop had been held on the 28/02/23 and had been very positive and well attended. SM advised that it had been scheduled in the middle of the planning	

	round, in the anticipation that there may have been some things that came out of the discussions that could help refine our plans. The work will continue to be taken forward post 30 March 2023. SM advised that are starting to work with partners, including local authority and voluntary sector, to start using the same approach to create a one workforce strategy for the system.. **ICB PCC NOTED the update.**	
PCC/2223/47	**People Services Collaborative 7x5 Work Programme Update** ICB PCC received the report, the purpose of which was to provide assurance to the committee on the progress that is being made. LG confirmed that the report also feeds into the Transformation Co-ordination Group and Provider Leadership Collaborative. LG noted that the report includes a summary of all the programmes that are happening through the collaborative work and there are now 43 initiatives that sit within the seven programmes of work and these are all now on the ePMO system and there is someone within each of the work programmes who are taking responsibility for maintaining the information in the system. This in turn will enable us to general reports for both performance management and assurance purposes. LG advised that the People Services Collaborative Delivery Board are comfortable with the position of all the programmes and the purpose is to give assurance that the programmes are clearly identified, are monitoring progress and being reported on and have properly constituted the People Services Collaborative Delivery Board meeting every month which has a more detailed look through the various reports. LG confirmed that the Delivery Board are now also working on what the programme will be for next year. There will be three headline projects that will be working on next year; Derbyshire Digital Project, International Recruitment for Domiciliary Care Workers and also working on progressing our collaborative approach and scaling around recruitment and other people services. JD queried how would know when something from the programme list moves into delivery and becomes business as usual. LG commented that have discussed this and at present there is probably too much information included in the programmes, but had initially wanted to have visibility and feeling of engagement and involvement, and some of these will begin to transfer into business as usual. LG noted that this is probably something would wish to think about in terms of how actually then capture the information. SM advised that discussions have taken place on this on the back of the workforce plan and also conversations around how can genuinely make some of the 7x5 programmes more targeted and around some of the gaps. JW noted the need to evidence how much impact this is having at trust level and assurance that things are actually changing.	

	LG advised that the individuals working on the programmes are all working in the organisations, so are all owning and delivering the work and is happening within day-to-day activities. LG also confirmed that following conversations at the People Services Collaborative Delivery Board, agreement was noted that do need to identify some key metrics that really want to see change on and not surprisingly included sickness and absence, turnover, vacancy rates and spend on agency, which are the things that everyone across the systems are focussed on. DT agreed that need to identify what will be the impact and outcomes once have identified those and are routinely measuring variance to the outcome of performance to the outcome. AR pointed out that as providers and that includes our local authority providers, through the development of our One Workforce Strategy, will identify the big significant things that wish to collaborate on and the 7x5 programme was the start. We now need to identify what the big things are that really want to work on going forward as we iterate the One Workforce Strategy and that will be around how we start to develop how and bring out workforce together as a system. AR noted that are currently a long way off that as yet, but that is the work over the next 3-6 months once the current operational planning round is complete. AR advised will see something different by mid to late year around the People Services Collaborative and tightening the collaboration and looking for efficiency as well as productivity around outcomes and things will evolve and mature over the course of the remainder of the year. CW commented that colleagues have realised that are getting to the point whereby good intentions of collaborating will only achieve limited success and have noted the need to scale up people services and the big transformation projects, e.g. digital and that real transformation will take time. CW noted that the scale and complexity of just NHS providers has become apparent but when you also add in local authority partners and social care, it becomes another level and conversations are taking place around realistic ambitions, scale of ambition etc. MG summarised that there are lots of projects going on and may be even too much, however it is organically moving to where are beginning to prioritise and are beginning to find the big-ticket items and are going to relate to the One Workforce Strategy and Plan. Have looked at where gaps in control are, but long-term transformation will take time, however are already getting some quick wins from collaboration. The task is hugely complex as bringing together a host of different providers and different parts of the NHS, but also different parts of local authority, but are starting to see results and can see that in the longer term, more results will come and will narrow down to the things that really matter at system level and what can be left at organisation level. Have good programme discipline in place and right escalation to the transformation group. Have received some helpful suggestions regarding phasing and clarity. If something is long term	

	transformation, then can understand that should not expect very much for however long, and what can expect for some quick wins. AR advised that a time out is due to take place on Tuesday 21 March 2023 on the digital programme work but also support from NHSE to look at people scaling. The people scaling will involve starting to think about what really want to scale up and look at differently and the people services model going forward, and this will follow on to a further workshop. By the next ICB PCC, should have a more refined people services focus which will dovetail into the One Workforce work. **ICB PCC noted the report and noted that were assured that were moving in the right direction.**	
PCC/2223/48	**Project Derbyshire Digital Work Programme** ICB PCC received the report which provided an update on the progress of the Derbyshire People Digital project. LS advised that this is a collaborative project with NHSBA and NHSE to enable achievement of multiple aspects in the NHS People Plan, the Future of HR&OD programme, and the Joined Up Care Derbyshire (JUCD) People Function responsibilities across the ICS in the areas of process improvement and consistency, improved data quality, existing digital optimisation, informing new operating models, enhancing digital capability, people digital strategy and culture change to enable the realisation of benefits in the people digital space. Objectives were noted as follows :- • Deliver an effective, efficient, value-adding People and OD function across Derbyshire ICS for the benefit of our people, addressing current pain points for users. • To support organisational readiness for the implementation of the Future NHS Workforce Solution (beyond ESR), and other people digital implementations. to improve the chances of them being truly transformational for the NHS and our people. • To be an example to the system of what good looks like in the people digital space. • To bring together support from across the system to make changes in an integrated, collaborative way between the ICS and nationally so benefits can be realised quickly. LS outlined the work that had taken place so far, or was in progress:- • High level mapping of workforce systems across the ICS. • Detailed mapping of ESR current state. • Key required developments identified for ESR functionality. • Review of data quality and key improvements identified – impact on workforce planning and reporting. • Identification of 3rd party workforce systems and costing across the ICS. • Identifying and alignment of JUCD and individual Trust programmes of work .	

	• UHDB and DCHS to pilot the new ESR standards/levels of attainment. • Project launch day for key stakeholders held on 21/02/23. • Work commenced with PwC to identify baselines, develop plans and the roadmap – 3 workshops are planned to support this work. LS outlined that working across all trusts there will be a network of Functional Implementation Groups (FIGs) that will enable and support the project outcomes. These groups will have the necessary technical, subject experts and user representation from each trust and will work closely with out ALB colleagues. The work will have interdependencies with the JUCD 7x5 workstreams. AR advised that workshops are planned on the 21/03/23 and 29/03/23, one for people scaling, one for general people work and one for digital / digital roadmaps. AR noted that will also require a lot of organisational development / culture work. RK suggested that, given the size and scope of everything, perhaps could schedule deep dives into specific areas, one at a time, would be useful. AR agreed and suggested that will be able to as the programmes start to mature. **ICB PCC NOTED the report.**	
CLOSING ITEMS		
PCC/2223/49	**Any Other Business** No items were raised. **Meeting Frequency -** AR suggested given the pace of changes, the frequency of meetings is correct at present. Committee members all agreed that were comfortable with quarterly meetings. Committee member also all agreed that it is more efficient for meetings to take place via Microsoft Teams as the geographic spread of members is wide.	
DATE AND TIME OF NEXT MEETING		
Wednesday 07 June 2023, 0900-1100, via Microsoft Teams		

MINUTES OF THE PUBLIC PARTNERSHIPS COMMITTEE

HELD ON 28 FEBRUARY 2023, 10:00 – 12:00

VIA MS TEAMS

Present:		
Julian Corner	JC	Non-Executive Member ICB **(Chair)**
Helen Dillistone	HD	Executive Director of Corporate Affairs, DDICB
Karen Lloyd	KL	Head of Engagement, DDICB
Tim Peacock	TP	Lay Representative
Jocelyn Street	JS	Lay Representative
Sue Sunderland	SS	Non-Executive Member, ICB
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:		
Lucinda Frearson	LF	Executive Assistant, DDICB (Admin)
Apologies:		
Steven Bramley	SB	Lay Representative
Kim Harper	KH	Chief Executive Officer, Community Action Derby
Harriet Nicol	HN	Engagement & Involvement Manager, Healthwatch Derbyshire
Maura Teager	MT	Lead Governor, University Hospitals of Derby and Burton NHS Foundation Trust

Item No.	Item	Action
PPC/2223/58	**Welcome, Introductions and Apologies** Julian Corner (JC) as Chair welcomed all to the meeting, with introductions being made around the virtual room. Apologies were noted as above.	
PPC/2223/59	**Confirmation of Quoracy** The Chair confirmed the meeting as quorate.	
PPC/2223/60	**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/2223/61	**The development, role and purpose of the ICB Public Partnerships Committee** Sean Thornton (ST) recapped from the last meeting outlining the defining role of the Public Partnerships Committee (PPC) in the context of it being: • A driver of citizen engagement in our planning and service development processes. • An assurer of engagement activities against ICB statutory duties • A component of the ICB Board sub-committee structure, with interfaces with other sub-committees. Key points extracted from the last discussion included: - • Amendments to the Terms of Reference with regard to interface with the Population Health and Strategic Commissioning Committee (PHSCC) • The pipeline approach to how other projects progress through ICB Committees and timelines. • Talked about 4 sub-groups as a kind of engine room to support the work of the committee • Formation of the committee membership and through the subgroup structure. • Remuneration of subgroup chairs to recognise the kind of work involved. From the discussion ST summarised: - • The TORs were fine • The pipeline approach was recognised as theoretical but required more work. • The committee requires a role earlier in the pipeline process to ensure engagement takes place in the priority setting. • Better definition or depth of information to be brought to committee so the assurance function can be performed. • More detail required around the roles of the subgroups and their functions to ensure they are necessary. • Review required of the committee membership. • Remuneration of lay members would do potential harm to their independence on the committee. • Better definition required around the role of the Voluntary Community Social Enterprise (VCSE) sector. **Focus**: What is the role of the committee and how do we balance the committee not having capacity vs sub structure?	

	Comments: • Jocelyn Street (JS) highlighted the need for the committee to have a high level of people who have the skills and knowledge but also those that are completely independent from the NHS or other partnership organisations. • Lynn Walshaw (LW) agreed with JS, and noting as a hybrid model, knowledge and experience of the system is required but also independence with a need to define what independence means adding there were opportunities here. ST offered to work on the membership and bring back for a final discussion on structures and roles. ST believed the PPC's main decisions were around: • Strategic Development • Policy • Compliance **Comments**: • LW felt the headings made it clearer when visualising the PPCs position within the bigger system and helping to clarify what comes back to committee and how we manage it. The committee is not about doing the detail of the work but the strategic oversight. • JS found the slide very helpful making clearer and shaping what members were required to discuss and decide, and also requesting some legal duties training because of the new legislation. • JS believed lay representatives required a title giving a better description of their role. Suggestions put forward included public partners or people representatives. • Helen Dillistone (HD) commented on the areas presented in terms of the role of the PPC, if generally accepted and agreed HD felt it would be helpful to explore where the PPC thought there were gaps in experience and skills to undertake those roles and look at possible training in those areas. **Sub-Structure Chart:** It was proposed within the structure to have one formal subgroup. Previously a Lay Reference Group (LRG) had been used, this may be re-established with a varied membership chaired by a lay member/public partner from the committee to reflect the formality of the subgroup. There were 3 areas proposed that were required to feed into the committee:	**ST**

	• System Insight Group: Already established and chaired by Karen Lloyd (KL) and suggested to continue. • Co-production: Set up as a Task and Finish Group with membership from the ICB and VCSE and those that sit around the ICP table that have a vested interested. Once the framework is established the group will finish and the framework linked to the work. • Confirm and Challenge Group: Which will be used as required to review service change schemes and bring wider thought and experience into approaches at an earlier stage of development. The LRG would be the only formal group and only group requiring members from the PPC. **Comments**: • JS supported the LRG due to the large number of attendees but felt it had little diversity in the membership. • LW asked if there was an absolute need for a confirm and challenge group or would it become a sub-activity of the other groups targeting different themes as it is the diversity that we need to feed in. • HD pointed out that the committee requires to remain strategic as it is an assurance committee of the ICB Board who have delegated those strategy duties and its work is centred around that. The question is where and how does the committee get its assurance and what form and shape does that take. This committee would need to take assurance that processes and reporting is accepted as part of the overarching strategic assurance. • Tim Peacock's (TP) main concern was the lack of information on which to base decisions and wished to see some structure in the information provided, which evaluations were made against, to provide some reassurance. • LW fully agreed that a compliance report which includes a filter process presented to the PPC would be really productive for the lower-level projects allowing time for the higher-level priorities to be reviewed and sighted on. • JC pointed out the PPC needed to be accountable for the assurance system of the ICS. At the moment the PPC was very reactive, there was a need to be able to map that assurance system, outlining the PPC could assure itself of the items presented but not be assured that they are the correct items that should be brought to committee. **Action: ST to prepare a filter process paper for the next meeting.**	**ST**

	Skills of PPC Members: There was a need to look at the current membership as set out in the Terms of Reference (TOR) and at what changes were being raised within these discussions; is it fair to expect more from our members without renumeration and maybe we require a larger pool. It is known there is a gap around Local Authority representation and voluntary membership. **Comments:** • LW believed thought should be given to how to triangulate with the Insight Framework work being done by comms, bringing all those levels of engagement together to provide assurance to the committee. • ST proposed restructuring the agenda for the next few meetings around the PPC roles due to there not being a lot of consultations but there will be information around the Joint Forward Plan (JFP) and IC strategy work which had now begun. • JC emphasised the fact that the ICB was a significant part of the ICP, and we should be fully integrating with our partners in the ICP and asked how do we integrate what we are doing here with engagement in the Local Authority. **Action: ST to provide a revised agenda structure based on current roles ie: less consultation, more information around the JFP and IC Strategy.**	**ST**
PPC/2223/62	**Board Assurance Framework (BAF) – Strategic Risk** HD presentation was a continuation from last month's meeting attended by 360 Assurance who provided a presentation to give members some knowledge around the framework. The BAF document outlines the strategic risks the ICB and more broadly now the system faces. All organisations have a BAF in place and all Boards work to this, its key role is to help the Board set strategic direction, understand the related risk and what could stop the strategic objectives from being delivered. The ICB has a policy on how to complete and incorporate the corporate risk register. A number of ICB committees have responsibility for their own risks, for monitoring those risks and looking at how a risk score can be moved and be more acceptable and these risks are reported to Board on a quarterly basis. **Comments:** • JS asked what happens when risk targets are not met. HD advised it would depend on if all mitigating actions had been exhausted and once seen by Board there would be a request for a deep dive and greater involvement.	

	• Sue Sunderland (SS) emphasised the need to ensure there was the correct level of involvement across the diversity and inclusion side of public engagement and at various levels as this did not come out in the risks' threats, believing this to be a gap and something that required tackling. • ST suggested adding to the table of information provided each month, deadlines, who is responsible and to give an update providing oversight of progress. **Action: BAF to be placed on the March agenda.**	**LF**
MINUTES AND MATTERS ARISING		
PPC/2223/63	**Minutes from the meeting held on: 24 January 2023** The Public Partnerships Committee **ACCEPTED** the Minutes as a true and accurate record of the meeting.	
PPC/2223/64	**Action Log from the meeting held on: 24 January 2023** The action log was reviewed and updated during the meeting.	
CLOSING ITEMS		
PPC/2223/65	**Any Other Business** No further business was raised.	
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 28 March 2023		
Time: 10:00 – 12:00		
Venue: MS Teams		

MINUTES OF THE PUBLIC PARTNERSHIPS COMMITTEE

HELD ON 28 MARCH 2023, 10:00 – 12:00

VIA MS TEAMS

Present:		
Julian Corner	JC	Non-Executive Member ICB **(Chair)**
Steven Bramley	SB	Lay Representative
Pat Coleman	PC	Deputy Lead Governor, University Hospitals of Derby and Burton NHS Foundation Trust
Helen Dillistone	HD	Executive Director of Corporate Affairs, DDICB
Karen Lloyd	KL	Head of Engagement, DDICB
Chris Mitchell	CM	Public Governor Derbyshire Dales and High Peak, Derbyshire Healthcare NHS Foundation Trust
Tim Peacock	TP	Lay Representative
Jocelyn Street	JS	Lay Representative
Sue Sunderland	SS	Non-Executive Member, ICB
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:		
Lucinda Frearson	LF	Executive Assistant, DDICB (Admin)
Monica McAlindon	MM	Head of Cancer, DDICB + JUCD Cancer Lead
Beth Fletcher	BF	Public Involvement Manager, DDICB
Apologies:		
Maura Teager	MT	Lead Governor, University Hospitals of Derby and Burton NHS Foundation Trust
Kim Harper	KH	Chief Executive Officer, Community Action Derby
Helen Henderson	HH	Chief Executive, Healthwatch Derbyshire

Item No.	Item	Action
PPC/2223/65a	**Welcome, Introductions and Apologies** Julian Corner (JC) as Chair welcomed all to the meeting extending a warm welcome to Pat Coleman (PC) who was attending her first meeting. Apologies were noted as above.	
PPC/2223/66	**Confirmation of Quoracy** The Chair confirmed the meeting as quorate.	

PPC/2223/67	**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/2223/68	**Buxton Colposcopy Outpatient Service** The Public Partnerships Committee are recommended to: - • **NOTE** changes to the Buxton Colposcopy Service Monica McAlindon (MA) informed members that University Hospitals Derby and Burton (UHDB) could no longer provide the Buxton Colposcopy service from April 2023 further to the retirement of the existing consultant in post. Every effort had been made to find a replacement but unfortunately unsuccessfully, therefore, UHDB will no longer deliver Colposcopy services from Buxton Hospital. MA added that the paper had been to Scrutiny Committee and explained that the services were moved in 2016 from DCHS to UHDB. The service is commissioned by NHS England specialised commissioning. Due to the very complex processes NHS England had suggested closing down Buxton, therefore, UHDB had paused services in Buxton whilst trying to get an alternative provider but with no success. There is to be a regional review of colposcopy services which will assist for future. The Committee offered the following comments and questions: - • JC queried why the paper had been presented. MA advised it was due to triggers and duties linked to public engagement and also services in this locality had been reduced in recent years so there could be reputational and political risk. • Jocelyn Street (JS) agreed that something as high profile as cancer treatment could have reputational affect and if there was a minimalist principle of patients involved, as the ones it affects it affects a lot, what the cut off would be. MA explained that it was more about what patients needed and something would be put in to mitigate the risk.	

	• Steve Bramley (SB) questioned the effect on Glossop. MA was not anticipating any as their services were received from Tameside and Stockport, but some patients had been coming from Stockport as the services were so good and this would be reviewed. • Tim Peacock (TP) asked if the cause was linked to the ongoing crisis to recruit. AM highlighted that gynae services were under pressure but did not know if the service would continue to be offered as it was not offered in other rural areas, and we require to get the equity message correct across all patients. • JC asked what constituted a robust plan to engage with our patients. MA was currently working with patients, had met them and also met those patients from the areas that were going to appointments at UHDB and Chesterfield Royal and linking in with nurses and senior leaders. The Public Partnerships Committee **NOTED** the changes to the Service.	
PPC/2223/69	**Non-Surgical Oncology (NSO)** The Public Partnerships Committee are recommended to: - • **SUPPORT** the case for change in relation to NSO outpatient services • **NOTE** the wider work on repatriation of SACT regimes to support delivery of chemotherapy closer to home to mitigate the impact of the change to outpatient services • **NOTE** the approach to co-production of the service model • and **SUPPORT** the planned approach to involving patients, carers, and local people in the development of and decisions about proposals for changes to these services. MA presented for information outlining the international workforce shortage and struggle to find consultants in oncology, therefore, changes were having to be made to the way non-surgical oncology was delivered. While the volume of treatments increases the workforce is not with Chesterfield Royal patients having to travel to Sheffield for outpatient appointments. Over the last 6 months there has been a wider system approach to improving with patient engagement, South Yorkshire are engaging with external consultants due to the large impact. A high-level options appraisal is being developed around future services. The Committee offered the following comments and questions: - • Lynn Walshaw (LW) wished to know if the review was looking at nurse specialists and practitioners in cancer care, and available across the region as travelling is another burden for patients who are ill.	

	• TP considered the engagements to be good and with some extra resource being found by South Yorkshire but how did the comms team feel it was going. Sean Thornton (ST) felt it to be a little digital heavy but slightly hampered by the purdah issue, but Derby and Derbyshire are not the direct commissioners with a joint Scrutiny Committee to be convened. • SB pointed out the amount of reference to digital and asked if there had been any specific contact with patients that use the digital pathway, and of those targeted digitally whether they were happy with the digital service. MA clarified that there had been contacted to see if digital or virtual worked for them and what else could be done and this piece of work was currently live. The Public Partnerships Committee **NOTED** the information provided. The Public Partnerships Committee **RECOGNISED** the case for change in relation to NSO outpatient services and **SUPPORTED** the planned approach. MA left the meeting.	
PPC/2223/70	**IC Strategy – Engagement Plan** The Public Partnerships Committee are recommended to: - • **NOTE** the Integrated Care Strategy – Engagement Approach The paper explained the purpose of the Joined Up Care Derbyshire (JUCD) Integrated Care Strategy which set out how Local Authority, NHS, Healthwatch, and Voluntary Sector organisations would work together to improve the health of Derby and Derbyshire citizens, and further the transformative change needed to tackle system health and care challenges. Beth Fletcher (BF) reported the strategy had been prepared in stages beginning by creating an insight document from previous engagements. That was used to focus on 3 key areas: - • Keep well • Stay well • Age/Die well. From an engagement point of view there are tiles on the engagement platform with timelines along with live events being arranged to introduce people to the key areas of focus. These will be followed by more targeted engagement. The Committee offered the following comments and questions: -	

	• LW commented on the amazing piece of work and how good to see a different approach. LW asked how each of the provider organisations doing their own plans were triangulated into the strategy and was that an ongoing dialogue. ST assured that triangulation was taking place and the insight document would continue to build a picture and be shared system wide. • TP highlighted the insight library being a good source of information for the report. BF agreed it was used as the backbone along with other sources and will continue to be used as contained mainly local information so really builds good foundation for the work being done. • PC was supportive of the approach although had concerns at the point of moving from engagement to practice and asked if there would be any piloting in the process to learn from what works and also adding or developing what comes out at the end. BF explained that each area of focus would go in a different direction but with an area of coming together for evaluation and this will be developed to see what success looks like and move forward. • SB noted the two briefing sessions for each being held at different times giving people alternative to be involved and there being evening meetings too. SB believe this would assist in reaching a wider audience and give them the opportunity to get involved. • JC asked if there was confidence the process was doing full justice to equality and diversity inclusion (EDI) needs and the processes were getting a representative and a sample of the population. BF emphasised that this was only the start of the engagement the initial collation and mapping with the next stage will be the engagement events. The Public Partnerships Committee **NOTED** the information provided.	
ITEMS FOR DISCUSSION		
PPC/2223/71	**Compliance Report Process** The ICB Public Partnerships Committee are recommended to: • **DISCUSS** and **AGREE** the compliance approach set out in this report, including the links to existing processes to assess activities against public engagement duties. • **APPROVE** the recommendation that PPC reviews and adopt a set of criteria by which projects can be assessed to ensure appropriate detail is provided for the committee to give assurance • **DISCUSS** and **AGREE** the criteria against which projects can be assessed to give assurance.	

	The report recognises the Public Partnership Committee in discharging its role as a sub-committee of the ICB Board. The paper seeks to develop an approach to compliance against the ICB's legal duties on public engagement which ensures that the committee time is maximised towards driving engagement in the ICB's strategic agenda, schemes of high risk or value are appropriately governed through our engagement infrastructure and schemes of low risk or value remain visible to the committee and available to be called in for scrutiny as required. ST highlighted the PPI form process that assess all schemes with any full public consultations, where there is a contract value, anything that triggers a negative assessment, anything that affects population of 50k people, patients or citizens and reputational damage coming through PPC and spot checks for those that are not being followed through to ensure they are progressing correctly. The Committee offered the following comments and questions: - • Sue Sunderland (SS) felt the report was logical and pragmatic and asked in 12 months how many projects would be pushed away. SS also highlighted the difference in 50k population or patients which required clarification. • ST suggested noting on the PPI log when a project has not triggered the criteria. The Public Partnerships Committee **AGREED** the recommendations within the report.	
PPC/2223/72	**Terms of Reference (TORs)** The ICB Public Partnerships Committee are recommended to: • **APPROVE** the amended Terms of Reference following recent development discussions on the role and membership of the PPC. ST presented the report setting out the proposed amendments to the TORs advising any agreed changes would be required to be ratified by the ICB Board. A secondary element was to align the TORs with those of the Population Health and Strategic Commissioning Committee (PHSCC), where there has been potential for duplication. The Committee offered the following comments and questions: - • SB reiterate the issue, if place members need to attend meeting clashes need to be resolved to enable them to attend both. • JS believed them to be good and comprehensive TORs given the new nature of how things are developing.	

	• JC noticed the DIN representative had been crossed out and referred to the reference group or confirm and challenge group. JC was informed this had been done as DIN members although they would give diversity the group contained internal members of staff as DIN was a staff group not public and such a diverse group it would be difficult to decide which member to invite. The Public Partnerships Committee **SUPPORTED** and **AGREED** the new Terms of Reference. BF left the meeting.	
	COMFORT BREAK	
CORPORATE ASSURANCE		
PPC/2223/73	**Clinical Advisory Policy Group (CAPG) Engagement Assessment** The ICB Public Partnership Committee are recommended to: - • **NOTE** the proposed operating model CPAG have adopted to meet legal duties. KL presented this paper to inform committee of a conversation that had taken place with CAPG on the 02 March 2023, relating to how the legal duties set out in the ICS guide to patient and public involvement, fit with their business. CPAG is a strategic, local decision-making committee, with responsibility for promoting appropriate, safe, rational, and cost-effective clinical policies to be used across Derby & Derbyshire. The Committee is accountable to the Derby and Derbyshire Population Health and Strategic Commissioning Committee (PHSCC) of Derby and Derbyshire ICB with representation from ICB Board members. The ICS Guide to patient and public involvement was written and distributed last year through the ICB and system with training provided. As a result, the CAPG realised they needed to look at the way they managed patient and public involvement when making policies so a paper was put together for the members and following discussion, they produced a model of how they would meet legal duties when making clinical policies. The document gives assurance that the guide is having the required effect within the system. The Committee offered the following comments and questions: - • SS commented on the positivity and how good that the training has had its desired effect. • JS asked out of interest if there were any Lay Representatives on the group, they may not help on clinical issues but may make some impact.	

	• SB informed members that he had been involved with a committee/group consultation with regard to reducing opiates in non-cancer patients which he found very interesting and was one of the few on the group that was non-NHS and had had opiates prescribed but was a good opportunity to get involved. The Public Partnerships Committee **NOTED** the information provided.	
PPC/2223/74	**Board Assurance Framework (BAF) Strategic Risk** The Public Partnerships Committee are recommended to: • **DISCUSS** and **AGREE** the Board Assurance Framework Strategic Risk 3. The full Board Assurance Framework was presented at the March Public Board meeting and covered the 9 risk areas identified for the ICB and also into the system. One strategic risk has been identified which is the responsibility of the Public Partnerships Committee which is strategic risk 3. **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.* Following the ICB Board and Internal Audit feedback, further development and strengthening of the risk has been undertaken. The risk score remains high at level 12 but would like by the end of the year to get to a target score of 9. During the forthcoming Quarter 1 2023/24, the BAF will be developed further, and action plans are to be devised to clearly articulate the planned actions and associated progress. The closing position in March is the opening position for April. The Committee offered the following comments and questions: - • ST reflected the need to look at due dates as a lot of work was underway. The Public Partnerships Committee **DISCUSSED** and **AGREED** the Strategic Risk 3. The Public Partnerships Committee **AGREED** a risk score level 12 for Strategic Risk 3.	
PPC/2223/75	**PPI Assessment Log** - ST The ICB Public Partnership Committee are recommended to: • **NOTE** the PPI Forms and take **ASSURANCE** that forms are being completed and actioned appropriately.	

	Included in the report were the following: • Oncology Services South Yorkshire led initiative • Video Consultations • Post Operation Cataract Discharges • Hypertension Case Finding (High Blood Pressure) • Understanding the impact on patients' physiology and experience with music therapy in critical care • Collect information about whether patients have followed the proper pathway following a finger fracture/ mallet finger injury • End of Pathway PIFU - Patient Initiated Follow-up Karen Lloyd (KL) informed members that it had been decided to promote the same process within provider organisations and were currently working with these organisations. Guidance to complete PPI forms will also be circulated. Attention has now been turned to Primary Care and how to ensure they have a process and inform ICB that service changes are being made. The Committee offered the following questions and comments: - • TP believed there should be visibility across the whole of Derbyshire and would like to see the full log and what was changing more frequently than monthly. The Public Partnerships Committee **REVIEWED** and **RECEIVED ASSURANCE** that the forms were being completed and actioned appropriately.	
PPC/2223/76	**Exception Risk Report March 2023 & Confidential Risk Report** The Public Partnerships Committee are recommended to: • **RECEIVE** and **DISCUSS** the risks responsible to the Committee. The purpose of the paper is to present the operational risk owned by the PPC held on the ICB's corporate risk register for review and to provide assurance that robust management actions are being taken to mitigate them. As at 31 March 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.*	

	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 to reduce slightly to an overall risk score of 12 due to work ongoing around IVF clinical policy. There will be no changes this initial year, but we will be taking part in a more formal process 2024/25 as this will now be looked at across the whole of the East Midlands. The Public Partnerships Committee **RECEIVED** Strategic 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. KL left the meeting.	
MINUTES AND MATTERS ARISING		
PPC/2223/77	**Minutes from the meeting held on: 28 February 2023** The Public Partnerships Committee **ACCEPTED** the Minutes as a true and accurate record of the meeting.	
PPC/2223/78	**Action Log from the meeting held on: 28 February 2023** The action log was reviewed and updated during the meeting.	
CLOSING ITEMS		
PPC/2223/79	**Forward Planner 2022/23** The Forward Planner was **ACCEPTED** by the Committee.	
	Assurance Questions: a) Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **Yes** b) 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** c) Were papers that have already been reported on at another committee presented to you in a summary form? **n/a**	

	d) Was the content of the papers suitable and appropriate for the public domain? **Yes** e) 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** f) 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** **g)** 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/2223/80	**Any Other Business** No further business was raised.	
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 25 April 2023 – **Development Session**		
Time: 10:00 – 12:00		
Venue: MS Teams		

MINUTES OF THE PUBLIC PARTNERSHIPS COMMITTEE

DEVELOPMENT SESSION

HELD ON 25 APRIL 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
Karen Lloyd	KL	Head of Engagement, DDICB
Tim Peacock	TP	Lay Representative
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
In Attendance:		
Lucinda Frearson	LF	Executive Assistant, DDICB (Admin)
Craig Cook	CC	Deputy Director Commissioning Ops / Director Contracting & Performance, DDICB
Apologies:		
Helen Henderson	HH	Chief Executive, Healthwatch Derbyshire
Chris Mitchell	CM	Public Governor Derbyshire Dales and High Peak, Derbyshire Healthcare NHS Foundation Trust
Maura Teager	MT	Lead Governor, University Hospitals of Derby and Burton NHS Foundation Trust
Carol Warren	CW	Lead Governor, Chesterfield Royal Hospital

Item No.	Item	Action
PPC/2324/001	**Welcome, Introductions and Apologies** Julian Corner (JC) as Chair welcomed all to the meeting. Apologies were noted as above.	
PPC/2324/002	**Confirmation of Quoracy** The Chair confirmed the meeting as quorate.	
PPC/2324/003	**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/2324/004	**Joint Forward Plan (JFP)** Craig Cook (CC) began by explaining to members the point of the presentation, which was to talk about the Joint Forward Plan (JFP) and how it fits with other planning activities undertaken by the NHS, along with the added value of the JFP for the next five years. At this early-stage conversations were being had around the best way to engage with staff and the citizens of Derby and Derbyshire. The JFP is the NHS's response to the Integrated Care Strategy (ICS) which sets out a number of priorities for the next 3-5 years and promotes the right priorities for the system by putting prevention in a more dominate space, and how we will tactically deliver that. It is informed by the ICS but associated to the Health Needs Assessment carried out with the Local Authority and the Local Health and Wellbeing Strategy and there was a need to ensure our plan is responsive to the developing strategic intent happening at different paces at different places. NHS England have set a target that all ICBs submit by Quarter 1, the end of June 2023. A plan will be submitted but not the finished article. The intention is to talk to people and get a consensus around what those improvements should be, keeping things true, and ensuring they are done in the correct way. So that all parties feel they have been listened to, as trust is so important, the intention is to build an honest and well considered view around what people do and do not value. The JFP needs to be giving people solid examples around changes so people feel confident to give their views which will reshape the future. Karen Lloyd (KL) reported that the comms and engagement team were already having conversations and beginning to pull together an outline of the plan. Conscious not to rush the improvement objectives the engagement team need that case for change that is being written and would like to set up continual conversations with communities so that there is an undercurrent of insight continually being collected and fed into decisions being made in the ICS using a three-pronged approach: - • the insight framework providing continuous insight to feed into the plan, • a bespoke piece of engagement to be carried out once the case for change is completed around the 8 objectives, • and the theming document that has collected a huge amount of insight already.	

	The Committee offered the following comments and questions: - • Jocelyn Street (JS) felt it gave a lot of heart and could envisage populating the plan but had concerns around gathering a plethora of information and then asking what to do with it outlining the vast amount of work to be done. JS did believe there was real scope for achieving the outcomes required from top down and PLACE and locality up. • Lynn Walshaw (LW) liked the approach of understanding the health demographics and prevalence's which are a really rich source of information pointing out a lot of people were still doing other work but actually to what purpose and were we duplicating effort unnecessarily. It is about getting that message across the system. • Steven Bramley (SB) commented that whilst he appreciated there was work to be done by June and this was only a portion, in the plan going forward it did mean embedding in every level and to achieve that a different approach to engagement was needed, there was a lot of information and data collated but was unsure how it was being used. • KL highlighted the insight framework which was about ensuring conversations were being had in the local communities and fed into decision making. The Insight Framework was also about building up regular conversations around what matters to help build trust so those difficult conversations can be had with people. • Tim Peacock (TP) added that it all sounded good and there was real intent to engage with a real commitment to try to engage across Derbyshire, largely the systems were there but there was an issue of quality which was often associated with resource. It is about judging how good it is and what we have done. • Helen Dillistone (HD) felt this was an excellent piece of work and had attended a session of the Patricia Hewitt Review around recommendations and process and the 5 year forward view was mentioned as a key piece of work, and believed we were not far from the direction of travel highlighted which was the 3 Ps prevention, purpose, and partnership. **Action: KL to bring an updated Engagement Strategy to the next meeting, for discussion.** The Public Partnerships Committee **SUPPORTED** the Joint Forward Plan.	**KL**
	COMFORT BREAK	

PPC/2324/005	**Public Engagement Annual Report Submission** KL presented the Public Engagement Annual Report submission explaining that when the CCG became an ICB on the 01 July 2023 NHSE requested people and communities be put at the heart of decisions being made along with our legal duties. The CCG had to complete an assessment framework around patient and public involvement at the end of the year but as the ICB had only recently been formed NHSE were thinking differently and asked for a narrative to go in the annual report, outlining specific areas that they required covering in that narrative. As this was interim the opportunity was taken to outline what had been put into the Engagement Strategy and contained everything believed to be the way forward in terms of engagement although there was still a long way to go in terms of the different frameworks with steps being made in all. The Committee offered the following comments and questions: - • LW felt it to be really helpful to see how it was broken down into the framework approach and thought it was quite an innovative way of actually portraying the work being done. • TP pointed out this had been brought for discussion, assurance and information and it did provide some assurance and the essence of what the point is that we must start to put emphasis on so that we can review on a regular basis but would also like an indication around how good we are or not within Derbyshire overall. • SB felt this to be the simplest appraisal of where we are, what has been done and what happens so far and as time goes on things will develop and draw altogether across the system into a single document. • JS commented on the terrific piece of work which made a lot of what had been talked about come together and seem clearer. • Sue Sunderland (SS) stated on how valuable it had been listening to the conversations, the document was a good summary of where we are and what we want to do and where we wish to be and how it will be developed. • JS highlighted assurance as two-way we have to give assurance and receive assurance and at the moment it did not feel there was good mechanisms in place for knowing how accurate the assurances received or the assurances given are and there was a need for proper mechanisms to ensure consistency. • SB was not sure a consistent system was achievable within the NHS.	

	Action: Evaluation Framework to be brought to the next Development Session for discussion. The Public Partnerships Committee **NOTED and DISCUSSED** the information provided. **HD and LW left the meeting.**	**KL**
MINUTES AND MATTERS ARISING		
PPC/2324/006	**Minutes from the meeting held on: 28 March 2023** The Public Partnerships Committee **ACCEPTED** the Minutes as a true and accurate record of the meeting.	
PPC/2324/007	**Action Log from the meeting held on: 28 March 2023** The action log was reviewed and updated during the meeting.	
CLOSING ITEMS		
PPC/2324/008	**Any Other Business** No further business was raised.	
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 30 May 2023		
Time: 10:00 – 12:00		
Venue: MS Teams		

MINUTES OF THE PUBLIC PARTNERSHIPS COMMITTEE

HELD ON 30 MAY 2023, 10:00 – 12:00

VIA MS TEAMS

Present:		
Julian Corner	JC	Non-Executive Member ICB **(Chair)**
Steven Bramley	SB	Lay Representative
Patricia Coleman	PC	Deputy Lead 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, ICB
Sean Thornton	ST	Deputy Director Communications and Engagement, DDICB
Carol Warren	CW	Lead Governor, Chesterfield Royal Hospital
In Attendance:		
Maria Muttick	MM	Corporate Development Officer, DDICB (Admin)
Hannah Morton	HM	Public Involvement Manager, DDICB
Clive Newman	CN	Director of Primary Care, DDICB
Kevin Watkins	KW	360 Assurance
Apologies:		
Helen Dillistone	HD	Executive Director of Corporate Affairs, DDICB
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/2324/009	**Welcome, Introductions and Apologies** Julian Corner (JC) as Chair welcomed all to the meeting extending particular welcomes to Kevin Watkins (KW) from 360 Assurance who was observing the committee in connection with work being carried out for the Integrated Care Board (ICB) around committee effectiveness and Amy Salt (AS) the new Engagement and Involvement Manager at Healthwatch Derbyshire who will now be attending moving forward. Apologies were noted as above.	
PPC/2324/010	**Confirmation of Quoracy** The meeting was confirmed as quorate.	

PPC/2324/011	**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 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: Jocelyn Street (JS) declared the Learning by Experience Group for Derbyshire Community Healthcare Services (DCHS) was being stood down and she was being co-opted onto the Patient Experience and Involvement Group (PEIG).	
ITEMS FOR DECISION		
PPC/2324/012	**General Practice (GP) Access** This paper was presented by Clive Newman (CN), the Director of Primary Care for the ICB who provided the committee with headline information around current performance and satisfaction, with regards to GP services in Derbyshire. GP access has been a matter for public scrutiny and media attention in recent years and particularly since the lifting of Covid-19 lockdown and other restrictions. CN highlighted a new national plan which was intended to improve access to GPs in the coming year and that plan was just beginning to be implemented. The Committee offered the following comments and questions: - • Patricia Coleman (PC) asked around the withdrawal of the online booking system and the retrograde step to joining the telephone queue. CN believed this may be due to capacity as too many channels were being made available. • Tim Peacock (TP) commented on some very useful data but pointed out that the committee was about what engagement there has been with the Derbyshire public and about the scope, how important to the people of Derbyshire and what are the engagement plans. • Sean Thornton (ST) agreed with TP, but now there was an opening position as CN had set the baseline there was a need to progress from there, working with CN's team. • Sue Sunderland (SS) felt this to be a really valuable conversation and had similar concerns, so was hoping to see how we shall be communicating with the public around the new plan as there are a lot of changes proposed which means the public will need to be engaged.	

	• JS also noted the report was very good and interesting but not really what the committee is about, but it was good to know comms would be linked into the National Plan and would like any communication strategy to come here before it is finalised. • JS believed the GP structure was fundamentally flawed and asked for some ruling to have lay representation on PCNs and GPs to have a template to work to on public engagement. • Steve Bramley (SB) gave an example at his current practice around their internet page adding there was no clear engagement from a public perspective who he believed would be more lenient if they had more understanding and be more involved. **Action:** CN to bring back to Committee in 2–3 months' time with more detail around the engagement element. **The ICB Public Partnerships Committee NOTED and DISCUSSED access to GPs.** CN left the meeting.	**CN**
ITEMS FOR DISCUSSION		
PPC/2324/013	**Engagement Strategy – Joint Forward Plan (JFP)** ST provided committee with a brief update on the Joint Forward Plan (JFP) emphasising the document to be a case for change type document and with amendments accepted after the 30 June 2023 submission date. A first draft had been submitted to NHS England and feedback was awaited. Karen Lloyd (KL) explained the JFP would be the case for change and the current document was a provisional plan until that case for change document was completed. There were 10 areas of focus and data will be taken from the Insight Library and the National Patient Experience Library along with a call out for insight. There will be some difficult conversations to have therefore co-production groups will be setup to be involved from the beginning and gather information to make informed contributions to the plan along with focus groups and surveys. The Committee offered the following comments and questions: - • SB felt this to be a good forward-looking plan around what was happening and how it had come about. **The ICB Public Partnership Committee DISCUSSED the NHS Joint Forward Plan engagement approach.**	

PPC/2324/014	**Insight Framework Progression** KL presented an update on the progress of the Insight Framework which had taken around 18 months with input from many people from different areas of the system. The aim of the work being to: **1.** Put the voice and lived experience of people and communities at the heart of what we do in Place. **2.** Enable local people to take action to promote good health and wellbeing in their place. **3.** Promote a culture of listening, learning, and taking action on that voice together. **4.** Create a long-term and continuous process, not a one-off conversation. **5.** Create an approach that is seen as a 'must have' not a 'nice to have'. Following the development of a reflection improvement development tool a presentation of progress will take place on 08 June 2023, and invites will be circulated to committee members. The Committee offered the following comments and questions: - • SS commented on a good approach and way of widening the groups worked with and from which information is gained but had concerns around gaps in some areas and asked if some mapping was taking place. • SB liked how this was progressing and agreed the difference between areas was a challenge. This works by 'getting a feel' for the whole of Derbyshire but there will be some areas missed. **The ICB Public Partnership Committee DISCUSSED and NOTED the Insight Framework update.**	
PPC/2324/015	**Evaluation Framework - Update** Hannah Morton (HM) presented the Evaluation Framework outlining the approach and design which was very much still in its infancy. An event was to be held on Monday 03 July 2023 giving an opportunity to hear about some of the work carried out along with updates on the Engagement Framework, Insight Framework, the Co-production Framework and also the Governance Framework. The second part of the session would be for discussions and sharing of ideas to keep momentum and to assist in designing what the framework needs to look like. There will be a follow up workshop which may also launch the Lay Reference Group. The Committee offered the following comments and questions: - • JS requested information from the event for those that were not able to attend who may wish to be involved in the follow up workshops.	

	The ICB Public Partnership Committee DISCUSSED and NOTED the development of the Evaluation Framework.	
	COMFORT BREAK at 11:22	
CORPORATE ASSURANCE		
PPC/2324/016	**Patient and Public Involvement (PPI) Assessment Log** The ICB Public Partnership Committee are recommended to note the PPI Forms and take assurance that forms are being completed and actioned appropriately. Included in the report were 7 PPIs received since the last report: - • Community Podiatry • Paediatric ADHD referral process • Derby Urgent Treatment Centre • Headache Pathway • Joy Marketplace • Minor Eye Conditions (MEC) • Post Covid Service **Community Podiatry**: This work has been paused due to the Quality Equality Impact Assessment (QEIA) being considered high risk which results in an escalation to the System Quality and Performance Committee. Currently awaiting the outcome of this discussion before deciding on an engagement approach. **Long Covid Service**: Funding for this service will be reduced next financial year. Regardless of whether funding is short-term or long-term in the initial set up of a project, it's important that commissioning colleagues recognise the impact on patients when a change to a service is made and will still need to be assessed and mitigations considered. The Committee offered the following comments and questions: - • SS raised the point around items with a funding stream which were temporary and ending and would have assumed that when the service was commissioned there would be an exit plan. SS asked if those exit plans incorporate the engagement approach for the population involved and affected, and if not, may require building in going forward. **Action**: KL to provide an update on progress regarding exit plans and temporary funding streams at a future meeting. **The Public Partnerships Committee NOTED and RECEIVED ASSURANCE that the forms were being completed and actioned appropriately.**	**KL**
PPC/2324/017	**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.* During quarter 1 of 2023/24, the BAF has been developed further including the cross referencing of gaps in control and assurance to the relevant actions. Action plans are to be updated to clearly articulate the planned actions and associated progress. The quarter 1 BAF position will be reported to the ICB Board public meeting on the 15 June 2023. 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: - • SS outlined the conversation around engagement of schemes that might be ending or temporarily funded and asked if that constituted another threat to the risk, that we do not have that arrangement in place. **Action:** ST to note on the BAF. **Action:** Updated action dates in the action plan on the BAF report to be factored into the Public Partnerships Committee Planner. ***The Public Partnerships Committee DISCUSSED and AGREED the Strategic Risk 3.*** ***The Public Partnerships Committee AGREED a risk score level 12 for Strategic Risk 3.***	**ST** **ST/LF**
PPC/2324/018	**Exception Risk Report May 2023 & Confidential Risk Report** The purpose of the paper is to present the operational risk owned by the PPC held on the ICB's corporate risk register for review and to provide assurance that robust management actions are being taken to mitigate them. As at 31 March 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.* Now in the process of formalising relationships with other departments and what their business plans are for the next 12 months, understanding what the rest of the organisation is expecting from the engagement team along with running cost allowance (RCA) conversations and conversations around core business. **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: - • TP asked whether ST's team were coping with regard to Risk 13 outlining the engagement team as the core, but all providers have engagement and asked how as a committee this was being measured. ST replied his team were coping and have been working really hard. Provider partners tend to have patient experience teams measuring the business of today the ICB is where it is going next and what the future looks like. • TP would like to see the Public Partnerships Committee having some indication of the capabilities of providers to actually engage. • SB understood that engagement was taking place in other places, but it was of interest to this committee especially if there was something major taking place within one of the providers. **Action:** Future Item - to look at engagement across the system. **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.** PC left the meeting.	**ST**
MINUTES AND MATTERS ARISING		
PPC/2324/019	**Minutes from the meeting held on: 25 April 2023** The Public Partnerships Committee **ACCEPTED** the Minutes as a true and accurate record of the meeting.	
PPC/2324/020	**Action Log from the meeting held on: 25 April 2023** The action log was reviewed and updated during the meeting. **Action:** Update in terms of membership, TOR and activities to implement actions made, to be brought to the next meeting.	**ST**
CLOSING ITEMS		
PPC/2324/021	**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? 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/2324/022	**Any Other Business** **Strategic Risk 8:** This risk is the responsibility of the Finance and Estates Committee. The risk identified is led by Jim Austin (JA) (Chief Digital Information officer), the risk states the system does not establish intelligence and analytical solutions to support decision making around digital improvements. **Action**: Digital improvements and engagement to be added to the forward planner for the next business meeting.	**LF**
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 27 June 2023 – **Development Session**		
Time: 10:00 – 12:00		
Venue: MS Teams		

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON
30th March 2023, 09:00
FLORENCE NIGHTINGALE BOARDROOM, CARDINAL SQUARE & MS TEAMS

Present:		
Margaret Gildea (Chair)	MG	Non-Exec Director, DDICB
Christine Fearns	CF	Non-Exec Director, UHDBFT
Brigid Stacey	BS	CNO & Deputy Chief Exec, DDICB
Richard Wright	RW	Non-Exec Director, DDICB
Robyn Dewis	RD	Director of Public Health -
Jayne Stringfellow	JS	Non-Exec Director – CRHFT
Lynn Andrews	LA	Non-Exec Director, DDICB
In Attendance:		
Jo Pearce (Minutes)	JP	EA to Brigid Stacey - DDICB
Dan Merrison	DM	Senior Performance & Assurance Manager, DDICB
Juanita Murray	JM	Designated Nurse Safeguarding Children Chair of CDOP
Ade Odunlade	AO	Chief Operating Officer - DHCFT
Libby Runcie	LR	Divisional General Manager Neurodevelopmental Services - DHCFT
Bill Nicol	BN	Asst Director of Safeguarding Adults
Jo Hunter	JH	Director of Quality, DDICB
Apologies:		
Chris Weiner	CW	Medical Director, DDICB
Craig Cook	CC	Chief Data Analyst, DDICB
Kay Fawcett	KF	Non-Exec Director, DCHS
Zara Jones	ZJ	Executive Director of Strategy and Planning - DDICB
Gemma Poulter	GP	Assistant Director, Safeguarding, Performance and Quality- Derbyshire County Council

Ref:	Item	Action
Q&P/2223/098	**Welcome, introductions and apologies** MG welcomed all to the meeting, introductions were made, and apologies noted as above.	
Q&P/2223/099	**Confirmation of Quoracy** The meeting was confirmed as being quorate, meeting the quoracy requirements of 2 Non-Executive Members, to include 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 or nominated deputies	
Q&P/2223/100	**Declarations of Interest** There were no declarations of interest noted.	

Q&P/2223 /101	**TCP Programme and progress** AO and LR presented the following information to the Committee. • **Workforce update**: ND services continues to have a good recruitment and retention rate with grow our own commitments. Dashboard demonstrates overall positive picture with some improvement required in supervision and appraisal. • **Partnership working**: Alliance working in partnerships are progressing well with relationships and joined up approaches and pathways forming cohesively. Committee in common received the joined-up finance report. • **Autism waiting times achieved:** Amendments to the clinical and operational model of Autism services has resulted in improvements to the performance with **the team starting to achieve the 26 contracted assessments per month**. However, this will not address the demand of an average of 65-70 referrals a month, as demand continues to outstrip current capacity. • **Positive Staff Survey Results**: ND services had incredibly positive staff survey results being the third highest of the whole organisation in response rate and engagement with the staff survey overall. **Key Next steps:** • **Supervision & Appraisal**: A targeted action plan is being established to address Supervision and appraisal rates to ensure ND as with other service provision lines is aiming to achieve 100% compliance. • **Demand and Capacity planning to meet demand**: A revised approach to waiting list management is being mobilised and should start to have an impact from quarter 4. • **Increase workforce capable of assessment:** 20 newly trained staff (pending ADOS licensing), by February 2024. • **Introduce robust flagging system on EPR,** accurate reporting data and consistency to operational processes, by Qtr. 2 2023. • **Review clinical processes to increase screening success** and increase the number of ASD assessments completed, to meet target for assessments by Qtr. 1 2023. • **ADHD:** DHcFT have proposed a range of posts to maximise output and integration to improve the patient's journey, quality of assessment and value for money for this service line, this is as a cost pressure to the organisation as not a commissioned service at present. • **Staff Survey**: plans are in place to take learning from the staff survey through the leads and development plans to be developed with staff and taken through COAT for actioning.	

	AO also added that despite a shaky start the TCP team have transitioned well from Derby and Derbyshire CCG into the Mental Health Trust, the workload is being reviewed due to how well they are working with other teams. There is also a plan for the Neuro Diverse patients within the mental health beds which will look at wrap around support in the community for the people who are due for discharge. In terms of Hillside Unit, there is currently one person in residence. There are issues around the utilisation, management, environment and quality status of Hillside at this present time. DHCFT are working with NHSE to look at the trajectory for 2023/24 and it is believed that there is a pragmatic and achievable plan now in place. AO confirmed that all patients on the TCP patient list have been reviewed and have a plan in place. JS noted a challenge around health checks and the relationship with GPs, commenting that over the last 5 years the amount of health checks increases towards the end of the year, and this can pose a risk around the quality of the health checks being performed. **ACTION** – BS will speak with Primary Care colleagues around the potential risks around the increased demand for health checks in the latter part of the year. RW noted the decision which had been made to invest in supporting people on the waiting list rather that employing more staff to undertake assessments which could reduce the waiting list. LR explained that through a number of co-production workshops with friends', families and service users that took place in October and November 22 , it was identified that relational support whilst waiting was one of the biggest areas of need. There has also been investment into in house training for additional psychologists who are embedded in the Community Mental Health Teams. RW referred to virtual wards and asked if the system is satisfied that the system have provisioned enough resource and whether assisted living technology is being used as part of the virtual wards. RW the asked about the usefulness of the health checks and what the results of the health checks are used for. AO explained the reason for the health checks is for prevention and possible early treatment. The contents of the paper were noted by the Committee.	**BS**
Q&P/2223 /102	**Integrated Performance Report** The paper was taken as read. **Quality** JH highlighted a number of quality issues.	

	The Midlands region are top performing in the country for the LeDeR process with Derbyshire placing in the top centile. There are several pieces of work progressing around health inequalities, particularly around DNA CPR linking into the EoL Group to ensure improved patient outcomes and ethical and quality focus within that cohort of patients. The ICB have been successful in leading a pilot across the whole of the Midlands on the NME programme and this work is progressing at speed. Elmwood MC in Buxton received an unannounced CQC visit on 23rd January 23 and were rated inadequate significant work is being undertaken with the practice and the Primary Care Quality Team to address issues that were raised. Maternity workforce pressures continue in CRHFT and UHDBFT within the maternity services and are limiting the ability to engage with the LMNS. Mitigations and actions to reduce the risks are underway CF commented on the increase in numbers of CYP with mental illness and complex behavioural needs who are admitted onto acute wards. CF asked for clarification around the Committees oversight of this issue in terms of improving the situation. BS explained to the Committee the recent difficult situation at CRHFT relating to 3 CYP on the acute wards and where CQC were considering taking regulatory action. Following detailed meetings with CRHFT, DDICB and CQC the issues were resolved. As a result, DDICB have commissioned Michelina Racioppi, DDICB Safeguarding Lead to undertake an individual review of the 3 cases. The outcome of the review will come to Quality and Performance Committee for assurance of the actions taken and learning. BS also noted a paper previously discussed at Quality and performance Committee that showed monitoring of the Bronze, Silver, Gold mechanism which has resulted in a sustained reduction at UHDBFT in children who are presenting at the acute hospitals with complex needs. BS assured Committee members that this is also being discussed System Quality Group. **PAPER** – BS will bring the outcome of the individual review and aligned metrics for both trusts to a future Committee meeting. CF raised her concerns that over the winter months found difficult to get children admitted into children's Emergency Department beds in a timely fashion because of pressures around the beds being occupied by children who do not have acute hospital needs. CF urged the Committee to look at the totality of impact on these children. **PAPER** - MG and CF agreed to have a fuller review of this subject at a future meeting. AO left the meeting. RD referred to challenges in maternity around staffing and leadership and asked if there is anything the system can be doing from a scrutiny perspective. BS acknowledged the changes in leadership in both acute trusts in the last year and noted her confidence of the new leadership in place at UHDBFT and CRHFT have long standing experienced HoM in place in the interim. BS added that at the last Quality and Performance	

	Committee meeting members gained assurance around the HSIB report and agreed to delegate monitoring to the LMNS and an assurance paper would be brought back to Quality and Performance Committee in 6 months or sooner if required. CF asked if Childrens Services have sufficient visibility in terms of the performance oversight at Committee meetings. BS explained that the Children's Delivery Board and MH LDA Delivery Board were merged about year ago due to complex issues that were occurring, however this has been disaggregated and the CYP Delivery Board is now in place to have oversight of Children's Services and is chaired by Andy Smith at Derby City Council. **Performance** DM noted the extra ordinary Quality and Performance Committee meeting on 20th March 2023 where details of the Operational Plan for the next financial year were discussed. Urgent Care preventative schemes doing well such as home visiting service and Community response. As result numbers into ED are relatively lower and co located UTCs have seen high numbers. Discharge is still slow with approx. 240 inpatients with NCTR, half delays are due to social care and quarter due to community bed availability. Ambulance handovers are fluctuating. The Bank holidays in April and May are being mitigated for as well as the planned Industrial Action. **Planned care** 52-week and 78 week waits numbers are decreasing overall and there is continued focus to reduce further. The diagnostic's waiting list has reduced but there are still hot points in endoscopy and echoes. Cancer performance is stagnant and there is still a high amount of 2 week wait referrals coming into the system. Mental Health - there are some indicators performing better than expected with good performance in IAPT and EIP (Early Intervention in Psychosis) Health checks for patients with severe MH illness is hitting trajectories. There is still, high demand for perinatal MH services and eating disorders for CYP and as a result these services are experiencing high waits. RW noted one area not covered within the IPR is Safeguarding and suggested the need to keep a watching brief on Safeguarding in both adults and children. BS gave assurance that the Safeguarding team report to SQG and escalations will come to Quality and Performance Committee as required. **PAPER** - BS offered for a report around the current position on Safeguarding adults and children to come to next Committee meeting. RW asked what the ICB should be looking at in totality as a system to try to solve some of the issues. CF made a comment that the IPR report describes the problems that the system is experiencing and asked at what stage will the system be	

	in a situation to look at the actions needed to improve positions. CF suggested testing out one certain pathway in order to get an entire view and to identify where the Committee needs to focus its assurance. **ACTION** - JH and DM will look at pathway reporting around improvement, change and mitigation. **ACTION** – JH will draft a schedule of deep dives that will be presented to the Quality and Performance Committee. **ACTION** – Committee members to share their thoughts on priorities within the Operational Plan with DM.	**JH /DM** **JH** **All**
Q&P/2223 /103	**Board Assurance Framework (BAF)** JH presented the paper and noted the two strategic risks that the Quality and Performance Committee are responsible for. Following on from the detailed discussion at the last Quality and Performance Committee, feedback from Committee members was fed back to the corporate team, in particular the comments received around being risk averse. The comments were also discussed at the ICB Board. There is a piece of work taking place on Q1 to further develop the BAF and action plans will be developed to ensure progress is being made. There is also a plan to modify the standard committee meeting cover sheet which will mean it shows links to the BAF. CF commented that there is a high reliance on the IPR to provide information on whether the risk is being mitigated effectively and questioned whether the IPR is adequate enough to deliver an understanding of the risk position. JH will feed back to the authors of the BAF. The Committee approved the BAF whilst recognising the comments received from CF and that there is further work to be done on the BAF.	

Q&P/2223/104	**Child Death Overview Panel (CDOP) Annual Report 2021/22** JM presented the Child Death Overview Panel (CDOP) Annual Report 2021/22. The CDOP Annual Report is written on behalf of the Child Death Review Partners to give assurance that the child death review arrangements are in place and are effective in meeting the statutory requirements set out in Working Together (2018) and Child Death Review Statutory and Operational Guidance (2018). The Annual Report sets out local patterns and trends in child deaths, learning and actions taken to prevent future deaths. Within 2021/22 there were 57 deaths which is consistent with previous years. There was an increase in unexpected and sudden deaths in older children which were mainly due to traumatic accidents. There were no increases in suicides. The report shows the increase in child deaths in Derby City is linked to deprivation, where 28% of children population is Derby City however 40% of the child deaths were in Derby City. 51 deaths were reviewed in 2021/22 and during this time there have been improvements in the identification of modifiable factors. The main three modifiable factors are smoking (parental and household) high BMI in women who have had babies and parental substance misuse. Contributory factors are medical conditions, gestation of babies and low birth weight. In 2021 there was a learning theme around sudden and unexpected deaths in teenagers. Themes identified were Autistic Spectrum Disorder, bullying, Adverse Childhood Experiences, previous self-harm and being a young carer. The learning from the theme panel has been shared across the system at Childrens Board, suicide partnership and DDSCB and a learning briefing has been produced. Work around keeping babies safe continues and progress is being made against the action plan which has been in place for the last two years. There has been work around the voices of parents and the lived experiences of children which gives a picture of the child when reviews are taking place. Challenges include the high level of cases that are sitting with the coroner which results in an increase in timescales as the reviews do not take place until the coroner has undertaken their process. All achievements and key priorities are listed within the report and JM confirmed that they are either completed or in progress. JH asked if there is any emotional support provided to the CDOP panel members given the distressing nature of some of the cases. JM confirmed that there is currently no offer other than herself, the Designated Doctor and Lead Nurse who provide support to the panel. There is a need for this as the panel are seeing an increase in traumatic deaths and complex child abuse cases.	

	ACTION – JH will undertake to have a conversation with relevant colleagues to identify whether this need can be addressed. RW asked if there has been an increase in the amount of child deaths. JM replied to say that although there is no increase in deaths the report shows an increase in complex families, more neglect, modifiable factor which show there are issues that need to be acted on as a system. LA asked if support services are being focused into schools and if services are being commissioned to support healthcare and voluntary sectors in the areas where there are the highest incidences. JM was unable to answer the question fully but felt that there are certain services which concentrate on areas of high deprivation such as family nurse support. There is also a focus on families with higher vulnerabilities and early identification. JH noted that both city and county councils have a SEND Board and asked if the areas for improvement around vulnerabilities could be fed into the SEND Boards. Both boards are developing a focused approach and one of the areas is early intervention. JH and JM agreed to discuss this further outside of this meeting. MG referred to a sentence within the report around the need to strengthen professional curiosity. MG asked if there has been a response from associate organisations to learning which is shared. JM confirmed that this is work that is ongoing as a Safeguarding partnership, it is a constant theme and something that should be encouraged within professionals. SQG members approved the Child Death Overview Panel (CDOP) Annual Report 2021/22.	**JH**
Q&P/2223 /105	**Serious Violence Duty** BN explained that the report is to evidence the work that is underway around serious violence and domestic abuse. This is a mandated government strategy and the ICB have been nominated as equal partners along with the Police and Probation services. The strategy is in draft form and will be complete and ready for sign off by a variety of partners in June 2023. The ICB are working closely with partners to ensure the NHS is influencing the strategy. Once the strategy is on place there will be the offer of training which will also be available to GP's. **PAPER** - BN suggested bringing this agenda item back to a future meeting once the strategy is on place.	
Q&P/2223 /106	**Assurance Report from System Quality Group** The paper was taken as read and there were no comments raised by Committee members. Members confirmed that they were assured by the report.	

Q&P/2223 /107	**Any Other Business** MG noted that this would be the last Quality and Performance Committee for Christine Fearns. MG expressed her thanks the Christine for her service to the Committee and for the quality and incisiveness of the comments made.	
Minutes and Matters Arising		
Q&P/2223 /108	**Minutes from the meeting held on 26th January 2023** The minutes were approved as an accurate record of the meeting, pending the following amendments. Lynn Andrews and Jayne Stringfellow had given apologies.	
Q&P/2223 /109	**Action Log and Future Papers** There were no outstanding actions. MG noted that from conversations that had taken place during the meeting there would be a schedule of deep dives planned for future Committee meetings.	
	Assurance/Meeting Evaluation Questions – Was the meeting attended by the right people? Yes. – Were the papers presented in the appropriate professional standard? Yes – Were papers already reported on to other committees presented in summary form? Yes – Was the content of the papers suitable and appropriate for the public domain? Yes – Were they sent to committee members at least five working days in advance? Yes – Does the committee want to undertake a deep dive? The proposal of the eating disorders deep dive was noted. – What recommendations does the committee want to make to the ICB Board?	
DATE AND TIME OF NEXT MEETING		
Date: Thursday 27th April 2023		
Time: 09:00		
Venue: Florence Nightingale Room, Cardinal Square, DE1 3QT / MS Teams		

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON
27th April 2023, 09:00 – 10:30
FLORENCE NIGHTINGALE BOARDROOM, CARDINAL SQUARE & MS TEAMS

Present:		
Adedeji Okubadejo (Chair)	AO	Non-Exec Director, DDICB
Lynn Andrews	LA	Non-Exec Director, DDICB
Robyn Dewis	RD	Director of Public Health – Derby City Council
Kay Fawcett	KF	Non-Exec Director, DDICB
Margaret Gildea	MG	Non-Exec Director, DDICB
Brigid Stacey	BS	CNO & Deputy Chief Exec, DDICB
Richard Wright	RW	Non-Exec Director, DDICB
In Attendance:		
Jo Pearce (Minutes)	JP	EA to Brigid Stacey - DDICB
Jo Hunter	JH	Director of Quality, DDICB
Craig Cook	CC	Chief Data Analyst, DDICB
Dan Merrison	DM	Senior Performance & Assurance Manager, DDICB
Bill Nicol	BN	Assistant Director Safeguarding Adult (Prevent Lead)
Michelina Racioppi	MR	Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children
Nicola Smith	NS	Assistant Director Children's Strategic Commissioning
Chris Burton – Fisher	CBF	Commissioning Manager for Children and Young People's Mental Health
Apologies:		
Zara Jones	ZJ	Executive Director of Strategy and Planning - DDICB
Chris Weiner	CW	Medical Director, DDICB
Jayne Stringfellow	JS	Non-Exec Director – CRHFT
Gemma Poulter	GP	Assistant Director, Safeguarding, Performance and Quality- Derbyshire County Council

Ref:	Item	Action
Q&P/2324/001	**Welcome, introductions and apologies** AO welcomed all to the meeting, introductions were made, and apologies noted as above.	
Q&P/2324/002	**Confirmation of Quoracy** The meeting was confirmed as being quorate, meeting the quoracy requirements of two Non-Executive Members, one ICB Executive or Deputy, one Provider Representative and one Local Authority Representative.	
Q&P/2324/003	**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 <u>Declarations of interest from sub-committees</u> No declarations of interest were made. <u>Declarations of interest from today's meeting</u> MG declared that she works with First Steps Eating Disorders and agreed to step back from the meeting if there was anything deemed inappropriate for discussion. AO conformed that he was unaware of any reason for MG not to take part in the discussions at today's meeting. There were no declarations of interest noted.	
Q&P/2324 /004	**Deep Dive - Childrens and Young Peoples Eating Disorders** NS explained that the Quality and Performance Committee are asked to give assurance for plans for improvement to meet the NHS performance standard for Children and Young Peoples Eating Disorders. NS shared the presentation and noted the format of *"what, why, how and when".* **<u>What is the performance standard?</u>** Urgent – 95% of urgent cases should commence a NICE concordant treatment within 1 week of referral Routine – 95% of routine cases should commence a NICE concordant treatment within 4 weeks of referral **<u>Why are we not meeting it?</u>** **Data/submission errors** • Resubmission of data problematic • Errors take time to drop out of the 12-month running total • Low numbers of CYP mean that our performance is significantly distorted by 1 breach **Increased referrals** • Initial increase in urgent, followed by a later surge in routine **Staff Vacancies/Recruitment** • Teams have been at half capacity or less at times through the mid, late and post-pandemic • Roles advertised but few applicants. • CYP Eating Disorders is a specialism within a specialism (e.g., Children's CBT for eating disorders) **Increase in acuity** • Some CYP are admitted to hospital requiring a period of medical stabilisation, if an urgent referral is made during this time but the CYP is not ready for assessment by the ED Team, this does not 'stop the clock' for a 1-week response and so we breach.	

- Other cases presenting as more complex and requiring high level of coordination across teams (e.g., ARFID)

How we will recover our performance?

Data/submission errors

Process review: Both teams were able to identify areas where processes could be adapted or improved. Providers adapted the reporting/submission process to remove ambiguity/room for error in submissions. Introducing team level submission audits to verify accuracy of submission by data team.

Increased referrals

Streamlining triage and assessment processes to support a timelier response. This included implementing a new initial contact template on System One to include a 60-minute initial assessment and a 30-minute Family Therapy Session.

Staff Vacancies/Recruitment

CAMHS ED – DHCFT (City and South Derbyshire)

- Increased banding of the Family Therapy post
- Separated out clinical and management responsibilities (to make the clinical role more attractive to prospective applicants)
- Secured a 12-month secondment of an Adolescent Focussed Therapist
- Supported training for established staff
- Successfully recruited to some of the vacant B6 roles to strengthen the family therapy team approach

CAMHS ED – CRHFT (North Derbyshire)

- Covered 2 out of 3 maternity roles
- Agreed retention of one of the maternity covers
- Separated out clinical and management responsibilities (to make the clinical role more attractive to prospective applicants)
- Secured some CBT hours to support additional stop-clock provision

The current vacancy position is South Derbyshire and City - 1.0 Family Therapist, 1.0 Dietitian, Intensive Community Engagement Worker. North Derbyshire - 0.6 Family Therapist.

Increase in acuity

There are aspects of performance that are nationally recognised and have impacted most systems, the commissioning and reporting guidance for eating disorders was written in 2015 and NHS England are currently reviewing and republishing this to make better sense of eating disorders. A clearer national view on changes in demand seen since the pandemic would have a focus on improving system efficiencies.

Refreshed SNOMED codes that will better reflect the types of presentations. There are more CYP requiring a period of physical medical stabilization before starting therapy. There is currently no stop clock code for this, and it does account for some of the breaches that have been seen locally.

	When we will achieve required performance and sustain it In Q1 22/23, a trajectory for recovery was agreed with both CAMHS ED teams. The trajectory was based on an average number of referrals coming in throughout the recovery period, setting the 95% target for end of Q4 22/23 and working back to set mid-points. The system is one quarter behind this trajectory due to recruitment delays and some 'stop clock' breaches, but its is expecting to achieve and sustain target by end of Q1 23/24 MG asked if either of the accountable Trusts use SPC charts. NS was unsure but confirmed she would obtain an answer and report back. MG asked if there is insight into how many people are requiring greater care as a result of waiting. CBF replied saying that a breach is a breach regardless of the amount of time. There is a strong feeling from both teams that that young people are not waiting significantly longer. MG raised an area for reflection around the people who are not being seen and also noted the excellent work being done in partnership with schools and the specialist eating disorders service. JH asked about the monitoring of outcomes for these children and families. CBF responded to say that CYP Eating disorder teams feed the output measures into MHSDT and also carry out the friends and families' test. KF asked for further assurance around sustainability of the service. CBF replied to say there is a clear role for early intervention and evidence shows that early access to support is key. There is a new clinical model being rolled out across the country specifically, around ensuring people receive treatment at an early stage in the first three years of the onset of an eating disorder. There is a huge role for early support which is the reason for recommissioning the early interventions specification to increase capacity. RD referred to the links between eating disorders, anorexia and the neuro-development pathway and asked if the pathways linked together. NS acknowledged the comment and noted but there is still a lot of work to do on the ND pathway to strengthen the support. MG noted the importance of GP awareness and highlighted system working between Local Authority, General Practice and the Primary Care network. CBF confirmed that first steps are collaborating with CAMHS on the Primary Care approach. BS added this is part of the GP mandatory training that is undertaken and suggested it is raised at the GP provider collaborative to ask if additional support or a more focused update is required. BS confirmed that she would be happy to raise this with Dr Andy Mott and the GP Provider Collaborative on behalf of this meeting. **The Committee were assured by the paper and its contents.**	
Q&P/2324/005	**Integrated Performance Report** The report was taken as read. CC noted the following points.	

	Performance UEC 4 hr standard – out turned at approx. 62% of patients dealt with within 4 hours. This metric was difficult to achieve during the winter. The plan for the next 12 months is to improve on that performance to 76% by end March 24. Actions taken as a system are Royal Derby Hospitals FT substantiating the Primary Care service at the front door and the aim to achieve a lower occupancy in the hospitals. Ambulance turnaround – hit high levels nationally last year, despite this Derbyshire are faring well with CRHFT being one of the best performing Trusts in the Midlands. Planned Care Good performance toward end of last financial year despite pressures around capacity in the acute sector being seen. 78ww were significantly reduced. All 78ww should be cleared by end May 23. 62day+ caner waits sustained reduction in long wait cohort, ambitious plan in 23 24 to reduce further. Good performance in terms of the 28-day faster diagnosis standard. The national target is to have cancer either diagnosed or ruled out within 28 days. The target is 75% and the ICB are reporting 72%. It is thought the target of 75% will be exceeded in 23/24. There are problem pathways in lower GI and Urological that are being worked on. MH Reduction in out of area placement bed days. The substantive solution to this is the PICU development in the county. Numbers continue to reduce despite the challenging target which has been set for 23/24. IAPT and Perinatal access – green shoots around sustained improvement in these areas. CC then referred to the Extra Ordinary Quality and Performance Committee meeting on 20th March 23 where the Operational Plan was discussed. CC noted that he would be happy to share the final version with Committee members and to discuss at the next meeting the priority areas and plans for improvements over the next 12 months. **ACTION** – CC will share the Operational Plan with Committee members. JH presented the Quality aspect of the IPR and noted the following points **Quality** A schedule of deep dives has been developed and will be presented to the SQG on Tues 2nd May 23. The deep dives are based on conversations that have taken place in this Committee meeting to date. LMNS review around Ockenden compliance – the Quality and Performance Committee have been well sighted on this subject and work continues in this area. Further compliance will be submitted to NHSE in April 23.	

	IPC – work continues across the system and a number of dd into breaches. There is an ICB and provider meeting lead by BS that will take place in May 23. TCP Programme and AHC – there was an extra ordinary meeting of the LDA MH Delivery Board to provide stronger focus on delivery in both areas sue to concerns being raised by NHSE Midlands region around performance. Out of Area placements – Work has commenced on the PICU building that will help eradicate dormitory accommodation across MH services. Delivery date is 2025. A deep dive around this work will be brought to this Committee later in the year. KF referred to LMNS and Ockenden compliance and noted UHDBFT position. KF suggested it would be helpful to have sight on the areas that UHDBFT are struggling with to see if they are triangulated. BS responded and highlighted that following receipt of the HSIB report assurance was delegated to the LMNS. BS suggested that Chris Weiner, as SRO for the ICB and Chair of the LMNS to present a Deep Dive on all aspects of maternity and the role of the LMNS. ACTION – JP to add to the agenda for the Q and P Committee meeting in June. KF asked about diagnostic waits, two in particular around MRI and Scanning. KF asked how these will affect 62 day waits. CC replied to say there is an ambitious improvement target in place which includes expansion of the CDC programme and recruitment drive in relation to endoscopy. The aim is to increase capacity to carry out more diagnostics and reduce waits. **The Committee were assured by the paper and its contents.**	
Q&P/2324/006	**Current Position On Safeguarding Adults And Children** BS explained the reason for the paper coming to the Q and P Committee is because it had been noted that Safeguarding was not included within the IPR. BS had agreed to invite Safeguarding leads for adults and children to Q and P Committee to look at Safeguarding performance and any issues and to give an oversight of activity and to note the challenges being faced. BN noted the Safeguarding adult's agenda is broader that it has ever been. Systems are improving and this is due to investment in Safeguarding adults that has not previously been seen. Safeguarding Boards are now a statutory requirement with the Boards having a subsystem to ensure work is progressing. There is continued focus to reduce referrals and to ensure referrals are appropriate. There is also a new area around the prevention of terrorism which is high on the government's agenda. There has been a recent review of the PREVENT strategy and BN offered to give an update to a future meeting if required. MR spoke about the 3 papers submitted to the Committee. Annual Report - Derby And Derbyshire Safeguarding Children Partnership. - which provides the committee with an overview of	

	performance, activity for 2022 and the priorities set for 2023. There is a significant amount of work taking place around the keeping babies safe agenda, which was one of the key priority areas ascertained from child practice reviews. Also included is a slide deck which provides the Committee an overview of the key assurance areas set by NHSE . MR confirmed that all areas are rated Green by NHSE. Performance report which gives provides an overview of the all the early help, children need, child protection, Looked After Children activity. Key priorities and areas of focus are: • Children at risk of exploitation and contextual safeguarding and understanding emerging vulnerabilities. • Promote and obtain assurance around early help arrangements. • Reducing the adverse impact of domestic abuse and family conflict and promoting and improving the safety of babies. • Driving forward the implementation of the serious violence duty and tackling organized crime. RW commented on the continued increase in asylum seekers, both adults and children and raised a question around the affects that will have on Safeguarding demand. BN confirmed that there is continual contact with Police to share information on the pressures that are being seen. MR continued to say there is no plans to reduce the amount of contingency hotels in Derby and Derbyshire and there is the potential for more to be opened as the warmer weather approaches. Demands on local GP services is significant which has a ripple effect on other services depending on issues the GP identifies when seeing this cohort of people. There is a Settlement and Cohesion Board which looks the how Local Authority and Health can meet the needs of asylum seekers across the footprint. RD noted the MH impact on asylum seekers who have been in the asylum hotels in excess of one year and the LA meet with hotel providers and GPs to look at tackling these MH issues. RD also highlighted the number of houses being rented in the City to provide settled asylum accommodation, long leases are resulting in an inflation in prices and decimating the provision of properties within the City. LA asked how the impact is measured in terms of adults or children that have been kept safe. MR responded to say that as chair of the Derby and Derbyshire Safeguarding Children Quality Assurance Committee multi agency deep dive audits of cases have been carried out which helps identify if a difference is being made, such as disseminating policies, procedures or guidance and learning from reviews. **The Committee were assured by the papers and the contents.**	

Q&P/2324/007	**System Quality Group Assurance Report** The paper was taken as read and presented to the Committee for assurance. JH asked the Committee to note the two pieces of work highlight in the report • CRHFT is currently piloting the Macmillan AHP project, where the MacMillan team are supporting the prehabilitation and rehabilitation needs of patients affected by cancer. The team are currently scoping four tumour sites: Lung, Colorectal, Urology and Breast. The Group asked that the team scope a business case for discussion at the NHS Executive Team Meeting. • Proposal to develop a pathway for a lower leg wound referral to an acute vascular department for surgical assessment – agreed to engage with relevant clinicians in the system with the aim of developing the pathway at pace at bring back a paper to SQG in July 2023. **The Committee were assured by the paper and its contents.**	
Q&P/2324/008	**Board Assurance Framework (BAF)** JH noted the ongoing work taking place to refine the BAF. JH asked the Committee to inform her of any specific comments, which will be fed back to the Corporate Governance Team. AO asked for an update on progress on the two BAF Strategic risks. JH confirmed that work is ongoing and that the BAF will always be a live document. BS suggested setting up an Operational BAF Group. The group would meet monthly to discuss the BAF and actions being taken so that highlights of the discussions that have taken place can be presented to the Committee with an updated proposal for approval. AO supported the suggestion and process. **ACTION** – JH will set up the Operational BAF Group in time for the next meeting. **The Committee were assured by the paper and its contents.**	**JH**
Q&P/2324/009	**NOF Q4 Templates** JH presented the paper on behalf of the Corporate Governance Team. The Committee were asked to support the provider NOF segmentation as earlier discussions indicated that there would be no changes to the ratings from the last quarter based on assumptions made to date. **The Committee supported the NOF Q4 segmentation.**	
Q&P/2324/010	**Has the Committee discussed everything identified under the BAF** AO confirmed that this has been delegated to the Operational BAF Group.	

	Are there any changes to be made to the BAF as a result of discussions AO confirmed that this has been delegated to the Operational BAF Group.	
Q&P/2324 /011	**Any Other Business** BS noted that from 1st April 23 the ICB has seen delegation from NHSE of Podiatry, Optometry and Dentists (POD). Nottingham and Nottinghamshire ICB have taken the lead for this role in terms of performance and quality on behalf of Derby and Derbyshire ICB and the East Midlands. A report on the process and actions being taken will be presented at the SQG on Tuesday 2nd May 23 and full report for assurance will come to Quality and Performance Committee on 23rd May 23.	
Minutes and Matters Arising		
Q&P/2324 /012	**Minutes From The Meeting Held On 20th March and 30th March 2023.** The minutes from the meetings on 20th March and 30th March 23 were approved as a true and accurate record.	
Q&P/2324 /013	**Action Log and Future Papers - From The Meeting Held On 30th March 2023** The action log was reviewed and updated. Action 101 – an update to this action was circulated on Wednesday 26th April 23, it was agreed that the action could be closed.	
	Assurance/Meeting Evaluation 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 • Were papers that have already been reported on at another committee presented to you in a summary form? Yes • 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 mostly • 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? LeDer process, 62 day waits and Maternity will be scheduled • What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? Will be made in the in the assurance report to the ICB Board	

DATE AND TIME OF NEXT MEETING
Date: Thursday 23rd May 2023
Time: 9.30am to 11.00am
Venue: Florence Nightingale Room, Cardinal Square, DE1 3QT

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON
25th MAY 2023, 09:00 – 10:30
FLORENCE NIGHTINGALE BOARDROOM, CARDINAL SQUARE & MS TEAMS

Present:		
Adedeji Okubadejo (Chair)	AO	Non-Exec Director, DDICB
Lynn Andrews	LA	Non-Exec Director, DDICB
Robyn Dewis	RD	Director of Public Health – Derby City Council
Kay Fawcett	KF	Non-Exec Director, DDICB
Margaret Gildea	MG	Non-Exec Director, DDICB
Brigid Stacey	BS	CNO & Deputy Chief Exec, DDICB
Richard Wright	RW	Non-Exec Director, DDICB
Chris Weiner	CW	Medical Director, DDICB
Zara Jones	ZJ	Executive Director of Strategy and Planning, DDICB
In Attendance:		
Sarah Carrington (Minutes)	SC	Senior Quality Administrator & interim PA to Jo Hunter - DDICB
Jo Hunter	JH	Director of Quality, DDICB
Samuel Kabiswa	SK	Assistant Director Planning and Performance
Dan Merrison	DM	Senior Performance & Assurance Manager, DDICB
Kevin Watkins (observing)	KW	360 Assurance
Apologies:		
Jayne Stringfellow	JS	Non-Exec Director – CRHFT

Ref:	Item	Action
Q&P/2324/014	**Welcome, introductions and apologies** AO welcomed all to the meeting, introductions were made, and apologies noted as above.	
Q&P/2324/015	**Confirmation of Quoracy** The meeting was confirmed as being quorate, meeting the quoracy requirements of two Non-Executive Members, one ICB Executive or Deputy, one Provider Representative and one Local Authority Representative.	
Q&P/2324/016	**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 MG declared that she works with First Steps Eating Disorders and agreed to step back from the meeting if there was anything deemed inappropriate for discussion. AO conformed that he was unaware of any reason for MG not to take part in the discussions at today's meeting. There were no declarations of interest noted.	
Q&P/2324/017	**Integrated Performance Report** The report was taken as read. JH and DM noted the following points. **Quality** JH noted 3 areas: **Children's Safeguarding** In terms of the Serious Violence Duty which sits with the ICB. Cresta advisory service have presented their joint readiness statement on the Derbyshire system and has declared the system to be at the preparing stage of the work. The work will continue to be reported as it progresses. Contingency Hotels – ensuring Safeguarding and community issues that have been raised are being managed. **Primary Care** Elmwood Medical Centre will be discussed in more detail in the confidential section of this meeting. **Learning and Sharing best practice and outcomes.** On the 25April 2023 the Regional Chief Nursing Officer & Derby & Derbyshire Integrated Care System Chief Nurse visited the Walton Unit at DCHS and EMAS and met the Quality Team. There was a presentation relating to the future of Nursing in EMAS and a tour of the Emergency Operations Centre. Future visits will be planned through the year. **Performance** **UEC** Ambulance handovers had improved during April however these have risen again in May. ED wait performance has not improved due to varying factors. There were a high number of trolley breaches (287 for April). There continues to be discharge delays due to the availability of community beds which account for approx. one third of the delays. DM noted community trusts were adversely affected by the industrial action. There has been a rise in delays due to hospital processes and SORG are exploring the reasons in more detail. The bank holidays during April and May also affected performance. **Planned Care** Overall waiting lists have risen along with the proportion over 18 weeks, however the 65+ and 78+ waits continue to reduce, and these patients are being targeted in the operational plan. Diagnostics are affected by urgent and planned care pressures. Echo and Endoscopy remain the areas of most concern. Cancer referrals	

	remain higher than pre pandemic levels and 62-day performance has seen an improvement in this report. **Mental Health** IAPT services are performing better than expected in terms of the 6 weeks wait to access and this is also the case for early psychosis intervention of two weeks and the out of area bed position. LD&A are exceeding local targets however the MHLDA Delivery Board are reporting these are below the national benchmarking. CYPED continues to improve. Perinatal access is also improving but remains below target. BS noted the requirement for zero 78 week waits by the end June 2023. BS asked if all organisations are committed and on target to deliver. ZJ responded to say that the 78 week wait position is being worked through by both acute trusts and numbers are significantly less than the previous 12 months. Validation is ongoing to obtain accurate figures. Trusts are encouraged to utilise independent sector providers however there are patients who are not wanting to move from the current wait list, and this is having an impact on the breaches that are being seen. A clear review on the 78-week elimination will be available within the next week. RW noted the continued addition of people onto the waiting lists and asked if there is a forward view to ensure the pressures do not continue. ZJ responded to say that whilst the focus is around the very long waits the system is looking beyond that, there is a future trend which is looking very fragile. Capacity in both NHS and independent sector and productivity will be key factors. AO asked if the capacity to maintain services is dependent on the independent sector and queried how confident is the system in gaining the most efficiency and productivity from the primary providers. ZJ stated the ICB is working to ensure everything is available when agreeing contracts next year's contracts with the independent sector providers for key specialties, however it is a fragile position. ZJ noted the financial constraints and that the Committee need to be sighted on the fact that difficult decisions may have to be made over the next few months about affordability. RW asked for details of the main constraints. ZJ responded to say this was due to a variety of factors including discharge and flow issues, staffing and industrial action. ZJ offered to provide more detailed data to the committee in the future. KF referred to the 12-hour trolley breaches and asked from a quality perspective how does the system monitor any difference in the patient's condition due to these prolonged delays. Are the conditions reviewed and does the system provide assurance anywhere else within the system other than quality and performance committee. BS confirmed that work is taking place around harm related to people on the waiting list. Harm reviews have been carried out on this cohort. Through the CQRG meetings both acute trusts have been asked to look at the outcome of a patient prior to discharge and whether their condition has deteriorated and if there are links to the long wait experienced. Work is also underway with local authorities around a pathway to look at what happens post discharge. BS confirmed that an update on the progress	

	of this project will be presented at the Quality and Performance Committee meeting in June 2023. KF also asked when the report around the multi-disciplinary review around perinatal mortality associated with UHDB could be expected. CW responded and noted the terms of reference for the investigation are still in development. Engagement with internal and external organisations to the ICS are continuing. The aim is for the initial report to be available in October 2023. CW highlighted the impending industrial action relating to Junior Doctors which starts on 14 June 2023. CW noted previous episodes of industrial action have all impacted on long waiters and wished for the Committee to be cited on the potential risk. AO referred to patients who have no criteria to reside in hospital who continue to remain in hospital. AO asked if there was any additional insight into this issue. BS responded stating that this is a long-standing issue particularly over the winter period. There has been a deep dive around discharge and the discharge process which came to the Quality and Performance Committee recently. Work across the system in this area is ongoing. BS referred to the ongoing work undertaken by the Strategic Discharge Group, led by Dean Wallace, Executive Director at DCHS. There is a plan to bring back a further deep dive in this area in the autumn. BS offered to provide a full update outside of this meeting. **The Committee were assured by the paper and its contents.**	
Q&P/2324/018	**POD Update** JH presented the paper to the committee. The paper is around the transfer of Pharmacy Optometry and Dental services from NHS England to the ICB. Work has been done across the system to understand the responsibilities of the ICB. The decision was made to have a hub model across the Midlands. The east of the region is hosted by Nottinghamshire ICB. Work is taking place to understand governance arrangements. This work will feed into the System Quality Group and escalate to Quality and Performance Committee if required. AO asked if existing governance arrangements will be satisfactory for the services coming into the ICB. JH confirmed that System Quality Group is the appropriate place for governance arrangement to sit. LA asked if there was any foresight into potential issues that may arise that would help understand the challenges prior to them occurring. JH responded and confirmed that work is taking place from both a safeguarding and quality perspective around prior knowledge of services, in particular, dental services to understand potential issues. One area that cannot be identified at this time is the size of any potential issues. **The Committee were assured by the paper and its contents.**	

Q&P/2324/019	**System Quality Group Assurance Report** The paper was taken as read and presented to the Committee for assurance. JH explained that the System Quality Group meeting on 2n May 2023 was well attended and detailed discussions took place. Positive assurance was received across a wide range of papers in particular the corporate risk register, ICS risk register and industrial action update. Other papers discussed at the meeting included medicines safety update, perinatal quality and safety forum update and workforce training and education update. The Oliver McGowan training is focused on wider aspects of the care and treatment around people with learning disabilities and autism. A more detailed report around this work which has been undertaken as a system is being presented at the System Quality Group meeting on 6 June 2023. **The Committee were assured by the paper and its contents.**	
Q&P/2324/020	**Board Assurance Framework (BAF)** JH presented the paper on behalf of the Corporate Directorate. JH noted the decision that was made at the last Quality and Performance Committee to implement a forum to discuss the BAF in more detail. JH confirmed that the first meeting of the BAF Forum is on 5 June 2023. Outcomes from this meeting will be featured in this report going forward. JH noted the updates to the BAF and asked the committee for any comments which will be fed back to the Corporate Directorate. LA asked whether a risk around industrial action and the impact on performance and quality should be included in risks. JH responded to say it has been agreed that this risk will sit with the Corporate Directorate and should not be replicated within other Committees risks. The risk does reference quality and performance and is presented at System Quality Group on a regular basis. **The Committee were assured by the paper and its contents.**	
Q&P/2324/021	**Schedule Of Proposed Deep Dives** JH presented the paper to the committee. The paper recognises the need for deep dives into particular areas, the paper sets out a proposed process for the deep dives to be presented at System Quality Group to ensure system leads are cited on the issues being presented. The deep dive will then be presented to the subsequent Quality and Performance Committee meeting. Items presented will be ones that are deemed as needing further information or examples of good practice. JH confirmed that at the Quality and Performance Committee meeting in June there will be two deep dives, one on the LeDeR process and the learning disabilities and autism annual health checks and one around maternity.	

	The Committee supported the process for the presentation of Deep Dives into SQG and Quality and Performance Committee.	
Q&P/2324 /022	**Has the Committee discussed everything identified under the BAF** Yes **Are there any changes to be made to the BAF as a result of discussions** AO confirmed that this will be taken further following the BAF Forum on 5 June 2023.	
Q&P/2324 /023	**Any Other Business** No other matters of business were raised by committee members.	
	Minutes and Matters Arising	
Q&P/2324 /024	**Minutes From The Meeting Held On 27th April 2023.** The minutes from the meetings on 27th April 2023 were approved as a true and accurate record. LA gave an update around two queries raised during the presentation around Children and Young People's Eating Disorders. LA confirmed that the use of SPC charts is not used due to the small volume of patients using the service. In terms of breaches, due to the small amounts, managers within the service are dealing with the breaches in a rapid manner. LA wished to give assurance to the committee and noted that she felt personally comfortable with the responses she had received.	
Q&P/2324 /025	**Action Log and Future Papers - From The Meeting Held On 27th April 2023** The action log was reviewed, and confirmation given that there were no outstanding actions.	
	Assurance/Meeting Evaluation 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 • Were papers that have already been reported on at another committee presented to you in a summary form? Yes • 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? A deep dive process was discussed and approved at this meeting. • What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? Will be made in the in the assurance report to the ICB Board	

DATE AND TIME OF NEXT MEETING
Date: Thursday 29th June 2023
Time: 9.30am to 11.00am
Venue: Florence Nightingale Room, Cardinal Square, DE1 3QT

NHS Derby and Derbyshire Integrated Care Board

Meeting in Public – ICB Business

Forward Planner 2023/24

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

ICB Key Areas	2023/24											
	20 Apr	18 May	15 Jun	20 Jul	17 Aug	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Introductory Items												
Welcome / Apologies and Quoracy	X			X			X			X		
Questions from Members of the Public	X			X			X			X		
Declarations of Interests • Register of Interest • Summary register of interest declared during the meeting • Glossary	X			X			X			X		
Minutes and Matters Arising												
Minutes of the previous meeting	X			X			X			X		
Action Log	X			X			X			X		

ICB Key Areas		2023/24											
		20 Apr	18 May	15 Jun	20 Jul	17 Aug	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Strategic Planning & Commissioning													
Commissioning Reports/Plans/Business Cases (where applicable)		X			X			X			X		
	Exec Lead (s)												
Planning for Winter (Operational/Care/Finance/Workforce)	ZJ/PL/KG/LG							X					
NHS Joint Forward View 2024 and beyond.	KG/ZJ/LG	X			X			X			X		
NHS Derby and Derbyshire ICB Annual Report and Accounts	HD/KG							X					
Amended Constitution	HD							X					
Integrated Assurance & Performance													
Integrated Assurance and Performance Report • Quality • Performance • Workforce • Finance		X			X			X			X		
Corporate Assurance													
Audit and Governance Committee Assurance Report		X			X			X			X		
Finance and Estates Committee Assurance Report – verbal		X			X			X			X		

ICB Key Areas	2023/24											
	20 Apr	18 May	15 Jun	20 Jul	17 Aug	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
People and Culture Committee Assurance Committee	X			X			X			X		
Population Health and Strategic Commissioning Committee Assurance Report	X			X			X			X		
Public Partnership Committee Assurance Committee	X			X			X			X		
Quality and Performance Committee Assurance Report	X			X			X			X		
Corporate Risk Register Report	X			X			X			X		
Corporate Committees' Annual Reports							X					
Update and review of Committee TORs	X						X					
For Information												
Ratified Minutes of ICB Corporate Committees	X			X			X			X		
Closing Items												
Forward Planner	X			X			X			X		
Any Other Business	X			X			X			X		
Items Received from members of the public	X			X			X			X		