NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC AGENDA

Thursday 16th May 2024 at 9am to 11:00am

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/2425/001	Welcome, introductions and apologies:	Dr Kathy McLean	Verbal
	ICBP/2425/002	Confirmation of quoracy	Dr Kathy McLean	Verbal
	ICBP/2425/003	Declarations of Interest • Register of Interests • Summary register for recording interests during the meeting	Dr Kathy McLean	Paper
09:05	**Minutes and Matters Arising**			
	ICBP/2425/004	Minutes from the meeting held on 21.3.2024	Dr Kathy McLean	Paper
	ICBP/2425/005	Action Log – March 2024	Dr Kathy McLean	Paper
09.10	**Leadership**			
	ICBP/2425/006	Chair's Report – April 2024	Dr Kathy McLean	Paper
	ICBP/2425/007	Chief Executive Officer's Report – April 2024	Dr Chris Clayton	Paper
09.20	**Strategy**			
	ICBP/2425/008	Primary Care Model Update	Dr Andy Mott, Dr Duncan Gooch	Paper and presentation
09.45	**Delivery and Performance**			
	ICBP/2425/009	Performance Report • Quality	Dr Chris Clayton Dr Deji Okubadejo, Prof Dean Howells	Paper

Time	Reference	Item	Presenter	Delivery
		• Performance • Workforce • Finance	Richard Wright, Michelle Arrowsmith Margaret Gildea, Linda Garnett Jill Dentith, Keith Griffiths	
	ICBP/2425/010	Operational Plan Update 2024/25	Dr Chris Clayton, Executive Leads	Paper
	ICBP/2425/011	Primary Care Access Recovery Plan	Michelle Arrowsmith	Paper
	ICBP/2425/012	NHS Impact Programme	Dr Chris Weiner	Paper
10:35	**Corporate Governance, Assurance and Risk**			
	ICBP/2425/013	Audit and Governance Committee Assurance Report – May 2024	Sue Sunderland	Paper
	ICBP/2425/014	Finance, Estates and Digital Committee Assurance Report – March and April 2024	Jill Dentith	Paper
	ICBP/2425/015	Quality and Performance Committee Assurance Report – March 2024	Dr Deji Okubadejo	Paper
	ICBP/2425/016	Population Health and Strategic Commissioning Committee – April 2024	Richard Wright	Paper
	ICBP/2425/017	People and Culture Committee Assurance Report – April 2024	Margaret Gildea	Paper
	ICBP/2425/018	Public Partnership Committee Assurance Report – April 2024	Richard Wright	Paper
	ICBP/2425/019	ICB Board Assurance Framework – Quarter 4 2023/24 and Opening 2024/25 position	Helen Dillistone	Paper
	ICBP/2425/020	Risk Register Report – April 2024	Helen Dillistone	Paper

Time	Reference	Item	Presenter	Delivery
10:50	**Items for information**			
	The following items are for information and will not be individually presented			
	ICBP/2425/021	Ratified minutes of ICB Committee Meetings can be found online. • Audit and Governance – 14.03.2024 • Finance, Estates and Digital –26.03.2024 • People and Culture – 22.02.2024 • Population Health and Strategic Commissioning – 14.03.2024 • Public Partnerships – 27.02.2024 • Quality and Performance – 28.03.2024	Dr Kathy McLean	Ratified Minutes of ICB Committee Meetings » Joined Up Care Derbyshire
	ICBP/2425/022	Forward Planner	Dr Kathy McLean	To note
	ICBP/2425/023	Glossary	Dr Kathy McLean	To note
10:55	**Closing Items**			
	ICBP/2425/024	Any Other Business	Dr Kathy McLean	Verbal
	ICBP/2425/025	Any risks identified during the course of the meeting	Dr Kathy McLean	Verbal
	ICBP/2425/026	Questions received from members of the public	Dr Kathy McLean	Verbal
Date and time of next meeting in public: **Date:** Thursday, 18th July 2024 **Time:** 9am to 11am **Venue:** Council Chambers, Council House, Derby			Dr Kathy McLean	Verbal

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

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

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					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Howells	Dean	Chief Nurse Officer	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee Local Maternity and Neonatal System Board Clinical and Professional Leadership Group Information Governance Assurance Forum ICS Executive Team Meeting	Honorary Professor, University of Wolverhampton	✓				13/09/23	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair.
Lumsdon*	Paul	Executive Director of Operations	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee Local Maternity and Neonatal System Board Clinical and Professional Leadership Board	Nil							No action required
McLean	Kathy	ICB Chair	N/A	Non Executive Director Barking Havering and Redbridge NHS Trust		✓			20/06/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Kathy McLean Limited - a private limited company offering health related advice	✓				05/08/19	Ongoing	
				Non Executive Director at Barts Health NHS Trust	✓				01/12/19	Ongoing	
				Occasional adviser for CQC well led inspections	✓				24/06/22	Ongoing	
				Chair of Nottingham and Nottinghamshire Integrated Care Board		✓			01/02/21	Ongoing	
				Chair of Nottingham and Nottinghamshire Integrated Care Partnership		✓			01/02/21	Ongoing	
				Joint Chair of Joint Negotiating Committee Staff and Associate Specialists on behalf of NHS Employers		✓			24/06/22	Ongoing	
				Member of NHS Employers Policy Board		✓			Ongoing	Ongoing	
				Senior Clinical Advisor for Public Sector Consultancy	✓				Ongoing	Ongoing	
				Chair of ICS Network, NHS Confederation		✓			01/04/24	Ongoing	
				Chair of East Midlands Specialised & Joint Committees		✓			01/04/24	Ongoing	
Mott	Andrew	GP Amber Valley (Primary Medical Services Partner Member)	System Quality Group Joint Area Prescribing Committee Derbyshire Prescribing Group Clinical and Professional Leadership Group Primary Care Network Delivery & Assurance Group End of Life Programme Board Children's Urgent Care Group Urgent Treatment Centres Delivery Group Amber Valley Place Alliance Group	GP Partner of Jessop Medical Practice	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Practice is shareholder in Amber Valley Health Ltd (provides services to our PCN)	✓				01/07/22	Ongoing	
				Medical Director, Derbyshire GP Provider Board	✓				01/07/22	Ongoing	
				I am the managing Partner at Jessop Medical Practice, involved in all aspects of provision of primary medical services to our registered population.		✓			01/07/22	Ongoing	
				Wife is Consultant Paediatrician at UHDBFT				✓	01/07/22	Ongoing	
Okubadejo	Adedeji	Clinical Lead Member	Population Health & Strategic Commissioning Committee Quality & Performance Committee Remuneration Committee	Director, Carwis Consulting Ltd. Provision of clinical anaesthetic and pain management services as well as management consulting services to patients and organisations in the independent healthcare sector	✓				01/04/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Provision of private clinical anaesthesia services	✓				01/04/23	Ongoing	
				Director and Chairman, OBIC UK. Working to improve educational attainment of children from black and minority ethnic communities in the UK			✓		01/04/23	Ongoing	
Posey	Stephen	Chief Executive Officer, UHDBFT (NHS Trust & FT Partner Member)	UEC Delivery Board (Chair) Provider Collaborative Leadership Board (Chair)	Chief Executive Officer of UHDBFT	✓				01/08/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Board Trustee of the Intensive Care Society		✓			10/12/19	Ongoing	
				Executive Well-Led Reviewer for the Care Quality Commission		✓			01/06/18	Ongoing	
				Chief Executive Member of the National Organ Utilisation Group		✓			02/07/21	Ongoing	
				Partner is Chief Executive Officer of the Royal College of Obstetricians and Gynaecologists				✓	01/08/23	Ongoing	
				Partner is a Non-Executive Director for the Kent, Surrey & Sussex (KSS) AHSN				✓	01/08/23	Ongoing	
				Partner is a Non-Executive Director for Manx Care				✓	17/05/23	Ongoing	

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

MINUTES OF NHS DERBY AND DERBYSHIRE ICB BOARD MEETING IN PUBLIC

Held on Thursday, 21st March 2024

via Microsoft Teams

Unconfirmed Minutes

Present:		
Richard Wright	RW	ICB Chair (Meeting Chair)
Tracy Allen	TA	Chief Executive DCHSFT / Participant to the Board for Place
Jim Austin	JA	ICB Chief Digital and Information Officer
Dr Avi Bhatia	AB	Participant to the Board for the Clinical & Professional Leadership Group
Dr Chris Clayton	CC	ICB Chief Executive Officer
Jill Dentith	JED	ICB Non-Executive Member
Helen Dillistone	HD	ICB Chief of Staff
Linda Garnett	LG	ICB Interim Chief People Officer
Margaret Gildea	MG	ICB Non-Executive Member / Senior Independent Director
Keith Griffiths	KG	ICB Chief Finance Officer
Ellie Houlston	EH	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)
Prof Dean Howells	DH	ICB Chief Nurse
Dr Deji Okubadejo	DO	ICB Board Clinical Other Member
Stephen Posey	SPo	Chief Executive UHDBFT / Chair of the Provider Collaborative Leadership Board (NHS Trust and FT Partner Member)
Mark Powell	MP	Chief Executive DHcFT (NHS Trust and FT Partner Member)
Sue Sunderland	SS	ICB Non-Executive Member
Dr Chris Weiner	CW	ICB Chief Medical Officer
In Attendance:		
Stephen Bateman	SB	CEO, DHU Healthcare CIC
Helen Blunden	HB	BSL Interpreter
Craig Cook	CCo	Director of Acute Commissioning, Contracting and Performance
Kate Durrant	KD	ICB Board Secretary (incoming)
Fraser Holmes	FH	BSL Interpreter
Dawn Litchfield	DL	ICB Board Secretary (outgoing)
Fran Palmer	FP	ICB Corporate Governance Manager
Suzanne Pickering	SP	ICB Head of Governance
Sean Thornton	ST	ICB Deputy Director Communications and Engagement
Apologies:		
Michelle Arrowsmith	MA	ICB Chief Strategy and Delivery Officer / Deputy CEO
Dr Andrew Mott	AM	GP Amber Valley (Partner Member for Primary Care Services)
Andy Smith	AS	Strategic Director of People Services – Derby City Council (Local Authority Partner Member)

Item No.	Item	Action
ICBP/2324/141	**Welcome, introductions and apologies:** Richard Wright (RW) welcomed everyone to the meeting. The size of the meeting pack was acknowledged, due mainly to the papers relating to the delegation of specialised commissioning arrangements. This is the second tranche of delegated services from NHS England, the first ones being primary care, pharmacy, optometry, and dentistry. There is a	

	commitment by NHS England to continue to delegate services to ICBs going forward. Apologies for absence were noted as above.	
ICBP/2324/142	**Confirmation of quoracy** It was confirmed that the meeting was quorate.	
ICBP/2324/143	**Declarations of Interest** The Chair reminded Committee Members of their obligation to declare any interests they may have on issues arising at Committee meetings which might conflict with the business of the ICB. Declarations made by members of the Board are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the ICB Board Secretary or the ICB website, using the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/integrated-care-board-meetings/ No further declarations of interest were made.	
ICBP/2324/144	**Minutes of the meeting held on 18th January 2024** **The Board APPROVED the minutes of the above meeting as a true and accurate record of the discussions held**	
ICBP/2324/145	**Action Log – January 2024** ICBP/2324/051 – Integrated Assurance and Performance Report – RW considered that today's report, compared to the one produced a year ago, has changed markedly, now better reflecting system working. Although improvements have been made, there is still more work to do to rationalise what is presented to the Board and to better reflect the strategic nature of the whole system. ICBP/2324/124 – ICB Risk Register Report – December 2023 – The Quality and Performance Committee is to conduct a forensic review on Risk 9 at its March meeting next week. **The Board NOTED the Action Log**	
ICBP/2324/146	**Chair's Report – February 2024** RW presented his report, a copy of which was provided with the meeting papers. The report was taken as read; the following points of note were made: • It was noted that Tracey Allen (TA), will be leaving the NHS later in the year. TA has been a brilliant asset to the ICB and will be missed, she has done a sterling job. • Dr Chris Weiner (CW) reinforced the message around measles and the importance of the MMR immunisation. Measles is currently circulating around the Midlands. The MMR immunisation is extremely effective in protecting children from the serious consequences of measles.	

	The Board NOTED the Chair's report	
ICBP/2324/147	**Chief Executive's Report – February 2024** CC presented his report, a copy of which was provided with the meeting papers. The paper was taken as read; the following points of note were made: • The exit position of 2023/24 will be focused upon at today's meeting; it is important to reflect on the achievements made during this year, prior to looking at the 2024/25 position and what the ICB wants to achieve going forward. • Ongoing industrial action by junior doctors was announced yesterday; assurance was provided that the whole system will prepare and respond as required. • The work around the ICB restructure of staff is now being concluded. Thanks were conveyed to all colleagues working through this with care, sensitivity, and determination to resize and reshape the organisation due to the forward focus. This has been approached with a kind, compassionate and thoughtful spirit. • Despite the challenges faced by the NHS, it is still a preferred future option of employment for young people, linking to the work being undertaken in partnership with the Anchor Institution. • Colleagues working at Acute sites who have been supporting ambulance handovers in Trusts were thanked for their hard work over the winter; it is hoped that this will be sustainable and continue to be embedded into the recovery of urgent and emergency care. RW congratulated Stephen Posey and Hal Spencer on the ambulance turnover improvements; he hoped that this could be continued. RW acknowledged the reduction undertaken within the centre of the ICB, which has been very professionally and compassionately handled. **The Board NOTED the Chief Executive's report**	
ICBP/2324/148	**Board Assurance Framework (BAF) – Quarter 3** Helen Dillistone (HD) advised that the narrative of some risk descriptions has been amended to strengthen the wording. The Board was requested to note the increased score of Strategic Risk 4 due to the likelihood of the system reporting a deficit position for 2023/24, resulting in a significant recurrent deficit in 2024/25. Work is being undertaken to end the year in the strongest possible position, notwithstanding the challenges being faced going forward as consequence of this. **The Board:** • **RECEIVED the Quarter 3 BAF strategic risks 1 to 10** • **NOTED the increase in risk scores for Strategic Risk 4 from a very high score of 16 to a very high score of 20**	
ICBP/2324/149	**ICB Risk Register Report – February 2024** Helen Dillistone (HD) presented the Risk Register as at the end of February 2024, which provides assurance to the Board on the operational risks faced by the organisation and demonstrates how they are allocated, monitored, and managed by one of the ICB's Corporate Committees.	

An increase was recommended in Risk 15 from a moderate 6 to a high 9, relating to the fact that the ICB may not have sufficient resource and capacity to facilitate the functions to be delegated by NHSE.

The closure of Risks 18 and risk 26 was recommended.

RW requested Sue Sunderland (SS), as Chair of the Audit and Governance Committee, to provide an update of the risk controls over the last year, and her thoughts on what is required going forward to continue to develop them. SS advised that a recent meeting between system Audit Chairs focused on the Risk Register; the Chairs were pleased to see that the strategic risks were system wide ones and not a duplication of their respective organisational risks. All ICB Corporate Committees have considered the Risk Register as part of the effectiveness review to verify the relevance of the risks. The focus going forward needs to be on the actions identified to deal with the threats, ascertain whether these are having the right impact or whether something else needs to be done. Discussion was undertaken at the last Audit and Governance Committee around the workforce risk and whether its wording is correct. Originally there was concern as to whether there was enough staff and the ability to recruit more, now the workforce is demonstrating a larger number of staff than is affordable; this risk may need to shift in focus towards having the right workforce for the resources available. The Risk Register is in a strong position and will continue to be developed in 2024/25.

<u>Questions/Comments</u>

- The risks are rated, and a tolerable risk rating was introduced against the target, however during the transformation, higher risk levels may need to be managed. RW enquired whether this is working to get the system thinking about managing risk as well as change. SS responded that some risks require long term actions, and in the meantime a certain level of risk will need to be accepted which is higher than would ultimately be liked. The tolerable risk score provides a more realistic interim position, recognising that some of the risks are huge and complex and will take time to improve, particularly given the external circumstances faced.
- It was enquired whether the Risk Register is being used as a management tool, a way of thinking about how the system works, and how to implement acceptable management controls and that the actions agreed will take it to the required position. It was asked if it is a live register, as opposed to a catch-up situation. CC responded that the focus of our attention is on the key risks and confirmed that the risks set out represent a true position; it is a live document and represents the focus of the Executive Team. RW considered the Risk Register to be an important document, being an overview of where the ICB is; however, it must be ensured that there is no doubling up with provider risks in order to prevent duplication.

The Board RECEIVED and NOTED:

- **the Risk Register Report**
- **Appendix 1, as a reflection of the risks facing the organisation as at 29th February 2024**
- **Appendix 2, which summarises the movement of all risks in February 2024**

and APPROVED the:

	• **CLOSURE of risk 18 relating to patients accessing their health records** • **CLOSURE of risk 26 (former confidential risk 11C) relating to additional investment and recruitment to increase appropriately trained staff and therefore the resilience of the LMNS PMO team**	
ICBP/2324/150	**Domestic Abuse Pledge** HD advised that this pledge is intended to sit alongside the ICB's Domestic Abuse Policy and the new ICB Sexual Safety in Healthcare Organisations Charter, due to be launched shortly. It demonstrates the ICB's commitment to enable its staff to access available support services if needed. The results of the recent ICB staff survey, which included aspects of health and wellbeing, will be presented to the Audit and Governance Committee. The pledge sits alongside staff wellbeing, and the broader work undertaken to keep staff safe in the workplace, recognising that this will be challenging should staff experience abuse outside of work. The Board was requested to support the principles set out. The Communications Team will be requested to raise awareness of this pledge and signpost staff towards the support services available. <u>Questions/Comments</u> • This is a valuable document and a sign of the ICB's commitment to supporting staff. Communications are key to liaising with staff and providing reassurance that help and support are available should they be needed. With reference to contact information, it was enquired whether there is a direct line to contact the police, other than 999 (JD). • CC fully supported this pledge. In the next 24 months, it is a personal strategic intent of his to increase the influence and power of other strategic partnerships which the NHS currently engages in, including the police and Local Authorities. • RW enquired how the pledge will be monitored to discover whether it is working, and followed up to ascertain whether it is right and fit for purpose. HD responded that it would not be monitored per se however it sits in the broader staff wellbeing and support work. Line managers, HR and the Safeguarding Team have an important role with the duties associated around this. The key initially will be the monitoring of communications and engagement, and staff knowing that the organisation is supporting them to feel safe to raise any issues and know where to go for help. CC added that it is an important transferable factor on how to move on from pledges to action; the ICB will be communicating and watching through staff surveys. Our staff are members of the broader population; the ICB playing a key role in the strategic partnership will help to make improvements and demonstrate change for the whole population, including our own staff. There is a difference between operational and strategic partnership approaches which the ICB needs to connect and increase power to. • This is a positive step to take and the commitment to strengthen the strategic partnership around this important agenda was welcomed. Derbyshire County Council has brought community safety and public health together which will help to strengthen strategic partnerships across the County (EH).	

	The Board DISCUSSED and APPROVED the ICB's Domestic Abuse Pledge that will sit alongside the ICB's Domestic Abuse Policy and the new ICB Sexual Safety in Healthcare Organisations Charter	
ICBP/2324/151	**Delegation of Specialised Services from NHS England (NHSE)** CC advised that the strategic intent of NHSE in delegating these commissioning services to ICBs is so that ICBs can have a more holistic view of the spend across all services. Last year saw the delegation of primary care services, dentistry, pharmacy, and optometry to the ICB; this is the next tranche, relating to approximately half of specialised services moving from NHSE to ICBs. The difference in specialised services, by their nature, is that they are provided across a larger footprint than one ICB; there is an expectation that ICBs will work in partnership to undertake primary care delegations across other ICBs. In terms of these additional delegations, which the ICB will be responsible for from 1st April 2024, it was recommended that the Board proceed to accept them, however, they are subject to ongoing work. These services are highly complex to understand; neither ICBs, nor former CCGs, have undertaken this level of commissioning since the 2012 Act when PCTs had more involvement in them. There is a commitment from NHSE in the Midlands region to manage them collectively and work in partnership on their handling over the coming months. A lead ICB is required to take a collective view of the services on our behalf; for Derbyshire this will be Leicester / Leicestershire / Rutland ICB, working in partnership with Birmingham and Solihull ICB, to undertake this on a whole midland's basis. There is a need to understand greater detail about these new delegations, including their performance and financial position; work is ongoing with NHSE in this regard. The benefits of moving forward outweigh the risks, however this will be subject to managing the transition of the services. <u>Questions/Comments</u> • RW has attended meetings about this matter; all of the points rasied today were directly made to NHSE. There is more clarity than before however, this is a position of transition and is as good as it can be at this stage. The ICB will be protected as much as it can be. RW agreed with the direction of delegation, and liked the fact that these services can be built into an offer which reflects the priorities of the Derby and Derbyshire population. • The opportunities that these delegations present to develop, design, and implement a holistic approach to services, and how they can be used to support the strategy for improving health of our population was commended; concern was expressed that this may be purely transactional. Assurance was requested that, particularly within the concept of the ICB restructure, there will be adequate resource to perform the new delegations (DO). CC responded that something commissioned regionally is being taken to be commissioned locally in partnership and this will be complicated to do. The ICB has a 30% running cost reduction over the next 2 years which is currently being worked through; NHSE also has a 30% running cost reduction to work through. This will have a consequence on capacity which needs to be kept in mind and be proportionate as to what can be achieved. In the first year NHSE will hold the staff base, due to its link to the retained services they will be commissioning, however it will be identifiable in terms of the colleagues working on the ICB's behalf. Assurance was	

	provided that the ICB is working through any potential challenges. CC requested HD to look at what transition time is required for the ICB to become an informed and informing commissioner of these services. For the delegation of the previous services, the ICB has yet to transition into a full commissioner. As a national progression, a view to Board is required on at which point the ICB becomes an influencing and informing commissioner; next year the ICB will hold the position, and the year after will change its influence. A balanced view as to what can be achieved in years 1, 2 and 5 is required. • Assurance was requested that control measures will be implemented to manage the risks (JED). CC concurred that there are risks in this, but there is clear sighting on them; CC supported a risk share approach for specialised commissioning, due to them being services better undertaken at scale. • Although this was supported, there are a lot of risks involved namely capacity, complexity and working collaboratively; a plea was made for feedback in early 2024/25 on a small number of key areas where the ICB wants to make a difference for the Derby and Derbyshire population through the changes implemented (TA). • Dr Chris Weiner (CW) was unable to provide full assurance on the management of the risks. It is important to note that the Chief Medical Officers (CMOs) in the East/West Midlands recognise the need to ensure sufficient capacity to manage the transition of specialised services over the next 5 years. The CMOs are actively discussing working collaboratively across multiple ICBs in order to ensure sufficient support. RW added that Derby and Derbyshire want to be a system in delivery mode, to work on things to get them right and embed them. **The Board NOTED the contents of this report and AGREED the sign-off of the attached documentation, with the following to be noted:** • **NHSE to provide more detail as to how they will work with ICBs and manage these services in partnership** • **A full pre-delegation pack has not yet been shared and therefore ICBs need clarity from NHSE ahead of transition in relation to any risks that may be present or might emerge in the 59 services to be transferred, along with a process for resolution of such risks** • **Greater clarity is required from NHSE on the role and expectations of the lead ICB** **The ICB will work with NHSE to resolve the above during the spring**	**HD** **CC**
ICBP/2324/152	**Year End Closing Position** Keith Griffiths (KG) advised that it is important to recognise that there are still 10 days to go until the end of the financial year. Craig Cook (CCo) provided an overview of urgent and emergency care, cancer, mental health, autism and learning disabilities, and General Practice performance over the last 12 months, advising that some issues had not been foreseen at the start of this period, including the impact of the industrial action on the operational situation. Although there are still areas of challenge, despite the pressures, the system has improved across all sectors compared to 2022/23. The finalised 2024/25 plan will be presented to the Board at its next meeting; the plan will strive to further improve performance in 2024/25.	

Linda Garnett (LG) highlighted that a steady growth has been seen in the workforce from the start of the year, with the increase in August due to the medical rotation plus the recruitment of new nurses and midwifes which were unable to be included in the plan. There was an increase in January to help manage operational pressures. A slight reduction was demonstrated in February; however, the likelihood is that the year will end on circa 300 staff above plan. Changes have been seen in the make-up of the workforce, with more substantive and less agency staff being used.

Keith Griffiths (KG) advised that in real terms the balanced plan will be achieved for 2023/24. Pressures in year include the cost of inflation and pay awards which will result in the ICB having a deficit of £44.7m by year end. £136m of efficiencies have been achieved in year. Bank and agency staff spend has been well controlled. There are two outstanding national financial risks to the delivery of this position - the costs of the Health Care Support Assistants re-banding, for which there are no costs in the forecast to accommodate and could be as high as £15m, and the change in treatment of PDC benefit for IFRS16 which could cost £7.2m; these issues need to be worked through with the national team.

<u>Questions/Comments</u>

- It was questioned that whilst Improvements have been made despite the difficult circumstances faced, whether the presentation provided an overly positive picture of the situation. Should the public read the presentation in isolation it may not provide a true picture and match the experiences they are facing. Concern was expressed that although there was progress in making efficiencies, these were non-recurrent efficiencies which will not provide a sustainable financial position going forward (SS).
- The hard work undertaken to reach this position was acknowledged, however the presentation could be accused of giving a glowing perspective of the situation; there is a need to be mindful of how it is articulated and the position managed, as it is building up a problem for 2024/25. Good progress has been made in relation to the workforce, however it was noted that it is now over target. The financial position will be hard to manage both now and moving forward (JED).
- It was asked if the level of spend is sustainable into 2024/25, particularly for performance and workforce. The workforce graph highlighted a gap between planned and actual which opened up at the start of the industrial action; it was enquired whether there is a handle on workforce across the system or if it is still a work in progress (DO).
- MG highlighted the forecast for this year and the deficit faced should no action have been taken; the system has a right to be proud of the achievements made to reach the current position, particularly when factoring in the unfunded pay awards and industrial action. This provides a positive when facing questions around sustainability and further demands for productivity and workforce going forward; undertaking the work this year provided confidence however further work is still required. The gap in workforce resulted from not being able to plan for the incoming new nurses and midwives.
- CC confirmed that the intent was not to paint too good a picture, but to set out the truth about the current position; the intent was to produce a balanced view which includes positives. There is a risk in looking at something at this level that the focus is narrowed to a few short metrics; it is difficult to take a view on the many care interactions happening every day. Should the outturn have been looked at from

	the start of the year, and the challenges to be faced, there would be pride in the improvements made. There is no denying the underlying challenge faced. Whilst the balance of recurrent/non-recurrent improvement is important, there is a risk of missing the improvements made in 2023/24. The 2023/24 learning is preparing for the key challenges in 2024/25 to build a more resilient health and care model. Conversations are now being held on how to develop plans to move towards a more sustainable footing. RW requested that public opinion forms part of how the system reviews where it is; the breaking down of inequalities needs to be considered in next year's year-end position. RW thanked colleagues involved in this work for making progress; however, it was acknowledged that there is still work to be done. **The Board NOTED the 2023/24 Year End Closing position**	
ICBP/2324/153	**Integrated Assurance and Performance Report** <u>Quality</u> Professor Dean Howells (DH) presented the slides on quality, highlighting the following: • <u>Maternity Assurance Approach</u> – The LMS is focused on the improvement plan. DH was impressed with the whole teams' approach to improvement; a follow up oversight meeting is scheduled for next week to focus on the re-inspection metrics. • <u>IPC</u> – The ICB is working closely with regional colleagues on this plan. DH confirmed that CRHFT has fully recruited to its leadership team around IPC which will be in place from April. • <u>Deep dive quality assurance report from NHSE into continuing health care services</u> – The ICB has performed in a consistent manner in this area, which is live and challenging. There is good joint working taking place with Local Authorities, however there is more work to do to land the final outcome. <u>Performance</u> Craig Cook (CC) presented the slides on performance, highlighting the following: • <u>Urgent and Emergency Care (UEC)</u> – The target was to achieve 76% A&E performance in 2023/24. There is daily oversight of this by the regional team, linking in with the ICB and providers; good progress has been made in this area, with day-by-day improvement in performance seen across UHDBFT. Concern was expressed around CRHFT's A&E performance; this will be picked up as part of the 2024/25 planning work. There is confidence that this target will be achieved overall. • <u>RTT/Cancer</u> – There is weekly oversight on this with regional colleagues, in which both Trusts are fully engaged. There is a route to achieve the 78 week wait close down in April, and the cancer targets are being delivered.	

	Workforce Linda Garnett (LG) presented the slides on workforce, highlighting the following: • The trend in growth has been flattening due to a focus on establishment and vacancy control with providers which is now having an impact and demonstrated a reduction in in agency use. Bank working is fluctuating as a response to operational pressures. Previously bank workers were permanently working in what should have been substantive roles. The staff survey demonstrated a greater satisfaction with opportunities for flexible working; this is enabling people to work in substantive roles with the same flexibility as bank working. Finance Keith Griffiths (KG) presented the slides on Finance, highlighting the following: • Every provider organisation in the Derbyshire system is now reporting a deficit for this financial year; this is included within the £44.7m deficit. The main risks to achieving the year end position are areas outside the system's control, as well as those that prevent delivery of the Operational Plan. There is an estimated £24.1m risk in meeting the recognised £44.7m yearend deficit. £20m relates to estimated costs at CRHFT and UHDBFT for the national Health Care Assistant claim for re-banding. Questions/Comments • A more comprehensive performance report is now being provided; however, the community data is an aggregation of a whole range of providers. No progress has been made this year by the community in reducing its long waits; there are still 1500 patients waiting for a first outpatient appointment. It is beholden on us to develop a more granular focus through the system on what those waits are, what their impact is and what more can be done, through productivity and collaborative working, and focus the resources to reduce them (TA). • Regarding the focus on the 76% 4 hour wait in the Emergency Department, this is an important measure of quality; however, it is disappointing, having worked all year as a whole system to drive improvement, to have a national incentive scheme at yearend that rewards acute trusts when a whole health and care system effort was required to achieve effective UEC flow. This was fed back on behalf of the non-acute health and care partners across Derbyshire. RW recognised this and took it on board. **The Board NOTED the Month 10 performance Operational Plan update against the plan commitments and targets**	
ICBP/2324/154	**Holistic Discharge Review** Sue Sunderland (SS) gave a presentation on the current discharge arrangements with a view to agreeing a way forward to improve their effectiveness.	

	Whilst the paper outlined questions for further exploration, the discussion focused on those areas that best link to the Intermediate Care Framework priorities. Progress in these areas has the potential to significantly impact on the speed and effectiveness of discharge and consequently increase bed availability as well as improving the patient experience; however, concern was expressed on the limited system resources available to take this forward. Some areas could make a big difference to the speed of discharge and costs of delivery. Although providers are committed to achieving this work, they are struggling to create bandwidth to make it happen; space needs to be created within the acutes to take this forward. <u>Questions/Comments</u> • It was enquired whether seven day per week discharging is taking place and if not, why not (DO). TA considered that consistently lower levels of discharges are made on Saturdays and Sundays from acute hospitals; flattening out discharges across 7 days would make better use of the community available. • For 90% of discharges, no interventions are required, however it is the remaining 10% of discharges which have an impact on system flow; this might not be the correct forum to look at this situation (JA). • CC considered this to be an important and complex area of health and care business. The questions asked of the Board are ones being worked on in relevant parts of system. Assurance was provided that there is a full commitment across the partnership to work on this. • CW praised this report as a useful and valuable insight and thanked SS for the work she has undertaken. It is important to recognise that discharge is happening 7 days per week however it is useful to look at whether this could be done better. There is inconsistent application of discharge pathways being used across the system benefits; there is an opportunity to make improvements to the approach used to drive forward the agenda of care. • Discharge works well for most people; the challenge occurs around those patients with complex needs. This is where the Integrated Care Partnership (ICP) is important and where the focus needs to be. For clarity, the Mental Capacity Act is different to the Mental Health Act. • This report has raised a lot of points, many of which are not surprising to those working in this space. The Integrated Place Executive receives a comprehensive performance report; it was suggested that adult social care discharges should be included in this. Further Business Intelligence support and data is required (TA). JA is currently working on a new digital system which could accelerate insight and drive rapid improvement. RW requested SS to look at this as a holistic issue, as there are a lot of people in hospital beds not being discharged. There needs to be system wide approach on this therefore consideration by the ICS Executive Team was requested. **The Board DISCUSSED the questions highlighted in the presentation and AGREED appropriate next steps**	**CC**
ICBP/2324/155	**Audit and Governance Committee Assurance Report – February and March 2024** SS presented these reports which were taken as read. SS requested that all colleagues ensure they respond to any requests from Internal Audit,	

	as currently a Head of Internal Audit (HOIA) Opinion cannot be provided due to outstanding issues. No questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/156	**Finance, Estates and Digital Committee Assurance Report – February and March 2024** Jill Dentith (JED) presented these reports, which were taken as read. JED highlighted the conversations were held at the meetings on the 2023/24 position and the positive workshops held to consider estates, digital and workforce in relation to the wider efficiency agenda on efficiencies. A close eye is being kept on the rollout of electronic patient records at acute hospitals. No questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/157	**Public Partnership Committee Assurance Report – February 2024** RW presented the report, which was taken as read. It is important that the committees are testing themselves on their plans for next year. No questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/158	**Population Health and Strategic Commissioning Committee Assurance Report – January and March 2024** RW presented the above report, which was taken as read. No questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/159	**Quality and Performance Committee Assurance Report – December 2023 and January 2024** Dr Deji Okubadejo (DO) presented the above report, which was taken as read. DO confirmed that the Committee has held many discussions on discharge and flow in the system. No questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/160	**People and Culture Committee Assurance Report – February 2024** Margaret Gildea (MG) presented this report, which was taken as read. No questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes**	

161	**Fit and proper person framework** **The Board NOTED the Fit and Proper Person Test Framework for information**	
ICBP/2324/162	**Derby City Council Health and Wellbeing Board ratified minutes from November 2023** **The Board RECEIVED and NOTED the above minutes for information**	
ICBP/2324/163	**Ratified Minutes of ICB Corporate Committees** • Audit and Governance Committee – 11.12.2023 / 8.2.2024 • People and Culture Committee – 6.12.2023 • Public Partnership Committee – 30.1.2024 • Quality and Performance Committee – 21.11.2023 / 30.11.2023 / 21.12.2023 **The Board RECEIVED and NOTED the above minutes for information**	
ICBP/2324/164	**Forward Planner** **The Board NOTED the forward planner for information**	
ICBP/2324/165.1	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.	
ICBP/2324/165.2	Did any of the discussions prompt us to want to change any of the risk ratings up or down?	
ICBP/2324/166	**Any Other Business** None raised.	
ICBP/2324/167	**Questions received from members of the public** One question was received from Richard Terry, on behalf of Babington Hospital Site Monitoring Group, Belper, which related to significant issues and concerns raised about emergency and urgent care in the ICB's Integrated Care Strategy and Joint Forward Plan, the current review of Urgent Treatment Centre provision across the county and the general NHS delivery plan for recovering urgent and emergency care services post-pandemic. Much of the Babington Hospital site in Belper is currently being offered for development by NHS Property Services, and a new DCHS community health services hub is in the contracting stage to replace the former Belper Clinic. Both DCHS and NHS Property Services have recently suggested that some of the capital raised from the Babington Hospital site sale may be redeployed to support local NHS Projects. Local demographic and other conditions mean the case for using this capital to help finance the further enhancement of the Babington hub's service delivery is especially strong. What is the Board's view on designating the Babington hub as a new UTC? Given the specific circumstances outlined above, will the current UTC review give due consideration to the viability of a Babington UTC?	

	The following response was provided: The former NHS Derby and Derbyshire CCG decided in 2018 that the Babington Hospital building was not viable for refurbishment as a healthcare facility, that the bedded care provided there would transfer to the newly-built Ada Belfield facility in Belper and that DCHS would progress plans to develop a new health centre on the remaining land on the current health centre site to accommodate the remaining services from the hospital. This decision followed extensive engagement with residents. Plans have since progressed in line with that decision; the bedded care has transferred; planning permission is now granted for the new health centre building and the remaining hospital site is now in the process of being sold by NHS Property Services for alternative use. NHS Derby and Derbyshire Integrated Care Board (ICB) – the successor to the CCG – does not intend to review the decision made regarding the viability of the hospital site for refurbishment for healthcare provision. The ICB will be conducting a review of urgent treatment centres across the county, and engagement with residents will commence in due course. The aim of the review is to consider the current and potential future use of urgent treatment centres across the NHS Derby and Derbyshire ICB footprint (including Glossop), to ensure that we are providing the right care at the right time in the right place and based on the identified needs of the local communities. These are to be considered within the context of the wider urgent care system in Derby and Derbyshire to ensure that we deliver an integrated urgent treatment system that fits the needs of the local population. The review will consider: • Derbyshire's five existing Community UTCs in Buxton, Whitworth Hospital, Ripley, Ilkeston, and Derby City. • Other services that fit within the wider community urgent care offer, such as walk-in centres e.g. Swadlincote, Ashbourne and New Mills. • And it will link in with Primary Care and Place developments across Derbyshire. The review will consider ideas and suggestions, and these will be fully evaluated, and the viable options then entered into an options appraisal process at a later date.	

Date and Time of Next Meetings

Date: Thursday, 16th May
Time: 2024 9am to 11.00am
Venue: via MS Team

NHS
Derby and Derbyshire
Integrated Care Board

ICB BOARD MEETING IN PUBLIC

ACTION LOG – MARCH 2024

Item No.	Item Title	Lead	Action Required	Action Implemented	Due Date
ICBP/2324/050 20.7.2023	NHS Long Term Workforce Plan	Linda Garnett	It was agreed that the Plan would return to a future Board for further discussion.		**July 2024**
ICBP/2324/051 20.7.2023	Integrated Assurance and Performance Report	Richard Wright	Support was sought for the Board to have a conversation on how to get this report right, to ensure it has oversight of the important matters and understands the position against plan. The sub-committees need to be used to their full effect to gain assurance, whilst ensuring that governance processes are adhered to.	RW considered that today's report, compared to the one produced a year ago, has changed markedly, now better reflecting system working. Although improvements have been made, there is still more work to do to rationalise what is presented to the Board and to better reflect the strategic nature of the whole system.	**Ongoing**
ICBP/2324/075 21.9.2023	Integrated Assurance and Performance Report	Keith Griffiths	UHDBFT provides services for Staffordshire residents; it must be ensured that Staffordshire ICB receives funding based on its population, some of which will support the pressures UHDBFT incur. It is a material boundary issue that will have implications on income flows this year, and baselines for future years.	A briefing note was circulated around the system after the last Finance, Estates and Digital Committee. This is an ongoing theme in conversations with regional and national colleagues. 18/1 RW has raised this with NHSE to support conversations regarding the 2024/25 planning round.	**Ongoing**

ICBP/2324/101 16.11.2023	System Level Primary Care Access Improvement Plan	Michelle Arrowsmith / Clive Newman	It was requested that a year-end report will be presented to a future Board in May 2024.	18/1 MA to present a paper in May 2024. **Update:** Item 011 on the agenda	**May 2024**
ICBP/2324/124 18.1.2024-1	ICB Risk Register Report – December 2023	Prof Dean Howells	Quality and Performance Committee to conduct a forensic review on Risk 9.	The Quality and Performance Committee is to conduct a forensic review on Risk 9 at its March meeting and feedback will be provided accordingly. **Update:** Discussions took place at Q&P Committee in March 24, further evidence to support the reduction in score to be discussed at May Q&P.	**July 2024**
ICBP/2324/151-2 21.3.2024	Delegation of Specialised Services from NHS England (NHSE)	Dr Chris Clayton	Although this was supported, there are a lot of risks involved namely capacity, complexity and working collaboratively; TA made a plea for feedback in early 2024/25 on a small number of key areas where the ICB wants to make a difference for the Derby and Derbyshire population through the changes implemented.	**Update:** June 2024 Board Development session focus on stocktake of NHSE Delegated Services	**June 2024**
ICBP/2324/154	Holistic Discharge Review	Dr Chris Clayton	RW requested SS to look at this as a holistic issue, as there are a lot of people in hospital beds not being discharged; there needs to be system wide approach on this therefore consideration by the ICS Executive Team was requested.	**Update:** Ongoing	**July 2024**

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 006

Report Title	Chair's Report – April 2024							
Author	Sean Thornton, Deputy Director Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Dr Kathy McLean, ICB Chair							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Not applicable							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Not applicable							

Recommendations
The ICB Board are recommended to **NOTE** the Chair's Report for April 2024.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
Opening Thoughts I am delighted to prepare my first report for the NHS Derby and Derbyshire Integrated Care Board, and to have joined the organisation as Chair at such an important point in its development, particularly as we enter the start of a new financial year. Thank you to those of you who have already offered me a warm welcome. I look forward to meeting colleagues across the system over the comings weeks and months and to everything we will achieve in our time together. As I begin in my new role, I would like to recognise the significant contribution of Richard Wright MBE who has been Acting Chair of the ICB board for the last year. I look forward to working with Richard in his capacity as a Non-Executive Member of the ICB Board and as chair for the ICB's Population Health and Strategic Commissioning Committee and Public Partnership Committee. As a Derby resident, and as a former hospital consultant at University Hospitals of Derby and Burton NHS Foundation Trust, I am committed to and passionate about the care provided to the Derbyshire community. I am excited to get to work and I hope to use my clinical experience and work in national and local leadership roles to support the system in improving health outcomes,

tackling health inequalities, and making sure our local NHS is as productive as possible for the people of Derby and Derbyshire. I look forward to collaborating with colleagues, partners, residents and patients across the system to support this and improve the health and wellbeing of local people.

I'm conscious that I arrive at the tail end of what has been an unsettling time for ICB staff, after the review of staff structures necessitated by NHS England's request for ICBs to reduce running costs by 30% by the end of the financial year 2025/26. I look forward to working with ICB staff and colleagues on the Board as we move towards a period of greater certainty. Understanding our priorities and how they inform our work and embracing our values as described in the strategic framework will be of great importance this year. Our system has delivered consistent improvement in the last year, despite significant challenges posed by the continued recovery from the Covid-19 pandemic and the ongoing periods of industrial action. I wish to place on record my thanks for everyone working within the health and care system in Derby and Derbyshire for the significant efforts that have gone into not only maintaining levels of care, but making inroads into waiting times and waiting lists, all progress which we hope to build upon this year.

I have now stood down from my role as chair of University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and will be performing my new role alongside my existing role as chair of NHS Nottingham and Nottinghamshire Integrated Care Board and Integrated Care Partnership. I am a firm believer in the benefits of partnership working and strongly believe that the two roles complement each other, especially as we will now have the East Midlands Combined Council Authority across Derby and Derbyshire and Nottingham and Nottinghamshire, and a new Mayor.

I have now also taken up my position as Chair of the NHS Confederation ICS Network Board. The Board is made of up of ICSs and Local Government Association (LGA) members who bring tremendous skills and experience. The ICS Network Board provides strategic oversight of the ICS Network, helping to shape its priorities and future direction and ensuring that it can build a strong and effective national voice for its ICS members. I am intending to ensure that the great work we are delivering in our system gets the national attention it deserves and also use the Network to bring new and innovative ideas from other systems here.

I am also a great believer it getting out and meeting colleagues to understand their work, their achievements and any barriers we can help to resolve. I always seek to take learning from visits and will be feeding thoughts back into relevant Board members and officers as necessary and using this report to highlight these findings for wider knowledge. I look forward to meeting as many colleagues as possible across the patch during my tenure.

Looking Forward

The wider Board agenda covers the latest position with our performance, workforce and financial planning. The ICB has delivered the financial commitments it agreed with NHS England for 2023/24 and there has been considerable work across the NHS system to complete our planning submission for 2024/25, for which I know the Board is grateful. The financial challenge is growing, and the deficit position we have submitted is both a concern and a limiting factor on our ability to invest in the areas which we know will support a move to care which is delivered increasingly out of hospital and seeks to prevent ill health alongside treatment services. It remains a fact that NHS care in Derby and Derbyshire costs more that we receive in our financial allocations, so we will need to carefully consider the systemic change required to bring us back to balance in the coming years and broaden our conversations with citizens about this. It will require the whole-hearted commitment of everyone in the ICB and system and the ICB has a unique position as system partner, facilitator and convenor – all of which mean we can and must deliver on the requirements for financial and performance oversight.

I attended my first Derby and Derbyshire Integrated Care Partnership (ICP) meeting in April and was interested to see how it compared to the equivalent meeting in the Nottinghamshire system.

There is clearly great work taking place in our three areas of focus of Start Well, Stay Well and Age/Die Well, as well as an exciting programme to develop insights from our services and citizens to help inform decisions. As with most ICSs, this work is embryonic, and it will be important for the ICP and the ICB Board to support the necessary prioritisation of this work and help teams unblock any barriers. Aligned to this, we will be embarking on a refresh of the Derby and Derbyshire NHS 5-Year Plan in the next few weeks, which responds to the Integrated Care Strategy alongside other key areas for development for the NHS. It will be important to ensure that we can maintain a line of sight on delivering against priorities, where our efforts and endeavours can be traced back to the continued need and desire to deliver these strategic goals. Resources are limited in the NHS, both in terms of money and people, so it is important that we are supporting our teams to focus on what matters the most.

We will also need to work closely with key stakeholders in delivering our agenda. This includes our system partners, across the health and care system, in particular our colleagues in the voluntary sector, primary and social care, but also our elected members and others as we seek to make progress in improving local care. I have already held constructive discussions with our two Local Authority Cabinet Members for Health and Care and will be joining the Chief Executive in his regular meetings with our Members of Parliament. In addition, we have a new political stakeholder after the East Midlands Combined County Authority Mayoral election took place at the start of May. I congratulate Claire Ward on their election to the role, which will lead this new Combined Council Authority for Nottingham, Nottinghamshire, Derby and Derbyshire for the next four years. Both ICBs will be prioritising engagement with the new Mayor and the Combined Authority as we seek to understand the possibilities for collaboration on the wider determinants of health.

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 a health and care workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

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

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

Not applicable to this report.

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

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

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

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

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

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

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16 May 2024

Item: 007

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

Recommendations
The ICB Board are recommended to **NOTE** the Chief Executive Officer's Report for April 2024.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
The Derby and Derbyshire NHS submitted its draft Operational Plan for 2024/25 on Thursday 2nd May. This has been a considerable undertaking across the system and I wish to thank colleagues on behalf of the Board for the role they've played. I believe the system has submitted a credible and deliverable plan, although there remains significant risk attached to achievement of performance targets. Within the plan we seek to achieve the majority of the stated national performance targets, with close achievement to other targets, and improvement in the performance position across the board. We have a better understanding of the year on year, like for like, workforce plan position and its stabilisation, together with a strategic understanding of the areas where workforce growth is planned and the operational improvements that are planned as a consequence. The system has submitted a financial deficit position which remains larger than the objective set by NHS England to submit a forecast at least as good as the 23/24 outturn position; recognising the achievements across the system on productivity improvement and other efficiencies in the last year which have played into the current planning position (including a 5% cost improvement contribution across all organisations), we continue to focus on how further improvements can be made.

The plan relies on ongoing productivity and efficiency improvements across services to deliver the operational and activity requirements of the national planning guidance and we will continue to balance our aspirations for service delivery alongside the finite resources available. Delivery Boards continue to consider what might be prioritised should we be required to further improve our deficit position. As part of the planning process, we will continue to work with regional and national NHS England colleagues to balance all of the above.

The 24/25 plan is year 2 of our Derby and Derbyshire NHS 5-Year Plan (Joint Forward Plan – JFP), which we will be refreshing. This will be a meaningful refresh which doesn't significantly change the ethos of the JFP, but which produces a deliverable implementation plan for the remaining years of the plan. The JFP was the NHS' response to the Derby and Derbyshire Integrated Care Strategy and set out five guiding policies, which at the time of publication would require improvement actions to be allocated in due course. These five principles remain true and our refresh will build from here in the context of the system's activity, workforce and financial positions:

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.

The plan identified the careful balancing act of managing immediate and short-term operational priorities with longer-term ambitions. As previously noted, 2023/24 has proved to be a year of significant operational challenge, with existing urgent and emergency care pressure overlaid by industrial action. To reflect this, NHS England has extended the deadline for refreshing of NHS Joint Forward Plans to 30 June 2024.

In early May the Department of Health and Social Care set out proposals regarding the process to complete the 10 year review of the NHS Constitution. The NHS Constitution sets out the principles, values, rights and pledges underpinning the NHS as a comprehensive health service, free at the point of use for all who need it. It applies to all those who use its many services, its staff and providers. During this consultation exercise, the Government wishes to hear from people across this broad spectrum (including the ICB), to help the completion of the review.

In the broader political arena, we congratulate Claire Ward on her election as the first East Midlands Mayor on 2nd May, and we will be seeking to build relationships with Claire and the wider East Midlands Combined Councils Authority (EMCCA) over the course of the year. The Mayor does not currently have direct responsibilities for health or healthcare, but there are significant connections in areas that we routinely describe as the wider determinants of health, such as housing, education and the environment and so it is important that we build those working relationship to support and influence the improvements in overall health and wellbeing that we are all wishing to see.

I extend a welcome to our new Chair, Dr Kathy McLean. We do know Kathy very well in the Derbyshire system through her extensive past leadership history and I am very much looking forward to working directly alongside Kathy. I know colleagues are already extending Kathy a very warm welcome. Having the same chair working in both NHS Derby & Derbyshire and NHS Nottingham and Nottinghamshire ICBs will clearly bring advantage in understanding how both organisations and systems can better work together to support the broader ambitions of the EMCCA.

I continue to attend a range of local, regional and national meetings on behalf of the ICB Board and the wider Joined Up Care Derbyshire system. Our local performance conversations, along with regional and national assurance meetings have been prominent since the last ICB Board meeting; I have represented the ICB on the East Midlands Joint Committee overseeing the new commissioning arrangements for the specialised services delegated to the ICB on 1 April 2024; and have continued my series of 1:1 meetings with local Members of Parliament to keep them abreast of developments and the system's performance position. Last week the system hosted a visit from Professor Claire Fuller, NHS England's National Medical Director for Primary Care, during which I was able to provide an overview of the Derby and Derbyshire NHS system along with leaders from our general practice community.

Chris Clayton, Chief Executive Officer

National Developments

Millions more GP appointments in March than before pandemic
GP teams delivered almost 30 million appointments for patients last month (March 2024), up almost a quarter on the same period before the pandemic, new data shows today (25.4.24). New NHS data published today shows there were around 29.8 million appointments delivered by GPs and their teams in just one month, compared with 24.2 million in March 2019 – an increase of 5.6 million (23.1%).

See also: Five million more GP appointments delivered in February than before pandemic

MMR catch-up campaign significantly boosts uptake across country
A campaign encouraging young people to get up-to-date with their measles, mumps, and rubella (MMR) vaccinations has led to a significant boost across the country.

NHS sets out measures to improve the working lives of postgraduate doctors
In a huge push to improve the lives of tens of thousands of postgraduate doctors, NHS England is pledging to enhance choice and flexibility with rotas, while reducing payroll errors and the financial burden of course fees.

Record NHS cancer checks top three million in one year
NHS cancer checks have topped three million in a year for the first time – more than doubling in the last decade. New analysis shows that there were 3,035,698 urgent cancer referrals for patients in the last year (March 2023- Feb 2024), compared to 1,335,350 in the same period ten years ago.

See also: Princess of Wales cancer diagnosis prompts 373% increase in searches for NHS advice

NHS staff deliver performance improvements despite record demand
The NHS exceeded its faster diagnosis cancer target for the first time in February amid record demand, according to new figures. Thanks to the hard work of NHS staff, almost four fifths (78.1%) of people received a definitive cancer diagnosis or all clear within four weeks – with almost 200,000 (199,659) patients getting the answer they need within 28 days.

NHS rollout of same day emergency care allows hundreds of thousands to return home quicker
An expansion of same day emergency care services across the country has seen thousands more people every week get the rapid tests and treatment they need to avoid an overnight stay in hospital – with the total up by more than a tenth in just a year.

NHS self-referral for tests and appointments for hundreds of thousands of patients
Hundreds of thousands more people a month will have the option to refer themselves for key services such as help with incontinence, podiatry, or hearing tests without needing to see a GP, as part of the NHS primary care access recovery plan.

NHS launches innovative new drive to recruit armed forces veterans
The NHS is stepping up a national campaign to recruit former members of the Armed Forces who want to join the health service and offer their valuable skills to caring for patients. Running until March 2025, the new NHS Long Term Workforce Plan drive will encourage serving and retired armed forces personnel and their families to consider a career in one of the 14 allied health professions on offer in the health service.

Local developments

New East Midlands Combined County Authority Mayor elected
Following voting on Thursday 2 May, Claire Ward (Labour and Cooperative Party) has been elected as the first East Midlands Combined County Authority Mayor. Nicolle Sibusiso Ndiweni (Labour and Cooperative Party) was elected as Derbyshire Police and Crime Commissioner.

Historic first meeting for new East Midlands Combined County Authority
The first meeting of the new East Midlands Combined County Authority (EMCCA) took place on Wednesday 20 March at Chesterfield Borough Council. Council leaders made a series of decisions that establish the organisation's constitution, budget and plans to improve the lives of everyone who lives and works in the region.

New Electronic Patient Record system supplier confirmed
University Hospitals of Derby and Burton and Chesterfield Royal Hospital have confirmed their future electronic patient record system (EPR) will be provided by Nervecentre, after signing a joint contract last week.

New Trust strategy published: Patient Experience, Engagement, and Insight Strategy 2024-29
University Hospitals of Derby and Burton has set out how it plans to work with its communities, staff, and partners to deliver better care and improve patient experience.

Changes to the early help service
Following a consultation, Derbyshire County Council is set to make changes to the early help service.

Anaesthetic teams become one of only 50 in UK to receive prestigious accreditation for patient care
Teams at both University Hospitals of Derby and Burton's (UHDB) acute hospitals have been recognised nationally for providing the highest standards of care to patients when they are 'at their most vulnerable' as they undergo anaesthesia or sedation.

Newholme Health Centre named as popular choice for new health facilities
The new NHS community health facilities taking shape on Baslow Road in Bakewell have been named following a public vote. Over a thousand votes were cast during the six-week voting period and the clear favourite is Newholme Health Centre with 54% of the votes cast.

Three more years for Derbyshire's drug and alcohol support service
A service that has helped hundreds of people in Derbyshire overcome problems with drugs and alcohol has had its contract renewed. Derbyshire Recovery Partnership has been awarded a

three-year contract by Derbyshire County Council to continue providing a drug and alcohol treatment service with the option of extending for another seven years.

Derbyshire County Council publish updated plan for 2024-2025
Derbyshire County Council's updated plan for 2024 to 2025 has now been published after it was agreed at Full Council.

Three Derbyshire Healthcare teams receive award for joint support for patient in the community
Three local teams at Derbyshire Healthcare NHS Foundation Trust, supporting the treatment and recovery of people who experience mental health difficulties such as psychosis, have all been recognised for the treatment they provided to a patient with mental health needs in the community. The teams are: Early Interventions Team South , Physical Health Monitoring Team and the Hope and Resilience Hub team.

Have your say on proposed changes to learning disability support
The consultation is seeking people's views on options to re-design day opportunities and short breaks provided directly by Derbyshire County Council.

Consultation on services for disabled children and their families is extended for further 10 weeks
Views are sought on The Getaway short breaks service, and the Outback early help services.

Executive Chief Medical Officer appointment
Dr Gisela Robinson has been appointed as permanent Executive Chief Medical Officer at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB).

Prem Singh appointed as new Trust Chair
UHDB has confirmed that Prem Singh has been appointed as its new Trust Chair. Prem has held senior CEO and Chair roles across healthcare in Derbyshire for over two decades. Prem retired from his last NHS roles as Chairman of Derbyshire Community Health Services NHS Trust (DCHS) as well as Chairman of Staffordshire and Stoke-on-Trent Integrated Care Board in 2022, before deciding to rejoin the NHS to become a part of his local acute hospital trust.

East Midlands Ambulance Service welcomes new Non-Executive and Associate Non-Executive Directors
East Midlands Ambulance Service have welcomes Murray MacDonald, Oliver Newbould and Ballu Patel as new Non-Executive and Associate Non-Executive Directors.

UHDB Chief Finance Officer and Deputy CEO set to leave in the autumn
Simon Crowther, Chief Finance Officer and Deputy Chief Executive will be leaving University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) in the autumn. Simon will be taking up a role as Deputy Chief Executive at another NHS Trust, which will announce his appointment in due course.

Publications that may be of interest: **Joined Up Care Derbyshire – April 2024 Newsletter**

Identification of Key Risks

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

				and achieve best value from the £3.1bn available funding.	
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☐	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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.

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NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 008

Report Title	Primary Care Model Update							
Author	Ian Potter, Managing Director Derby & Derbyshire GP Provider Board							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Presenters	Dr Andrew Mott, Medical Director Derby & Derbyshire GP Provider Board Dr Duncan Gooch, Clinical Lead Derby & Derbyshire GP Provider Board							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☒
Appendices	Appendix 1 – National and Local Context Appendix 2 – High-level Implementation Framework Appendix 3 – Progress on Priority Goals							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Extensive engagement in developing the Primary Care and recent paper to the Integrated Place Executive.							

Recommendations
The ICB Board are recommended to: • **NOTE** the update and progress made implementing the Primary Care Model and **CONSIDER** it in the context of the current planning process; • **AGREE** to receive regular updates and assist unlocking strategic risks; and • **SUPPORT** a greater System focus on enablers including workforce, data and digital which impact on implementation of the Model.
Purpose
This paper provides an overview of the strategic and operational context for the Primary Care Model, a summary of the Model, an update on implementation progress, and the priority tasks and enabling actions, now required to facilitate a positive shift in implementation momentum.
Background
1. Introduction The Primary Care Model, approved by the ICB in November 2023, sets out a vision for a sustainable, thriving primary care system that is at the core of integrated care delivery in Derby and Derbyshire. The aim is to give people hope, by demonstrating how we can mitigate the crisis facing primary care, through a shared vision for improving quality of care and staff working lives. In doing so we will build on improvement work already in train and the considerable strengths of our current services.

The GP Provider Board (GPPB) has been tasked by the ICB to lead the implementation of the Model. This will require collaborative working with Joined Up Care Derbyshire (JUCD) partners and clarity on governance arrangements, including the decision-making roles of the Primary and Community Care Delivery Board, the Integrated Place Executive and the Provider Collaborative Leadership Board.

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

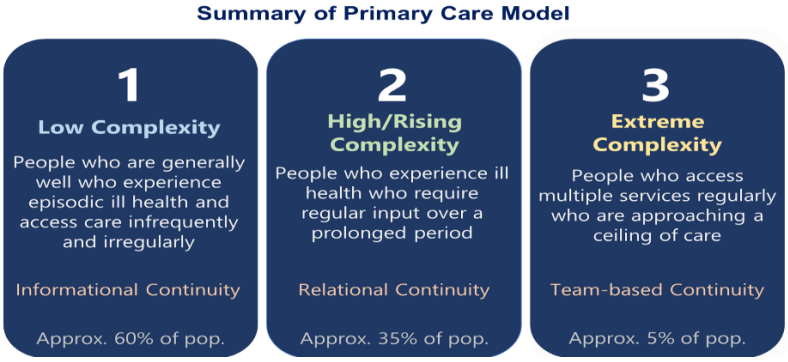
2. National and Local Context

The Model is based upon key national policy recommendations (primarily the Fuller Stocktake) and the document provides a comprehensive set of national and system level drivers for the changes included within the Model. It also summarises key strengths of primary care in Derby and Derbyshire, the key challenges it faces and opportunities for change. Additional information on alignment to national and local documents are attached in appendix 1.

It is important to reflect the extremely challenging environment we are all working in which in turn will have an impact on scale and pace of local transformation initiatives. Whilst General Practice continues to deliver an increased number of appointments health expenditure on general practice is decreasing1. The outcome of the recent BMA referendum reflects the strength of feeling amongst GPs regarding the 3rd year of an imposed contract. Increasing financial challenges will impact on the resilience and financial viability of practices. Within this environment the Primary Care Model becomes more important and more challenging to deliver.

3. Primary Care Model

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



[1] making_care_closer_to_home_a_reality_summary_2024.pdf (kingsfund.org.uk)

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

Aims for the Model

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

Year 1 (24/25) Improvement Goals are set out in appendix 3 and have been designed to support delivery of the Integrated Care Strategy and the guiding policies for action from the Five-Year Plan and illustrate how primary care is central to the delivery of JUCD health and care system objectives.

4. Progress to Date

4.1 Governance

The Primary Care and Community Delivery Group (PCCDG) is responsible for driving implementation of the Primary Care Model. The group contains senior leaders from the ICB, primary / community providers and public health and has recently revised it's terms of reference to focus on supporting delivery of the Model. Following recent discussion with Place leads and a paper presented to the Integrated Place Executive (IPE) it has been agreed to develop a stronger link to Place recognising the interdependencies and alignment to Place priorities. Going forward PCCDG will become a subgroup of IPE and provide regular progress reports on implementation of the Model.

4.2 Implementation

A high-level Implementation Framework for the Model has been developed which includes a set of principles to guide implementation and an outline methodology, see appendix 2. PCCDG members debated how the Model should be rolled out and the agreed position is reflected in the methodology i.e. there is a need for some local determination of pace and approach (so that *Primary care teams will have the freedom and ability to deliver the new model in ways that best suit their local population*), whilst ensuring all localities operate within the same tramlines, to avoid unwarranted differences that might exacerbate inequalities between localities.

Priority Goals

Through discussions held at PCCDG it has been agreed that transformational delivery plans for Goals 1 & 4 are a priority for 2024/25, given plans for the other Goals are already in train and are being driven by other parts of the System. Progress on delivery against all year 1 goals is attached in appendix 3.

Building on the positive discussion at IPE and associated alignment to Place, work is underway to scope a range of actions to support implementation. These include developing a consistent offer around Quality Improvement, scoping the concept Local Place Alliance / PCN innovator sites, developing a joint approach to addressing key enablers (workforce, digital, data, estates) and ensuring the learning from Team Up informs and shapes delivery of the Primary Care Model.

Following a series of PCN visits undertaken by the ICB Chief Executive and GGPB, Good Governance Improvement have been commissioned to undertake a programme of work to support and strengthen PCN governance. The innovative programme is delivered through action learning sets and events bringing together all PCN Clinical Directors and Managers and will support all PCNs across the ICB.

4.3 Alignment to the 2024/25 Planning Process

A workshop was held with PCCDG members on 26.01.24 to agree prioritised actions to mobilise the Model that align with 24/25 operational planning requirements. Using the outputs from the workshop, a clear set of next steps was produced and played back to PCCDG on 23.02.24 along with some key questions;

1. What resources are required to implement the Primary Care Model, as a major, system-wide transformation programme? (e.g. programme, change management, external expertise, IT, estates, PPI, commissioning)
2. What resources and support can be co-ordinated and jointly deployed across Community Transformation and the Primary Care Model?
3. How do we ensure the Primary Care Model is implemented in the construct of Place? Where do we go for support to do this?
4. What are the sources of transformation funding for the resources we identify as not currently being available within the System?

Although progress has been made with the implementation of the Primary Care Model given the resources available it has not been possible to develop a robust implementation plan and associated business case. It is hoped that recently allocated programme management support and strengthened alignment to Place will assist taking forward these issues. Undoubtedly the challenges of the current operational planning round will impact on the delivery of the model and we will continue to work with partners to make best use of available resources.

4.4 Over-arching Next Steps and Enabling Actions

PCCDB will oversee production of an Implementation Plan which will be linked to the 2024/25 Operational Planning Priorities. The Implementation Plan will need to reflect the following requirements;

- Further development of outcomes framework with high-level evaluation methodology.
- Risk management framework – Including initial risk and issues logs.
- Communications and engagement plan.
- Governance arrangements.
- Roll-out methodology and timescales.
- Alignment with Community transformation.

There will also be a focus on the enabling functions that will be critical to the successful delivery of the Model. Whilst not all of these areas are in the gift of PCCDG there are parallels with the transformation work led by IPE and opportunities for learning, alignment and more effective use of resources are being explored. Key areas include; culture and organisational development (including quality management and leadership), governance, workforce, digital/ AI, data, estates, engagement and communications.

Report Summary
Whilst significant progress has been made, the external influences on the ICB and the points identified in section 4.3, influence our ability to create the right environment for change and will impact on the scale and pace of implementation. It is envisaged that the dedicated programme management support and strengthened alignment to Place will further enhanced implementation of the Primary Care Model. The ICB are asked to consider these points and how we can harness support for the next stage of implementation.

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

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

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

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

None identified.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☒	No☐	N/A☐	**Details/Findings** A quality impact assessment will be undertaken with the outcomes included in update reports on implementation.
Equality Impact Assessment	Yes ☒	No☐	N/A☐	**Details/Findings** An equality impact assessment will be undertaken, with support provided by the ICB. It is expected that the Model will help to address health inequalities, given the

				intention to address unwarranted variation in the delivery of services.

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

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

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

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

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

Details/Findings
Not applicable to this report.

Appendix 1 National and Local Context

National Policy Context

The Primary Care Model has been informed by a range of national policy documents relating to the future of primary care (see ICB approved Model for further details). The Fuller report and its three essential offers serve as a foundational reference point – (1) streamline access to care, (2) provide more personalised, proactive care, and (3) ensure a far more ambitious and joined up approach to prevention. Fuller also emphasises key implementation factors, including the importance of avoiding a top-down approach to change, advocating instead for cultural shifts and trust-building in the workforce.

National Planning and Contractual Context

NHS Planning Guidance 2024/25 – The guidance includes a focus on the recovery of core services including a requirement to make it easier for people to access community and primary care services. This will be achieved by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.

There is also a clear focus on transformation and planning for the future which includes the requirement to expand evidence-based approaches to prevention and join up care closer to home through integrated neighbourhood teams and placed based arrangements. Systems are also required to set out steps to address the most significant causes of morbidity and premature mortality, and improve service co-ordination, and prevention priorities relating to hypertension and CVD scores, as well as addressing inequalities in line with Core20PLUS5. The guidance includes specific metrics for general practice around people with severe mental illness, dementia and learning difficulties.

***PCN DES* 2024/25 –**

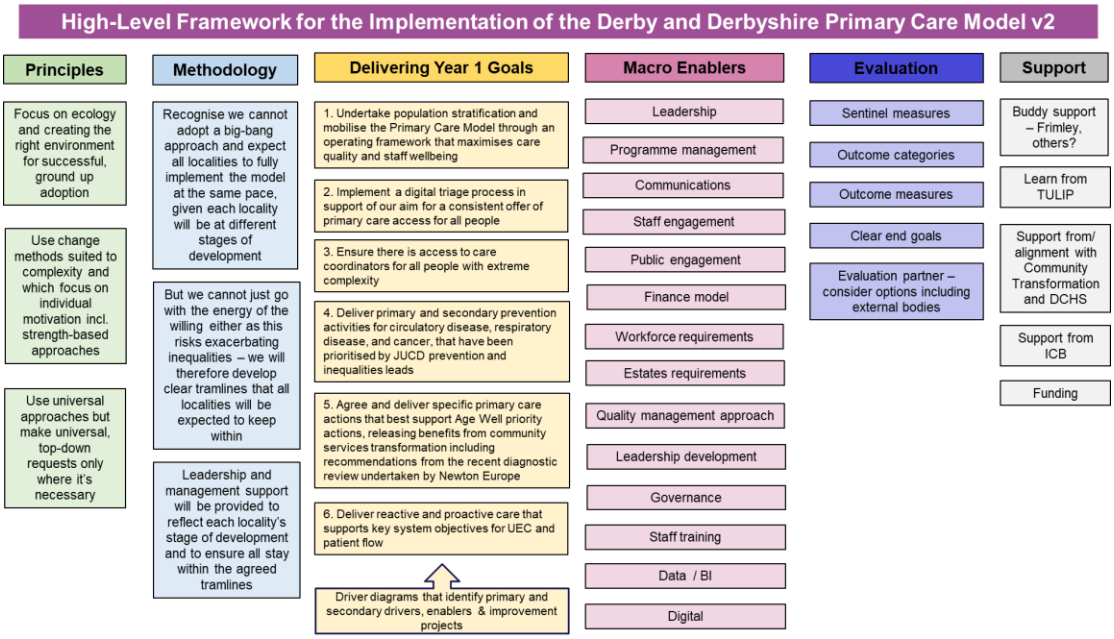
Funding and incentives within the DES have been streamlined to help reduce bureaucracy and support leaders to use funding in line with local priorities. A strong focus remains on delivery of the Capacity and Access Plans, Additional Roles Reimbursement Scheme (ARRS) and renewed focus on health inequalities, prevention and collaborating with non-GP providers to provide better care, as part of an integrated neighbourhood teams.

JUCD Planning Documents

The aims and key areas of focus from the Derby and Derbyshire Integrated Care Strategy were used to inform the Primary Care Model and the Year 1 Improvement Goals. The Model is also consistent with and will actively support the prioritised actions to strengthen primary care included within the Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28.

The Hub+ Derbyshire have led on and completed the first General Practice Intentions Survey Local to help enhance understanding of current workforce status, issues and needs. The local workforce data is being used along with national data to inform implementation of the Model and describes concerning trends in general practice retention and wellbeing alongside ever-increasing patient demand.

Appendix 2


High-Level Framework for the Implementation of the Derby and Derbyshire Primary Care Model v2
Principles
Focus on ecology and creating the right environment for successful, ground up adoption
Use change methods suited to complexity and which focus on individual motivation incl. strength-based approaches
Use universal approaches but make universal, top-down requests only where it's necessary
Methodology
Recognise we cannot adopt a big-bang approach and expect all localities to fully implement the model at the same pace, given each locality will be at different stages of development
But we cannot just go with the energy of the willing either as this risks exacerbating inequalities – we will therefore develop clear tramlines that all localities will be expected to keep within
Leadership and management support will be provided to reflect each locality's stage of development and to ensure all stay within the agreed tramlines
Delivering Year 1 Goals
1. Undertake population stratification and mobilise the Primary Care Model through an operating framework that maximises care quality and staff wellbeing
2. Implement a digital triage process in support of our aim for a consistent offer of primary care access for all people
3. Ensure there is access to care coordinators for all people with extreme complexity
4. Deliver primary and secondary prevention activities for circulatory disease, respiratory disease, and cancer, that have been prioritised by JUCD prevention and inequalities leads
5. Agree and deliver specific primary care actions that best support Age Well priority actions, releasing benefits from community services transformation including recommendations from the recent diagnostic review undertaken by Newton Europe
6. Deliver reactive and proactive care that supports key system objectives for UEC and patient flow
Driver diagrams that identify primary and secondary drivers, enablers & improvement projects
Macro Enablers
Leadership
Programme management
Communications
Staff engagement
Public engagement
Finance model
Workforce requirements
Estates requirements
Quality management approach
Leadership development
Governance
Staff training
Data / BI
Digital
Evaluation
Sentinel measures
Outcome categories
Outcome measures
Clear end goals
Evaluation partner – consider options including external bodies
Support
Buddy support – Frimley, others?
Learn from TULIP
Support from/ alignment with Community Transformation and DCHS
Support from ICB
Funding

Appendix 3

Progress on Priority Goals

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

Some discussions have been held on creating a programme architecture to oversee the testing and roll out of stratification once an approach has been agreed. This needs further discussion. Otherwise there has been limited progress against the next steps agreed at the PCCDG workshop, however these actions will be a priority for the new programme manager to focus on.

Goal 4 – Deliver primary and secondary prevention activities for circulatory disease, respiratory disease, and cancer, that have been prioritised by JUCD prevention and inequalities leads

The February meeting of PCCDG received a presentation from Allan Reid on 'Primary care from a population health perspective', which included a focus on addressing inequalities and risk factors and behaviours relating to Stay Well and cancer, circulatory and respiratory diseases. The presentation was well received and was seen an excellent platform to develop priorities for 2024/25 for primary and secondary prevention activities led by General Practice. Building on many examples of good practice discussions are taking place within the 2024/25 planning process to align and confirm the contribution of general practice to this important area of work. Further clarity is awaited from the ICB as to what activities will be prioritised in 24/25, after which General Practice actions will need to be agreed in the context of Primary Care Model implementation.

Progress on other Goals and agreed Next Steps

Goal 2 – Digital triage

PCN Managers have led on the development of a specification following extensive engagement with general practice and key stakeholders. Although delayed, the intention remains to utilise national funding and procurement processes to identify a supplier in line with the agree service specification. Unfortunately, the scheme has been delayed at a national level and we are awaiting further guidance on the next steps.

Goal 3 - Enhanced care-coordination for all people with extreme complexity
Goal 5 - Agree and deliver specific primary care actions that best support Age Well priority actions

Goal 6 - Deliver reactive and proactive care that supports key system objectives for UEC and patient flow

The key action relates to same day access and the need for General Practice to take a lead role on further development of services.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 009

Report Title	Performance Report
Author	Jo Hunter, Deputy Chief Nurse 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 – Prof Dean Howells, Chief Nurse Officer • Performance – Michelle Arrowsmith, Chief Strategy and Delivery Officer • Workforce - Linda Garnett, Interim ICB Chief People Officer • Finance – Keith Griffiths, Chief Finance Officer
Paper purpose	Decision ☐ Discussion ☐ Assurance ☒ Information ☐
Appendices	Appendix 1 – Performance Report
Assurance Report Signed off by Chair	Not applicable
Which committee has the subject matter been through?	Finance, Estates & Digital Committee: 27th February 2024 Quality & Performance Committee: 25th April 2024

Recommendations
The ICB Board are recommended to **NOTE** the Performance Report.
Purpose
To update the ICB Board on the Month 12 performance against: • quality standards in areas like planned, cancer, urgent and emergency and mental health care; • the 2023/24 operational plan objectives/commitments; • workforce; • the position against the 2023/24 financial plan including income and expenditure, efficiencies, capital and cash.
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 the 4th May 2023. The report attached represents the current assessment (M12 position) based on published data. In October, we undertook a progress review to assess performance against our earlier projections and forecasts, test the assumptions underpinning our original plan, and test our winter preparedness (H2) in line with NHSE guidelines and new requirements.

This was followed, in December, by a system wide finance and operational performance outlook review for 2023/24 (the reset) designed to address the significant financial challenges created by industrial action.

As a result, the ICB:

- committed to delivering the A&E 4hr target of 76% by March 2024. Our plan to support this drives improvement on the current level of performance and is considered a 'best case scenario' for both Acute Trusts;
- committed to delivering the ambulance handover trajectory – with both Acute Trusts clear on their role in this regard to support East Midlands Ambulance Service NHST and its delivery of the category 2 response target;
- committed to delivering a reduction in the number of people waiting longer than 62 days for their first definitive treatment for cancer, with a focus on achieving the year-end target;
- committed to delivering the faster Cancer Diagnosis Standard, so that on average at least 75% of people have their diagnosis of cancer confirmed or ruled out within 28 days; and
- restated our best endeavour to also achieve the RTT target of having no 65 week waits by the end of March 2024, and set out key aspects of our operational plan supported with the necessary financial resource.

Report Summary

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

Quality

Personal Health Budgets

The Operational Planning Guidance required ICBs to submit trajectories via their ICS for the number of Personal Health Budgets to be in place by the end of 2023/24. DDICB submitted PHB Trajectories on behalf of the ICS with performance monitored against them. The trajectory submitted for the end of 2023/24 was 3240. At the end of Q4 2023/24 the ICB has achieved this trajectory with 3308 individuals having received a PHB.

CYP Neurodisability (ND) Pathway

YPMH Access Performance Target that by March 2024, 14,431 children will have at least one contact with MH Services across Derby & Derbyshire. Last set of data indicated that 11,525 children had contact. System wide working group to develop plans to tackle CAMHS and BSM waiting lists. Examples of work include the creation of practitioner led assessment-based hubs with targeted triage/waiting list teams for North and South & ND Research Project and pre and post diagnostic support Hubs for CYP and their families with early intervention.

Infection Prevention and Control

NHSE HCAI thresholds for 2023/24 are predicted to breach at both acute trust and System level. Recovery plans remain in place. CRH and UHDB remain on enhanced monitoring and support as per the NHSE Midlands IPC escalation matrix. Assurances received relating to the implementation of Trust focused recovery action plans are via each Trust's internal IPC Committee, and IPC System Assurance Group.

Summary of Performance against key NHSE 2023/24 Operational Plan Objectives and Targets

Urgent and Emergency Care

- 4 hr A&E: For March CRH achieved a performance of 61.1% on average (against an operational plan trajectory of 64.0%) while UHDB achieved 74.7%. Through Tier 3 monitoring meetings and local initiatives both acutes saw a significant improvement in performance through March. This was recognised regionally and nationally with request to attend regional meetings to share improvement methods and good practice. This work will be built on for 2024/25 with a trajectory to achieve 78% by March 2025.
- Category 2 999 response times: The March performance has improved but wait is still longer than planned. The local standard is 39 mins and Derbyshire has an average of 41 minutes. Sustained improvement for Ambulance handovers at RDH led Derby & Derbyshire to be the best performing area in the East midlands for handovers for acutes of equivalent size.
- The ICB has worked with EMAS to understand the links between improved handovers and overall performance and intend to build on this for the coming year with a challenge to achieve a reduction to 30 minutes.
- Length of stay: Our providers are on average delivering average LOS performance at a level which places them in the top 25% of all Trusts nationally.
- Urgent Community Response: The ICB has continued to achieve performance levels above the national target that 70% of appropriate referrals for Urgent Community Response receive a (largely nursing or therapy) response within 2hrs. In the last quarter on average 680 people per month were considered as needing a 2hr response and performance has been routinely above 80%. In addition DDICB has a high quality, multi-disciplinary home visiting service (as part of our Team Up provision) that is integrated with the UCR services and links well to routine and proactive services. This has continued to be expanded and in 2023/24 over 55,000 visits were made (which is more than double the number in 22/23).

Planned Care

UHDB has been in Tier 1 Performance regime with NHS E for planned care with particular scrutiny on eliminating 78 weeks and reduction in overall total weighting list size. Both trusts had worked towards a route to zero for 78w breaches for the end of Mar-24 through insourcing/outsourcing and mutual aid for Orthopaedics, however multiple periods of industrial action, higher than anticipated staff sickness and some patient complexity resulted in UHDB closing March-24 with 55 x 78w breaches. This number will reduce to 42 in April with a revised ambition for zero in June. There are clear plans in place for each patient with system oversight to support earlier completion if possible. Both trusts are committed to having no patients waiting over 65 weeks by the end of September 2024. The overall reduction in waiting list size has been recognised as one of the best Regionally and will help put the ICB into a stronger position to make further reduction.

Cancer

UHDB is in Tier 1 Cancer. For reduction in 62 days backlog - CRH was compliant against its trajectory and UHDB were very close to their planned reduction in backlog. In addition CRH has been compliant for several months and in February UHDB was also compliant with achieving 76% against the 28 day Faster Diagnosis Standards and closed March-24. This significant improvement has resulted in recognition from the national team “for the fantastic progress” made on reducing the 62 day backlog over the past year and improving Faster Diagnosis performance. Since the beginning of April 2023 the 62 day backlog has shown an improvement of 42.2% and the Faster Diagnosis performance improved by 9%. Seen as some of the most positive progress nationally it was also recognised as a significant contributor to the overall national position

As a result of improved assurance and overall reduction in waiting list size UHDB have now officially been moved out of Tier 1 to Tier 2 which represents an increased level of confidence.

Mental Health, Autism and Learning Disabilities

- Talking therapies, Dementia diagnosis rate, Perinatal, Adult SMI contacts, Early Intervention for Psychosis, Urgent CYP Eating Disorder Waiting time: Achieving or exceeding the planned trajectory for all 7 metrics.
- CYP access & Routine CYP Eating Disorder waiting timers: There are ongoing issues with data capture at national level still showing in performance of CYP Community Access requirement, issue now resolved, however performance measured against 12 month rolling total. Improvement required in relation to CYP routine eating disorder referral to assessment waiting times, 78% of referrals are seen within 4 weeks against constitutional standard of 95%.
- MH Out of area placements: is off trajectory. As with many parts of the country continued issues with flow through acute services resulting in higher length of stay, high occupancy levels and increased use of out of area placements (AMH and PICU). Recovery action plan in place and under review. MADE event held to expedite plans for clinically fit for discharge patients.
- LD&A Transforming Care Program: Achieved national standard for CYP however non-compliant with national and locally agreed trajectory for adults (secure and non-secure) as at end March 24. Recovery action plan and assurance oversight in place. Significant reduction in number of admissions into AMH beds. Focus on long stay patients to expedite discharges.

General Practice

General Practice Appointments: Despite the sustained pressure across General Practice, we have delivered our planned level of appointments in 23/24 which is ~2% higher than 2022/23.

Finance

As of the 31st March 2024, JUCD delivered the H2 reset position of a £42.3m deficit but with technical adjustments (IFRS16 and Health Care Support Worker re-banding), the reported figure is £59.8m. The £42.3m deficit was an accepted deviation from the original breakeven plan due to excess inflation, underfunding of the pay award, the change in national policy on revenue support for cost of capital and insufficient funding to cover contractual obligations for Primary Care.
The system has been subject to additional liabilities previously notified to NHSE, these are on top of the H2 reset target and outside of system control. The first, an expected benefit of £9m relating to a reduction in PDC with the revaluation of PFI assets under IFRS16. Due to a change in national policy this benefit can no longer be recognised in the System position. Secondly, health care support worker re-banding costs of £8.5m, that were previously reported as risks, are expected to materialise and have been included in the year end position.

JUCD has delivered £134.7m of efficiencies in year (99% of the plan), despite pressures from high inflation and industrial action, which has led to management and clinical leadership being directed away from the efficiency challenge.

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**	There is a risk that the system does not create and enable a health and care workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital	☐

	direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.			transformation in order to improve outcomes and enhance efficiency.	

No further risks identified.

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

[To be completed by Finance Team ONLY]

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.	Not applicable.

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

There are no risks that would affect the ICB's obligations.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
The ICB is committed to the achievement of Net Zero Targets and the delivery of the Derbyshire ICS Green Plan.

Derby and Derbyshire
Integrated Care Board

Integrated Assurance and Performance Report

March 2024

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

Quality

Prof Dean Howells, Chief Nurse Officer
Dr Deji Okubadejo, Non-Executive Member

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

Derby and Derbyshire Integrated Care Board

#	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	Delivery of Maternity Services	**UHDB** **High Perinatal Mortality:** In February 2024 the stillbirth rate was 4.07/1000 births and is stabilising with no stillbirths in month. It is the lowest rate in the last 12 months but remains above the England average of 3.52/1000 births. The Trust's Maternity Improvement Plan Priority 1 workstream areas addressing fetal heart monitoring and post-partum haemorrhage as well as the work and progress against Saving Babies Lives Care Bundle v3 is supporting this. The neonatal death rate was 0.96/1000 live births and remains stable below the England average of 1.6/1000 live births. The extended perinatal mortality thematic review action plan is to be shared with the LMNS in April once it has been through internal governance at UHDB. A regulation 28 Preventing Future Deaths notice was issued to UHDB in March 2024 following a neonatal death in November 2022. UHDB have to provide a response and an action plan by May 2024. **Maternal Mortality**: In January 2024, 2 indirect maternal deaths were reported due to a death in another unit were postnatal care was provided by UHDB and a case under police investigation. **Maternal Morbidity:** The rate of third- and fourth-degree tears is 41.42/1000 (3 month rolling) remaining above the national average of 27/1000 (3 months rolling). The rate of postpartum haemorrhage is 36/1000 deliveries remaining above the national average of 30/1000 deliveries. The maternity improvement plan includes quality improvements for management of obstetric haemorrhage however this still remains an area of concern. **Neonatal care:** UHDB were identified as a Midlands outlier in Q2/3 for off pathway preterm births however no cases were found to be unavoidable due to late presentation in labour. **Quality and Safety of Maternity services:** The NMC has undertaken a review with UHDB relating to University of Derby students and the final report is awaited. The LMNS is leading an insight visit and Ockenden review in April. Senior leadership has improved with the recruitment of an associate Director of Midwifery, 2 Deputy Heads of Midwifery and 2 Consultant Midwives. SBLCBv3 compliance improved to 54% in March. CQC Regulations 31 and 29a action plans for RDH and QHB are monitored monthly by NHSE and DDICB through tier 3 oversight. **CRH** **Perinatal Mortality:** The stillbirth rate increased to 4.29/1000 births in January following 2 stillbirths over 37 weeks. The rate is above England average and is the highest rate in the last 12 months. A thematic review is being undertaken due to the increased rate to identify any learning with preliminary data identifying deprivation as a theme. **Maternal Morbidity:** The rate of third- and fourth-degree tears has remained consistently above the national average (24/1000) of 51.98/1000. NHS Midlands have offered support in embedding the Obstetric Anal Sphincter Injury Care Bundle. **Maternal Mortality**: An indirect maternal death was reported in February 2024 due to cancer

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

Derby and Derbyshire Integrated Care Board

#	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
2	Safety	IPC	System wide	NHSE HCAI thresholds for 2023/24 are predicted to breach at both acute trust and System level.	**Position for March 2024 (*data at 8/4/24 not finalised for year-end):** • DDICB system CDI numbers at year end* are 350 cases against a threshold of 262 (34% above expected) CRH – 52 (73% over threshold of 30). UHDB – 187 (93% over threshold of 97) • DDICB provider organisations MRSA blood stream infections – 17 cases reported against a zero tolerance (UHDB – 6, CRH – 5, community cases - 6) • The year end* position of Gram-negative infections have breached thresholds at both acute trusts due to high numbers in the first half of the year. UHDB - 281 total cases (28% over threshold of 219). CRH 96 total cases (20% over threshold of 80). This is in line with the national picture. Since November the numbers have stabilised and are within expected range. Recovery plans remain in place. CRH and UHDB remain on enhanced monitoring and support as per the NHSE Midlands IPC escalation matrix. UHDB have received updated report from NHSE December 2023 visits. This identified that further work is needed around use of PPE, surgical site infection surveillance, storage and embedding responsibility for IPC standards at ward/department level. Improvements seen in IPC leadership and governance. CRH - Continued support offered by regional team/ICB to CRH. Progress made around embedding skin decolonisation for MRSA, but further work is needed around maintenance of estates. Assurances received relating to the implementation of Trust focused recovery action plans are via each Trust's internal IPC Committee, and IPC System Assurance Group. DHcFT – concerns identified in CQC report around cleanliness of ward environment. IPC lead has provided assurances around actions taken and improvements to monitoring and audit with NHSE/ICB visit being planned to review.

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

Derby and Derbyshire Integrated Care Board

#	Concern or Issue	Programme/Specialty i.e. Maternity, cancer	Organisation/ Place/ System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
3	Waiting Times	CYP Neurodisability (ND) Pathway	DHcFT	CYPMH Access Performance Target that by March 2024, 14,431 children will have at least one contact with MH Services across Derby & Derbyshire. Last set of data indicated that 11,525 children had contact.	• **ND Assessment Transformation Programme:** Creation of practitioner led assessment-based hubs with targeted triage/waiting list teams for North and South & ND Research Project • **ND Community Hubs:** Pre and post diagnostic support for CYP and their families with early intervention • **Autism in Schools:** Tailored support packages for 'highly Autistic Children and Young People' transitioning between classes, year groups or schools • **CYP Keyworker service:** Better care and support for autistic CYP or CYP with LD and their parents. Reduce pressure on T4 Hospital beds the need for Out of Area Placements • **Emotionally Based School Absence Project:** 12-month pilot to support children across Derby + Derbyshire who are starting to become absent from school due to a psychosocial problem. • **Mental Health pathway transformation:** System wide working group to develop plans to tackle CAMHS and BSM waiting lists • **Autism Portal on Derby and Derbyshire Emotional Health and Wellbeing Website:** 24 hr on-line free resource for parents/families & professionals , providing pre and post diagnostic support including recorded videos with information, advice, website links and strategies to help with concerns about their child's development. Also covers Behaviour support, Communication, Food & Nutrition, sensory needs, Sleep, ND assessment process
4	Safety	HSMR	UHDB	UHDB has seen an increase in Hospital Standardised Mortality Ratio (HSMR) moving to 104.96 from 103.07 (December 2023).	Although still within acceptable confidence limits, this marks the fifth consecutive month of HSMR trending above the national average and the highest point in a rolling 12-month period. Similarly, the Summary Hospital-level Mortality Indicator (SHMI) has increased, although the Trust remains among the top three of its peer organisations. To address this, the Trust has implemented a new facility to delve deeper into diagnostic codes, enabling a thorough examination of any areas where deaths exceed expectations. Departments are being engaged to identify potential contributing factors, focusing on conditions such as Stroke, COPD, GI Haemorrhage, fluid and electrolyte disorders, pleurisy, pneumothorax, and pulmonary collapse.
5	Quality	PHB	JUCD	The Operational Planning Guidance required ICBs to submit trajectories via their ICS for the number of Personal Health Budgets to be in place by the end of 2023/24.	DDICB submitted PHB Trajectories on behalf of the ICS with performance monitored against them. The trajectory submitted for the end of 2023/24 was 3240. At the end of Q4 2023/24 the ICB has achieved this trajectory with 3308 individuals having received a PHB.

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

Derby and Derbyshire Integrated Care Board

LEARNING AND SHARING - best practices, outcomes
UHDB ITU Capacity – The Intensive Care Unit is currently undergoing a Trust-wide capacity review due to heightened demand for non-elective services, surpassing the commissioned critical care capacity. Consequently, both capacity and staffing levels have exceeded the budgeted amounts. To address this, additional staff have been recruited through off-framework agencies at enhanced rates. This situation has been escalated to the Trust's Extreme Risk Register and is under the oversight of the Surgery Directorate. **Safeguarding Children** - The child practice review report on TDS20 was published on the 27th March 24. The report is on the Derby and Derbyshire Safeguarding Children Partership website. This report attracted national and local significant media attention over a number of days.

Performance

Michelle Arrowsmith, Chief Strategy and Delivery Office
Dr Deji Okubadejo, Non-Executive Member

Planning Compliance with Operational Plan

Derby and Derbyshire Integrated Care Board

Area	Objective	Level	2324 YTD Plan / Latest Monthly Position	2324 YTD Actual / Latest Monthly Position	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Comment
Cancer	Ensure that at least 75% of people receive communication of a diagnosis for cancer or ruling out of cancer, or a decision to treat if made before a communication of diagnosis, within 28-days	CRH	79%	78%	77.0%	77.8%	78.2%	79.4%	78.1%	76.7%	80.5%	80.4%	76.5%	75.0%	80%	*76.60%*	*74.50%*	March / April data taken from Tier 2 slides - 01.05.24
		UHDB	70%	70%	66.9%	70.0%	71.6%	71.6%	69.5%	66.9%	65.4%	67.2%	71.6%	71.5%	76%	*71.30%*	*72.00%*	
	Reduce the number of people waiting longer than 62 days for their first definitive treatment for cancer.	CRH	43	39	47	48	47	47	53	54	49	47	52	46	43	39	*46*	April data taken from Weekly CWT PTL3 Report - 28.04.24
		UHDB	268	271	473	453	310	366	416	516	458	466	420	393	327	271	*317*	

Area	Objective	Level	2324 YTD Plan / Latest Monthly Position	2324 YTD Actual / Latest Monthly Position	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Comment
Planned Acute Care	No person waiting longer than 65 weeks on an RTT pathway at the end March 2024.	CRH	65	318	314	313	314	312	342	291	317	264	328	343	318	*303*	*278*	The March and April position is based on a draft unvalidated position taken from Foundry. March is at 31.03.24 April is at 28.04.24
		UHDB	122	1,275	1,704	1,924	1,985	2,073	2,572	2,588	2,391	1,824	1,883	1,639	1275	*991*	*968*	
		DDICB	214	1,545	1,813	1,988	2,059	2,143	2,776	2,803	2,660	2,097	2,278	2,191	1545	*1,294*	*1,246*	
	No person waiting longer than 78 weeks on an RTT pathway.	CRH	0	8	16	14	6	12	14	13	7	10	11	6	8	*6*	*2*	
		UHDB	0	167	144	130	99	112	200	241	299	237	242	243	167	*81*	*50*	
		DDICB	0	156	195	193	129	148	201	230	263	247	313	309	156	*87*	*52*	
	No person waiting longer than 104 weeks on an RTT pathway.	CRH	0	0	0	0	0	0	0	0	0	1	0	0	0	*0*	*0*	
		UHDB	0	1	0	0	1	0	0	0	0	0	0	0	1	*1*	*2*	
		DDICB	0	1	3	6	0	2	0	1	1	1	0	3	1	*1*	*2*	
	At least 85% of people receive a diagnostic test within 6 weeks by March 2024.	CRH	78%	86%	82.9%	82.5%	85.1%	84.0%	83.3%	84%	87%	90%	88%	88%	88%			Percentage compliance is based on seven diagnostic tests (MRI / CT / Non Obs Ultrasound / Echocardiography / Colonoscopy / Flexi Sigmoidoscopy / Gastroscopy
		UHDB	74%	76%	68.1%	70.0%	71.6%	71.1%	70.9%	75%	80%	83%	81%	80%	85%			

- **Planned Care** UHDB is under Tier 1 regulation. UHDB closing March-24 with 55 x 78w breaches , will reduce to 42 in April aiming for zero in June. The overall reduction in waiting list size recognised as one of the best Regionally
- **Cancer Care** UHDB is also in Tier 1 Cancer. For reduction in 62 days backlog - CRH was compliant against its trajectory and UHDB were very close to their reduction in backlog.
- 28day Faster Diagnosis Standard CRH compliant for several months, February UHDB was also compliant with achieving 76% against the standard. Nationally recognised significant improvement on reducing the 62 day backlog over the past year and improving Faster Diagnosis performance. Since April 2023 62 day backlog improvement of 42.2% and the Faster Diagnosis performance by 9%.
- UHDB moved out of Tier 1 to Tier 2 which represents an increased level of confidence and assurance.
- **Diagnostics:** Based on the 7 tests measure CRH are at 88% and UHDB are at 85% (7 tests include: MRI / CT / Non-Obstetric Ultrasound / Echocardiography / Colonoscopy / Flexi Sigmoidoscopy / Gastroscopy)

Planning Compliance with Operational Plan

NHS
Derby and Derbyshire
Integrated Care Board

Area	Objective	Level	2324 YTD Plan / Latest Monthly Position	2324 YTD Actual / Latest Monthly Position	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Comment
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	64%	64%	67.9%	64.8%	68.8%	70.9%	65.7%	69.1%	63.8%	59.9%	59.9%	61.4%	59.0%	61.1%		The April figure is a 6 weekly average taken from the Analytics Hub - National AE Dashboard.
		UHDB	64%	69%	66.7%	68.4%	67.7%	71.8%	69.4%	69.4%	67.9%	67.6%	68.9%	69.5%	70.8%	74.7%	*68%*	
	30 minutes or less for EMAS to respond to a category 2 incident, on average.	ICB			00:31:00	00:35:00	00:40:00	00:38:48	00:39:33	00:42:31	00:49:27	00:42:48	01:00:11	00:48:56	00:53:54	00:41:22		From December the target has been amended to 39 mins (original target 30 mins) in line with revised trajectory.
		EMAS			00:33:32	00:34:23	00:39:34	00:36:16	00:36:49	00:42:33	00:52:44	00:41:02	00:56:09	00:49:59	00:49:36	00:43:06		
	Both Acute Trusts to operate at an average general and acute occupancy rate of 92%.	CRH	92.3%	95.3%	94.2%	94.5%	94.0%	92.4%	91.8%	93.3%	94.6%	96.2%	94.1%	96.4%	96.5%	96.9%	*94.9%*	The April data is a draft snapshot taken on 30.04.24 from Foundry
		UHDB	93.3%	94.4%	89.8%	93.3%	94.0%	92.2%	91.7%	92.5%	94.0%	96.1%	93.9%	96.7%	95.4%	93.7%	*94.0%*	
	At least 70% of referrals into the Urgent Community Response Service to be responded to within 2 hours.	ICB	70%	67%	67%	90%	89%	91%	91%	88%	88%	78%	50%	67%	67%			Local data consistently shows 80% achievement, national data for Dec - Feb has some data issues (DCHS data not showing).
	Increase virtual ward capacity.	ICB	255	165	120	120	120	140	160	165	165	165	165	165	165	165		Month end snapshot
	Increase virtual ward utilisation.	ICB	80%	43%	33.0%	26.0%	60.0%	21.0%	36%	46%	39%	49%	35%	62%	38%	43%		

4 hr A&E: For March CRH achieved a performance of 61.1% on average (against an operational plan trajectory of 64.0%) while UHDB achieved 74.7%.

- Significant improvement made through continued bi weekly monitoring meeting's and March push on national requirement for 76%
- Both Acute sites have created a performance bridge to ensure focussed actions to improve ED performance to the new 24/25 trajectory of 78% set by NHSE
- Derby & Derbyshire system and UHDB colleagues have attended multiple regional meetings to share the improvement methods used and seen as good practice for other systems to adopt

Category 2 999 response times:

- The March performance has improved but wait is still longer than planned. The local standard is 39 mins and Derbyshire has an average of 41 minutes.
- Joint EMAS and ICB deep dive into C2 performance to understand improvement seen from a reduction in handover delay
- We are now exploring with EMAS colleagues the actions needed to create a performance bridge to reduce the mean time to 30 mins

Handovers:

- Sustained improvement for Ambulance handovers at RDH bringing Derby & Derbyshire to the best performing area in the East midlands for handovers for acutes of equivalent size.

Planning Compliance with Operational Plan

Derby and Derbyshire Integrated Care Board

Area	Objective	Level	2324 YTD Plan / Latest Monthly Position	2324 YTD Actual / Latest Monthly Position	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Comment
Mental Health, Autism & Learning Disabilities	Increase the dementia diagnosis rate (Quarterly Target)	ICB	65.5%	67.5%	66.3%	66.4%	67.1%	67.7%	68.0%	68%	68%	68%	68%	68%	68%	
	Provide access for 28,294 people to receive IAPT in 23/24 (Quarterly Target)	ICB	25,871	26,355	2,265	4,700	7,205	2,370	4,895	7,355	2,720	5,375	7,185	2,375	4,610	Rolling total each quarter
	Increase the number of women accessing specialist perinatal services in 2023/24 (Quarterly Target).	ICB	1,018	1,045	260	370	465	535	595	665	745	830	900	985	1,045	
	Increase the number of children and young people accessing a mental health service (Quarterly Target).	ICB	14,104	13,735	10,630	10,720	11,205	11,545	11,660	11,750	11,870	12,410	12,725	13,015	13,735	Monthly activity number is a rolling 12 month total
	Increase the number of adults with a severe mental health illness receiving 2+ contacts with a community health service (Quarterly	ICB	11,745	12,100	11,730	11,685	11,690	11,635	11,530	11,520	11,590	11,645	12,015	12,135	12,100	Monthly activity number is a rolling 12 month total
	Ensure that 75% of individuals listed on GP registers as having a learning disability will receive annual health check (Quarterly Target).	ICB	65%	59%	2.7%	6.7%	11.5%	15.7%	21%	24%	29%	36%	41%	49%	59%	Rolling total
	Reduce the number of adults who are autistic, have a learning disability or both who are in beds commissioned by the ICB and NHSE.	ICB	34	36	45	49	48	42	47	43	39	37	37	36	36	Revised targets have been agreed with the Regional Team. The revised target for February is: Adults - 34 C&YP - 3
	Reduce the number of children who are autistic, have a learning disability or both who are in inpatient beds	ICB	3	4	6	7	4	3	2	2	5	6	5	5	4	
	Reduce out of area placements - Bed Days	DHCFT	3,557	9,615	555	1,200	2,065	785	1,675	2,675	1,135	2,395	3,685	1,190		Rolling total each quarter

- **Talking therapies, Dementia diagnosis rate, Perinatal, Adult SMI contacts, Early Intervention for Psychosis, Urgent CYP Eating Disorder Waiting time**: Achieving or exceeding the planned trajectory for all **7** metrics.
- **CYP access & Routine CYP Eating Disorder waiting timers:** Improvement required in relation to CYP routine eating disorder referral to assessment waiting times, 78% of referrals are seen within 4 weeks against constitutional standard of 95%.
- **MH Out of area placements:** is off trajectory, national picture of continued issues with flow through acute services resulting in higher length of stay, high occupancy levels and increased use of out of area placements (AMH and PICU). Recovery action plan in place and under review.
- **LD&A Transforming Care Program:** Achieved national standard for CYP however non-compliant with national and locally agreed trajectory for adults (secure and non-secure) as at end March 24.

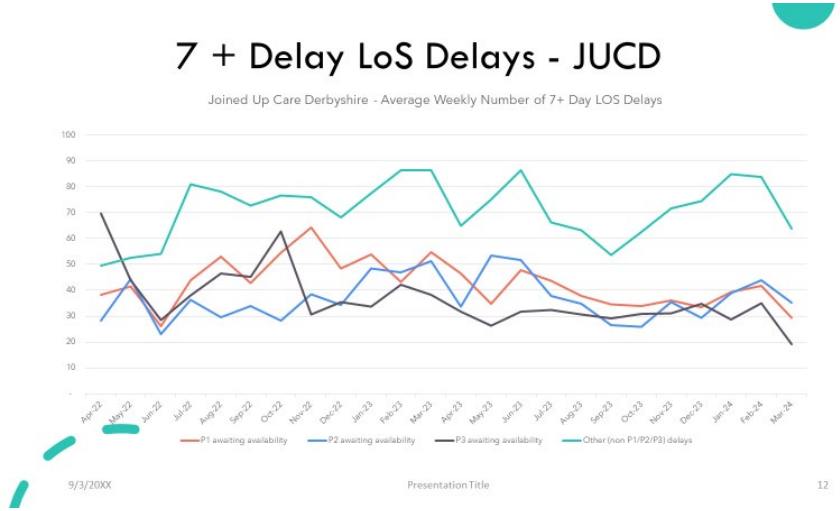
Planning Compliance with Operational Plan

Derby and Derbyshire Integrated Care Board

Area	Activity Metric	Level	2324 YTD Plan / Latest Monthly Position	2324 YTD Actual / Latest Monthly Position	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Comment
Community Data	D2A - The number of people discharged by location and discharge pathway per month	ICB	89,063	96,721	7,585	8,360	8,378	8,654	8,525	8,096	8,138	8,324	7,819	8,258	7,860	6,724	
	D2A - Pathway 0 - Non-complex discharge		80,683	88,418	6,989	7,676	7,652	7,943	7,834	7,422	7,464	7,614	7,186	7,368	7,146	6,124	
	D2A - Pathway 1 - Home with Support		4,948	4,489	300	381	384	380	382	376	394	380	331	497	372	312	
	D2A - Pathway 2 - Intermediate Care		2,745	3,044	236	256	276	259	250	243	232	268	239	311	266	208	
	D2A - Pathway 3 - 24-hour care placement		687	770	60	47	66	72	59	55	48	62	63	82	76	80	
	Community Waiting List - Quarterly Target	ICB	21,600	22,247	24,352	23,483	24,186	21,865	25,971	24,703	24,573	22,846	23,207	21,949	22,247		24,026 target is the Mar 23 waiting list position
	Community Waiting List by weeks - 0-1 weeks	ICB			4,260	3,343	3,217	3,081	3,770	3,242	2,724	2,231	1,899	2,597	2,241		Full year target is the Mar 23 waiting list position Red / Green highlights indicate monthly position in comparison to previous month
	Community Waiting List by weeks - 1-2 weeks				2,360	2,124	2,304	2,046	1,961	2,003	1,923	1,627	1,577	1,863	1,797		
	Community Waiting List by weeks - 2-4 weeks				2,688	3,184	3,231	3,236	3,240	2,991	3,021	2,550	2,807	2,463	2,832		
	Community Waiting List by weeks - 4-12 weeks				6,956	6,590	6,368	6,417	7,672	6,787	6,667	6,392	6,636	4,983	5,612		
	Community Waiting List by weeks - 12-18 weeks				2,198	2,458	2,594	2,369	2,841	2,879	3,271	2,855	2,860	2,889	2,509		
	Community Waiting List by weeks - 18-52 weeks				4,413	4,493	4,994	3,781	4,860	5,118	5,429	5,683	5,827	5,471	5,439		
	Community Waiting List by weeks - over 52 weeks				1,124	1,291	1,478	935	1,627	1,683	1,538	1,508	1,601	1,683	1,817		
	Community Waiting List by weeks - Unknown				353												

Discharge to Assess:
Target of a 15% reduction in P1-P3 delays for patients with 7+ day LOS achieved, having been set in the last planning round.

- Whilst being a challenging year, we have seen improvement across the pathways underpinned by interim arrangements particularly in P1 capacity whilst more permanent transformation is being delivered in the coming year.
- Between the 2 acutes, we are seeing a more marked improvement in the South compared with the North position
- Work over the last year has shown a reduction in average number of people, who have a 7 day LOS and are in delay (see the graph to the right). The biggest impact has been in delays for P1 where there has been a 20% reduction in numbers year on year.

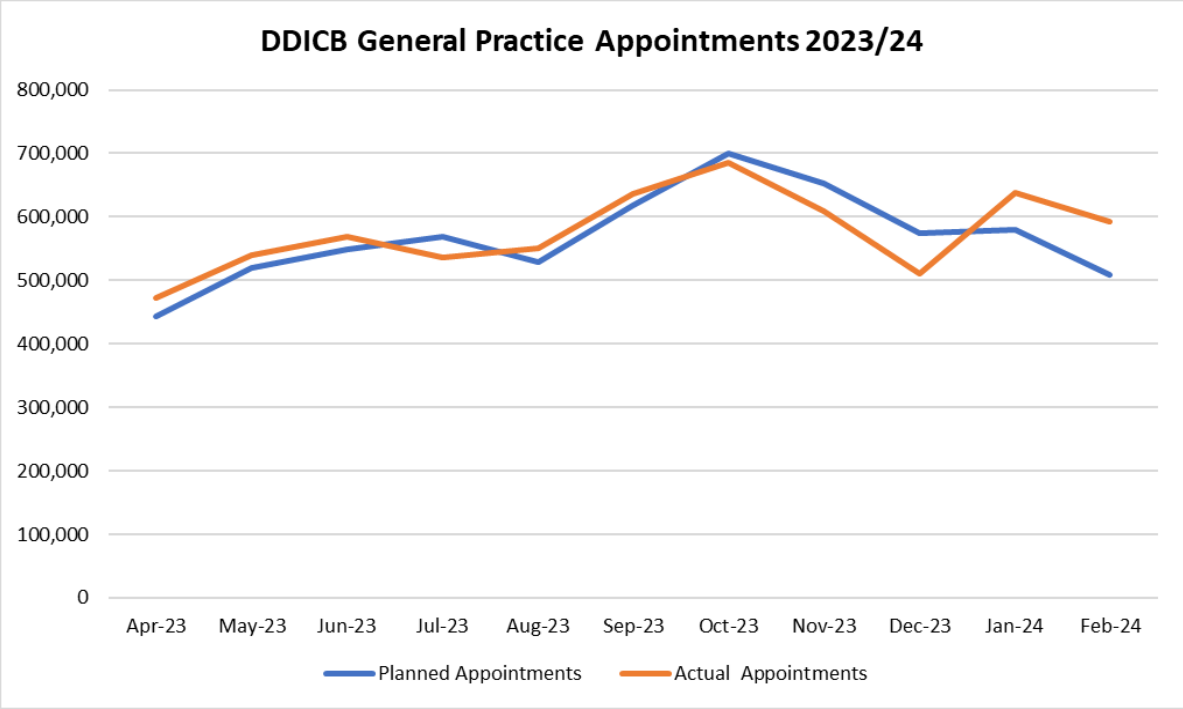


Planning Compliance with Operational Plan

Derby and Derbyshire Integrated Care Board

Key to RAG Ratings
On Plan
Close to Plan
Off Plan

Objective	Level	2324 YTD Plan / Latest Monthly Position	2324 YTD Actual / Latest Monthly Position	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Increase General Practice appointment activity	ICB	6,243,760	6,336,086	471,753	538,841	568,802	536,175	549,860	635,504	684,853	609,378	510,009	638,360	592,551
Increase referrals into Community Pharmacy Consultation Services (Quarterly Target)	ICB	31,875	23,283	*2,562*	*2,484*	*2,305*	*2,338*	*2,013*	*1,963*	*2,353*	*2,093*	*2,862*	*2,310*	
Recover dental activity to pre-pandemic levels (Quarterly Target)	ICB	1,531,764	1,288,035	*1,288,035*										



- Demand has remained high, with number of appointments offered significantly exceeding pre-pandemic levels.
- Successfully launched the Pharmacy First project.
- We have made good progress in 23/24, including:
- 100% of practices have enabled patients to order repeat medications, book/cancel appointments and receive secure messaging through the NHS App
- 47.% of practices are utilising the automatic GP registration service
- Supported and funding (over £1m) our practices to move to digital phone systems
- 17.9% increase in the number of online consultations since April 2023
- 49 practices have taken part/taking part in the National General Practice Improvement Programme
- 82% of appointments seen within 2 weeks

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

CRHFT Activity Measures Operational Plan

Derby and Derbyshire Integrated Care Board

CRH

Data Extracted from NHS Futures - Operational Planning Tool - Activity and Performance

Provider	Subject	Measure Name		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
CRH	Elective	Elective day case spells - E.M.10a	2023/24 Actuals	2,156	2,493	2,440	2,317	2,398	2,347	2,536	2,683	2,085	2,547	2,344	
			2023/24 Plans	2,289	2,421	2,326	2,690	2,378	2,463	2,683	2,366	2,418	2,637	2,419	2,479
		Elective ordinary spells - E.M.10b	2023/24 Actuals	255	330	343	310	357	323	361	387	319	315	361	
			2023/24 Plans	321	385	373	393	389	364	414	351	292	344	348	382
	Outpatients	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance - E.M.32g	2023/24 Actuals	6,196	7,153	7,190	6,670	6,686	6,637	6,627	6,941	5,859	7,130	6,583	
			2023/24 Plans	6,841	6,922	6,440	7,401	6,467	7,485	8,225	7,073	6,825	7,683	6,977	7,673
		Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance - E.M.32h	2023/24 Actuals	18,087	19,822	20,011	18,821	18,988	19,121	20,653	21,059	17,359	20,267	19,069	
			2023/24 Plans	18,325	19,551	18,238	20,038	17,997	19,978	21,764	19,760	18,160	20,974	19,545	20,862
	A&E	A&E - Type 1 - E.M.13a	2023/24 Actuals	5,365	5,697	6,487	7,573	7,128	7,262	7,488	7,392	6,993	7,106	7,030	7,301
			2023/24 Plans	5,673	5,762	5,700	5,925	5,720	5,661	5,787	5,844	5,703	5,567	5,003	5,787
		A&E - Other - E.M.13b	2023/24 Actuals	2,552	3,067	2,192	1,185	1,364	1,233	1,423	1,176	1,646	1,659	1,538	1,757
			2023/24 Plans	2,668	2,841	2,765	2,685	2,479	2,673	2,776	2,683	3,035	2,667	2,446	2,758
		A&E - Total - E.M.13	2023/24 Actuals	7,917	8,764	8,679	8,758	8,492	8,495	8,911	8,568	8,639	8,765	8,568	9,058
			2023/24 Plans	8,341	8,603	8,465	8,610	8,199	8,334	8,563	8,527	8,738	8,234	7,449	8,545
	Non Elective and Emergency Care	Non-elective spells with a length of stay of 1 or more days - E.M.11b	2023/24 Actuals	2,158	2,170	2,290	2,341	2,254	2,163	2,441	2,406	2,257	2,381	2,245	
			2023/24 Plans	2,131	2,187	2,143	2,111	2,101	2,076	2,097	2,253	2,235	2,324	2,030	2,200
		Non-elective spells with a length of stay of zero days - E.M.11a	2023/24 Actuals	1,370	1,600	1,613	1,599	1,509	1,557	1,592	1,576	1,606	1,687	1,657	
			2023/24 Plans	540	555	567	590	467	537	485	556	558	502	490	542

Provider	Subject	Measure Name		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
CRH	RTT	New RTT pathways (clock starts) - E.M.20	2023/24 Actuals	4,766	5,735	5,521	5,353	5,337	5,164	4,817	5,556	4,402	5,635	5,618	
			2023/24 Plans	3,443	3,941	3,864	4,030	4,019	3,778	3,811	4,124	3,122	3,709	3,724	4,232
		Number of 52+ week RTT waits - E.B.18	2023/24 Actuals	1,211	1,242	1,183	1,184	1,190	1,223	1,390	1,295	1,286	1,300	1,235	
			2023/24 Plans	1,698	1,665	1,605	1,547	1,488	1,421	1,353	1,286	1,240	1,158	1,076	991
		Number of 65+ week RTT waits - E.B.20	2023/24 Actuals	314	313	314	312	342	291	317	264	328	343	315	
			2023/24 Plans	467	452	417	382	347	302	257	212	187	126	65	0
		RTT completed admitted pathways - E.M.18	2023/24 Actuals	326	411	508	360	390	379	544	430	277	371	351	
			2023/24 Plans	660	789	593	659	510	524	643	573	447	554	571	363
		RTT completed non-admitted pathways - E.M.19	2023/24 Actuals	3,964	4,426	4,685	4,173	4,307	4,464	4,114	4,418	4,142	4,448	4,234	
			2023/24 Plans	4,673	4,802	4,468	5,036	4,333	4,629	5,337	4,609	4,159	4,917	4,620	4,586
		RTT waiting list - E.B.3a	2023/24 Actuals	25,108	25,638	25,294	26,015	26,133	26,436	27,614	27,356	27,260	20,228	28,314	
			2023/24 Plans	24,595	24,672	25,081	25,989	26,554	25,276	24,087	23,824	24,565	24,090	23,426	22,774

UHDBFT Activity Measures Operational Plan

NHS
Derby and Derbyshire
Integrated Care Board

UHDB

Data Extracted from NHS Futures - Operational Planning Tool - Activity and Performance

Provider	Subject	Measure Name	Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
UHDB	Elective	Elective day case spells - E.M.10a	2023/24 Actuals	8,443	9,212	9,338	8,697	9,319	8,896	10,132	10,379	8,671	10,217	9,718	
			2023/24 Plans	9,414	10,404	9,909	10,404	10,900	10,900	10,404	10,900	9,909	10,404	9,909	11,395
		Elective ordinary spells - E.M.10b	2023/24 Actuals	955	1,150	1,221	1,155	1,218	1,177	1,362	1,359	1,122	1,052	1,242	
			2023/24 Plans	1,089	1,204	1,146	1,204	1,261	1,261	1,204	1,261	1,146	1,204	1,146	1,318
	Outpatient	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance - E.M.32g	2023/24 Actuals	25,864	30,892	32,204	29,884	30,176	30,902	33,050	34,221	28,632	33,274	31,813	
			2023/24 Plans	30,681	33,910	32,296	33,910	35,525	35,525	33,910	35,525	32,296	33,910	32,296	37,140
		Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance - E.M.32h	2023/24 Actuals	63,131	73,243	73,533	70,124	74,051	71,362	77,526	79,367	64,237	76,899	70,972	
			2023/24 Plans	64,583	71,382	67,983	71,382	74,781	74,781	71,382	74,781	67,983	71,382	67,983	78,180
	A&E	A&E - Type 1 - E.M.13a	2023/24 Actuals	14,480	15,992	15,999	15,491	16,534	20,278	21,591	20,276	20,261	20,793	20,280	21,739
			2023/24 Plans	15,398	16,029	15,799	15,443	14,567	14,585	15,018	15,696	15,809	13,042	13,989	15,488
		A&E - Other - E.M.13b	2023/24 Actuals	12,831	14,370	14,170	14,435	12,088	9,904	10,501	9,502	9,779	9,904	9,960	10,539
			2023/24 Plans	8,612	9,377	9,181	9,341	8,584	8,398	9,118	8,976	10,086	7,544	8,245	9,128
		A&E - Total - E.M.13	2023/24 Actuals	27,311	30,362	30,169	29,926	28,622	30,182	32,092	29,778	30,040	30,697	30,240	32,278
			2023/24 Plans	24,010	25,406	24,980	24,784	23,151	22,983	24,136	24,672	25,895	20,586	22,234	24,616
	Non Elective and Emergency Care	Non-elective spells with a length of stay of 1 or more days - E.M.11b	2023/24 Actuals	4,998	5,228	5,396	5,204	5,248	5,226	5,194	5,211	5,236	5,450	5,004	
			2023/24 Plans	4,733	4,891	4,733	4,891	4,891	4,733	4,891	4,733	4,891	4,891	4,418	4,891
		Non-elective spells with a length of stay of zero days - E.M.11a	2023/24 Actuals	2,521	2,680	2,723	2,810	2,772	2,904	2,952	2,980	2,683	2,903	2,855	
			2023/24 Plans	2,805	2,898	2,805	2,898	2,898	2,805	2,898	2,805	2,898	2,898	2,618	2,898

Provider	Subject	Measure Name	Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
UHDB	RTT	New RTT pathways (clock starts) - E.M.20	2023/24 Actuals	19,474	22,704	23,166	22,769	22,589	21,289	23,002	22,393	18,826	22,967	22,331	
			2023/24 Plans	18,729	21,518	20,367	20,399	21,583	22,022	21,467	23,816	18,637	23,338	19,386	21,373
		Number of 52+ week RTT waits - E.B.18	2023/24 Actuals	6,218	6,654	7,049	7,226	7,392	7,538	7,467	6,682	5,950	5,816	5,267	
			2023/24 Plans	6,698	6,469	6,273	6,063	5,882	5,744	5,554	5,376	5,188	5,000	4,794	4,641
		Number of 65+ week RTT waits - E.B.20	2023/24 Actuals	1,704	1,924	1,985	2,073	2,572	2,588	2,391	1,824	1,883	1,639	1,275	
			2023/24 Plans	2,156	1,935	1,729	1,511	1,304	1,135	925	732	531	329	122	0
		RTT completed admitted pathways - E.M.18	2023/24 Actuals	3,200	3,610	3,829	3,155	3,459	3,127	3,894	4,043	3,262	3,890	3,776	
			2023/24 Plans	4,522	4,857	4,756	5,405	4,591	4,696	5,025	4,707	4,053	4,805	4,412	3,252
		RTT completed non-admitted pathways - E.M.19	2023/24 Actuals	11,835	14,038	14,086	12,987	13,164	13,556	14,804	15,846	13,122	14,888	14,923	
			2023/24 Plans	13,306	14,100	13,475	14,913	13,345	13,915	15,078	14,930	13,074	15,495	13,266	12,689
		RTT waiting list - E.B.3a	2023/24 Actuals	109,698	110,032	110,690	110,973	114,652	112,816	109,606	107,945	105,690	106,928	104,404	
			2023/24 Plans	110,285	107,883	105,275	100,337	99,113	97,611	94,048	93,096	90,106	87,845	83,036	85,592

Independent Sector Activity Measures Operational Plan

NHS
Derby and Derbyshire
Integrated Care Board

Provider	Subject	Measure Name	Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
ISP	Diagnostic Tests	Diagnostic Tests - All	2023/24 Actuals	245	225	276	289	283	207	255	308	271	260	316	
			2023/24 Plans	350	385	427	405	427	405	426	427	369	428	404	395
	Elective	Elective day case spells	2023/24 Actuals	1,053	1,150	1,284	1,319	1,106	1,162	1,225	1,378	975	1,378	1,337	
			2023/24 Plans	816	907	998	952	998	952	998	998	862	998	952	904
		Elective ordinary spells	2023/24 Actuals	178	173	174	176	200	221	206	232	177	207	232	
			2023/24 Plans	204	227	249	238	249	238	249	249	216	249	226	227
	Outpatient	Consultant-led first outpatient attendances (Spec acute)	2023/24 Actuals	1,480	1,806	1,820	1,817	1,483	1,715	1,906	1,936	1,499	1,959	1,974	
			2023/24 Plans	1,326	1,473	1,621	1,547	1,621	1,547	1,621	1,621	1,399	1,621	1,547	1,475
		Consultant-led first outpatient attendances with procedures (Spec acute)	2023/24 Actuals	201	206	221	184	193	176	213	162	136	159	164	
			2023/24 Plans	170	188	206	197	206	197	206	206	180	206	197	194
		Consultant-led follow-up outpatient attendances (Spec acute)	2023/24 Actuals	2,856	3,308	3,388	3,275	3,124	3,320	3,387	3,546	2,835	3,591	3,407	
			2023/24 Plans	2,328	2,588	2,847	2,718	2,847	2,718	2,847	2,847	2,459	2,847	2,718	2,582
		Consultant-led follow-up outpatient attendances with procedures (Spec acute)	2023/24 Actuals	374	420	369	422	418	368	448	458	383	462	466	
			2023/24 Plans	306	338	374	356	374	356	374	374	324	374	356	336

Data Source

NHS
Derby and Derbyshire
Integrated Care Board

Area	Data source	Link
Increase General Practice appointment activity	NHS Digital - Appointments in General Practice	Appointments in General Practice - NHS Digital
Increase referrals into Community Pharmacy Consultation Services (Quarterly Target)	NHS Futures - NHS England Pharmacy Integration Programme Workspace - Primary Care Pharmacy - Monthly Report by phODS - Pharmacy Regional Reports - Midlands Regional Report - Latest month -	https://future.nhs.uk/connect.ti/PharmacyIntegration/view?objectId=38360112
Recover dental activity to pre-pandemic levels (Quarterly Target)	eDEN Dental data via BSA	
Increase the dementia diagnosis rate (Quarterly Target)	NHS Futures - Mental Health Core Data Pack	2324_DASHBOARD_CDP_VW - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform
Provide access for 28,294 people to receive IAPT in 23/24 (Quarterly Target)		
Increase the number of women accessing specialist perinatal services in 2023/24 (Quarterly Target).		
Increase the number of children and young people accessing a mental health service (Quarterly Target).		
Increase the number of adults with a severe mental health illness receiving 2+ contacts with a community health service (Quarterly Target).		
Ensure that 75% of individuals listed on GP registers as having a learning disability will receive annual health check (Quarterly Target).	Foundry - NHS Performance Overview - Learning Disabilites & Autism - Annual Health Check	
Ensure that at least 75% of people receive communication of a diagnosis for cancer or ruling out of cancer, or a decision to treat if	Statistics » Cancer Waiting Times (england.nhs.uk)	https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
Reduce the number of people waiting longer than 62 days for their first definitive treatment for cancer.	Statistics » Cancer Waiting Times (england.nhs.uk)	https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
No person waiting longer than 65 weeks on an RTT pathway at the end March 2024.	Statistics » RTT (england.nhs.uk)	Statistics » Referral to Treatment (RTT) Waiting Times (england.nhs.uk)
At least 85% of people receive a diagnostic test within 6 weeks by March 2024.	Statistics » Monthly Diagnostic Waiting Times and Activity (england.nhs.uk)	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
No less than 76% attending ED waiting longer than 4 hours either to be treated, admitted or discharged, by March 2024.	Data taken from: A&E 4 hour performance - NHS England,	https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
30 minutes or less for EMAS to respond to a category 2 incident, on average.	https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators).	
Both Acute Trusts to operate at an average general and acute occupancy rate of 92%.	Statistics - NHS England - Critical care and General & Acute Beds – Urgent and Emergency Care Daily Situation Reports 2023-24	https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/critical-care-and-general-acute-beds-urgent-and-emergency-care-daily-situation-reports/critical-care-and-general-acute-beds-urgent-and-emergency-care-daily-situation-reports-2023-24/
At least 70% of referrals into the Urgent Community Response Service to be responded to within 2 hours.	https://www.england.nhs.uk/statistics/statistical-work-areas/2-hour-urgent-community-response/	
Increase virtual ward capacity.	Foundry (Virtual Ward Dashboard)	
Increase virtual ward utilisation.		
D2A - The number of people discharged by location and discharge pathway per month	NECS - Paul	\\ntpcts60.nntha.loc\shared_info\Collaborative Working\NECS Derbyshire Contract Reporting\Sitrep_metrics\Intial_Sample_data.xlsx
D2A - Pathway 0 - Non-complex discharge		
D2A - Pathway 1 - Home with Support		
D2A - Pathway 2 - Intermediate Care		
D2A - Pathway 3 - 24-hour care placement		
Community Waiting List - Quarterly Target	Statistics - NHS England - Community Waiting list	Statistics » Community Health Services Waiting Lists (england.nhs.uk)
Activity	NHS Futures	NHS Futures – NHS Planning Workspace – Tools – Activity and Performance Plan VS Actual Tool

Workforce

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

Workforce Summary: Month 12 (including EMAS)

NHS
Derby and Derbyshire
Integrated Care Board

Tables 1a-1c Workforce Plan Position, 2a-2d Workforce Trend & 3 Primary Care:

- The total workforce across all areas (substantive, bank and agency) was 1352.70WTE above the original 2023/24 plan (as submitted on 4 May 2024) at M12.

- Compared to M11, there was an increase in substantive positions (+3.56WTE) and agency usage (+4.55WTE), but there was a decrease in bank usage (-45.48WTE). The majority of the increase in substantive positions was from Support to Ambulance Staff (+53.80WTE) and Registered nursing, midwifery and health visiting staff (+19.98), while there was a decrease from Mental and Dental staff (-40.39WTE) and Support to Nursing Staff (-29.62WTE).

- Tables 2a-2d identify the workforce trends and year end position. Between 2022/23 M12 actual and M12 2023/24 actual there has been 6.2% growth (1,783WTE). The plan was adjusted following the H2 reset and the variance between the revised H2 plan and M12 actual is 656WTE; if monitoring against the original plan this would have been a year-end variance of 1357.70WTE. The charts demonstrates the point at which the system began to observe variance to plan; notably when industrial action first commenced which was further compounded by the M12 actual out-turn position being greater than the M1 baselines (this has been rectified in the 2024/25 plans to ensure the baselines reflect the out-turn position).

- For Primary care in table 3, the total workforce was 76WTE below M12's plan.

Tables 4a: Workforce establishment V M12 actuals (WTE) comparison to pay-bill (£)

- As a system, work continues to improve workforce and finance pay bill alignment.

- The pay cost reporting lines have now been aligned from both a workforce and finance perspective. All trusts are using 'Total employee benefits excluding capitalised costs' for both budget & actual in this report.

- Table 4a aims to demonstrate the pay costs associated with the workforce plan staff in post actuals (note this is with the recognition that there is some misalignment between ESR and finance ledger systems, but the differences are generally within acceptable tolerance levels). At M12 the system is £62.4m overspent on the pay-bill with 798 WTE over the total establishment (substantive, bank and agency). There was adjustment to the full year pension contributions booked in month 12. They are related to an increase of in pension contributions which is picked up by NHSE and brought into the accounts at year end.

Workforce Summary: Month 12 (including EMAS)

Derby and Derbyshire Integrated Care Board

Agency KPIs

- In M12 JUCD agency cost amounted to 1.2% of total pay costs, 2.5% under the national target of 3.7%. YTD 2.9%

- Our current agency spend is £42.3m, which is 161% of our planned spend of £26.3m, resulting in a £16m overspend. However, it is at 109% of the annual cap of £38.7m (an overspend of £3.6m).

Actions

- As well as the plans to hold substantive workforce growth to year end, all Trusts continue to make concerted efforts to reduce agency usage.

- Additional controls have been put in place in relation to agency and vacancies, which are beginning to demonstrate impacts (e.g. UHDB and DHcFT reduction in agency as a result of admin and clerical exit strategies).

- Further work is required to breakdown all pay elements including sickness, maternity, study leave, overtime etc, is important in developing the understanding of where temporary staffing is being utilised to cover such elements, which in turn will be impacting on the overall pay position. This requires the support from the finance community as the data will need to be extracted through the ledger systems.

Risks

- Further ongoing industrial action will continue to impact on the pay-bill position, particularly with regards to the ability to significantly reduce the need for temporary staffing which will incur greater costs.

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

Table 1a: 2023/24 Workforce Plan Position Month 12 (NHS Foundations Trusts, including EMAS)

Derby and Derbyshire Integrated Care Board

*Plan figures are as submitted in the 23/24 operational plan submission.

ICB Total	Reporting Period: Mar 2024					
	Month 12			Trend		
	Plan*	Actual	Variance from plan	Previous month	Changes in actual vs previous month	Trend (Actual) previous 12 months
Workforce						
Total Workforce (WTE)	29,110.58	30,463.28	-1,352.70	30,500.66	↓	
Substantive (WTE)	27,695.89	28,389.45	-693.57	28,385.90	↑	
Bank (WTE)	1,167.22	1,600.46	-433.24	1,645.94	↓	
Agency (WTE)	247.47	473.37	-225.90	468.82	↑	
Cost						
Pay Cost (£'000) ^	123,262	185,659	-62,397	130,185	↑	

^ Planned pay costs include the agreed AfC pay uplift from M5, but do not fully reflect the workforce impact as a result of efficiency plans consistently for all Trusts.
^ For the Pay Cost, UHDB use 'Total employee benefits excluding capitalised costs' for both budget & actual, while the others would be using 'Total gross staff costs' for both budget & actual.

- The total workforce across all areas (substantive, bank and agency) was 1352.70WTE above plan at M12.
- Compared to M11, there was an increase in substantive positions (+3.56WTE) and agency usage (+4.55WTE)but there was a decrease in bank (-45.48WTE).
- The majority of the increase in substantive positions was from Support to Ambulance Staff (+53.80WTE) and Registered nursing, midwifery and health visiting staff (+19.98), while there was a decrease from Mental and Dental staff (-40.39WTE) and Support to Nursing Staff (-29.62WTE).

Table 1b: 2023/24 Workforce Plan Position Month 12 - Provider Summary

NHS Derby and Derbyshire Integrated Care Board

The table below identifies the original WTE plan figures alongside the revised H2 system reset FOT plans (substantive) and demonstrates the year end-position by Provider

		2023/24 Plan	M12 Actual	Variance from plan	Revised H2 FOT Plan	Variance from H2 FOT Plan
CRH	Workforce (WTE)					
	Total Workforce	4,720.19	5,039.21	-319.02	5,001.71	-37.50
	Substantive	4,332.74	4,621.58	-288.85	4,597.00	-24.58
	Bank	295.20	310.86	-15.66	278.85	-32.01
	Agency	92.26	106.77	-14.51	125.86	19.09
	Cost (£)					
	Pay Cost (£'000)	£19,410	£29,421	-£10,011		
DCHS	Workforce (WTE)					
	Total Workforce	3,868.01	3,851.23	16.78	3,881.58	30.35
	Substantive	3,797.85	3,714.63	83.22	3,686.00	-28.63
	Bank	45.55	99.17	-53.62	95.70	-3.47
	Agency	24.61	37.43	-12.82	99.88	62.45
	Cost (£)					
	Pay Cost (£'000)	£13,804	£21,317	-£7,513		
DHcFT	Workforce (WTE)					
	Total Workforce	3,187.97	3,160.74	27.23	3,262.33	101.59
	Substantive	2,988.11	2,972.16	15.95	3,055.00	82.84
	Bank	156.05	164.16	-8.11	180.79	16.63
	Agency	43.81	24.42	19.39	26.54	2.12
	Cost (£)					
	Pay Cost (£'000)	£13,038	£19,356	-£6,319		
EMAS *	Workforce (WTE)					
	Total Workforce	4,260.30	4,641.30	-381.00		
	Substantive	4,187.64	4,354.18	-166.54	4,187.64	-166.54
	Bank	52.66	59.28	-6.62		
	Agency	20.00	227.84	-207.84		
	Cost (£)					
	Pay Cost (£'000)	£17,427	£26,053	-£8,626		
UHDB	Workforce (WTE)					
	Total Workforce	13,074.11	13,770.80	-696.69		
	Substantive	12,389.55	12,726.90	-337.35	12,717.00	-9.90
	Bank	617.76	966.99	-349.23		
	Agency	66.79	76.91	-10.12		
	Cost (£)					
	Pay Cost (£'000)	£59,584	£89,512	-£29,928		

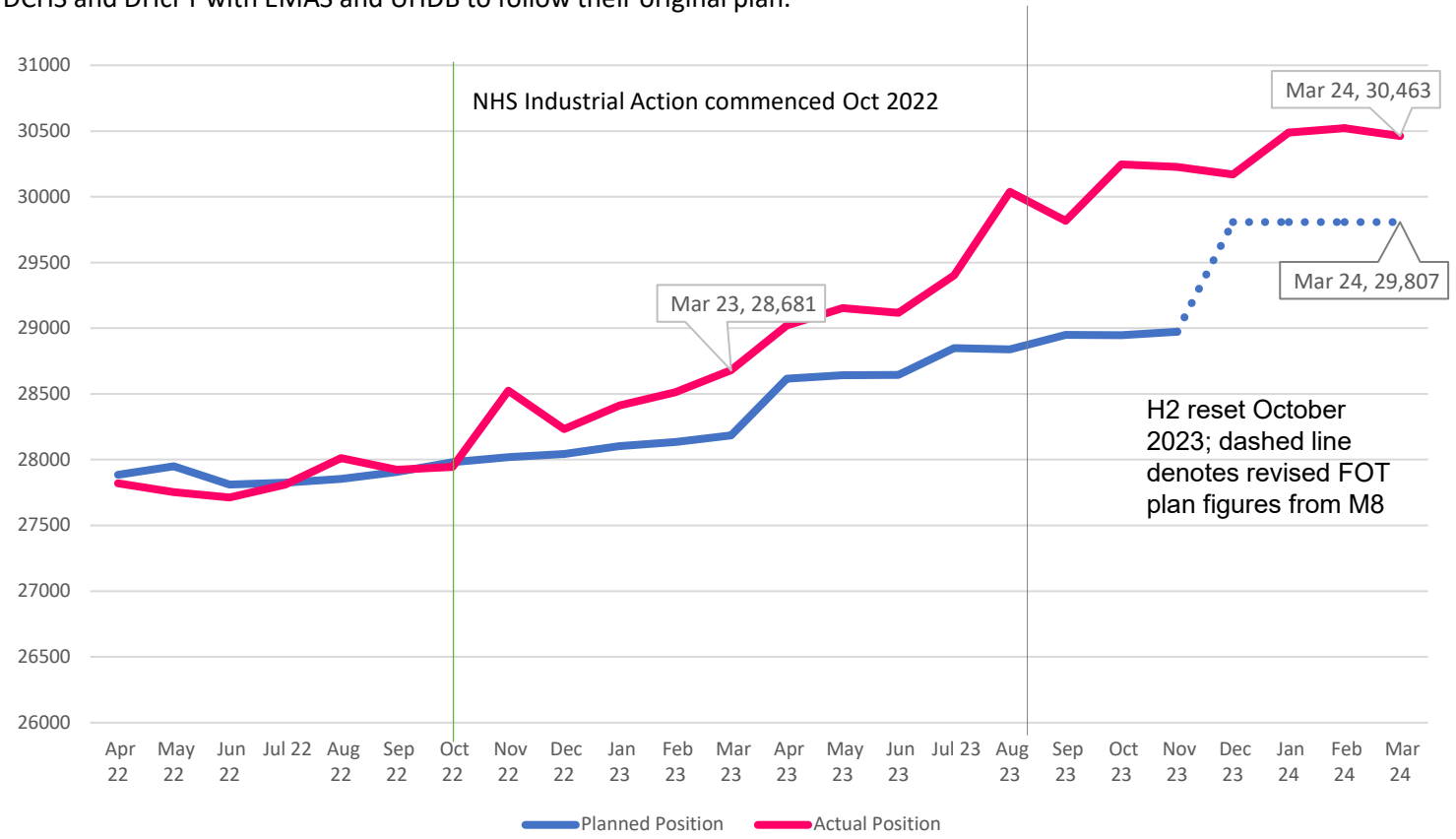
* EMAS figures include all component parts i.e. core service, Cat2 additional investment and additional contracted PAS

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

Table 2a: Workforce Trend (Total WTE)

Derby and Derbyshire Integrated Care Board

During the H2 system reset, we received a revised forecast outturn plan position for substantive workforce. Bank and Agency have also been supplied by CRH, DCHS and DHcFT with EMAS and UHDB to follow their original plan.



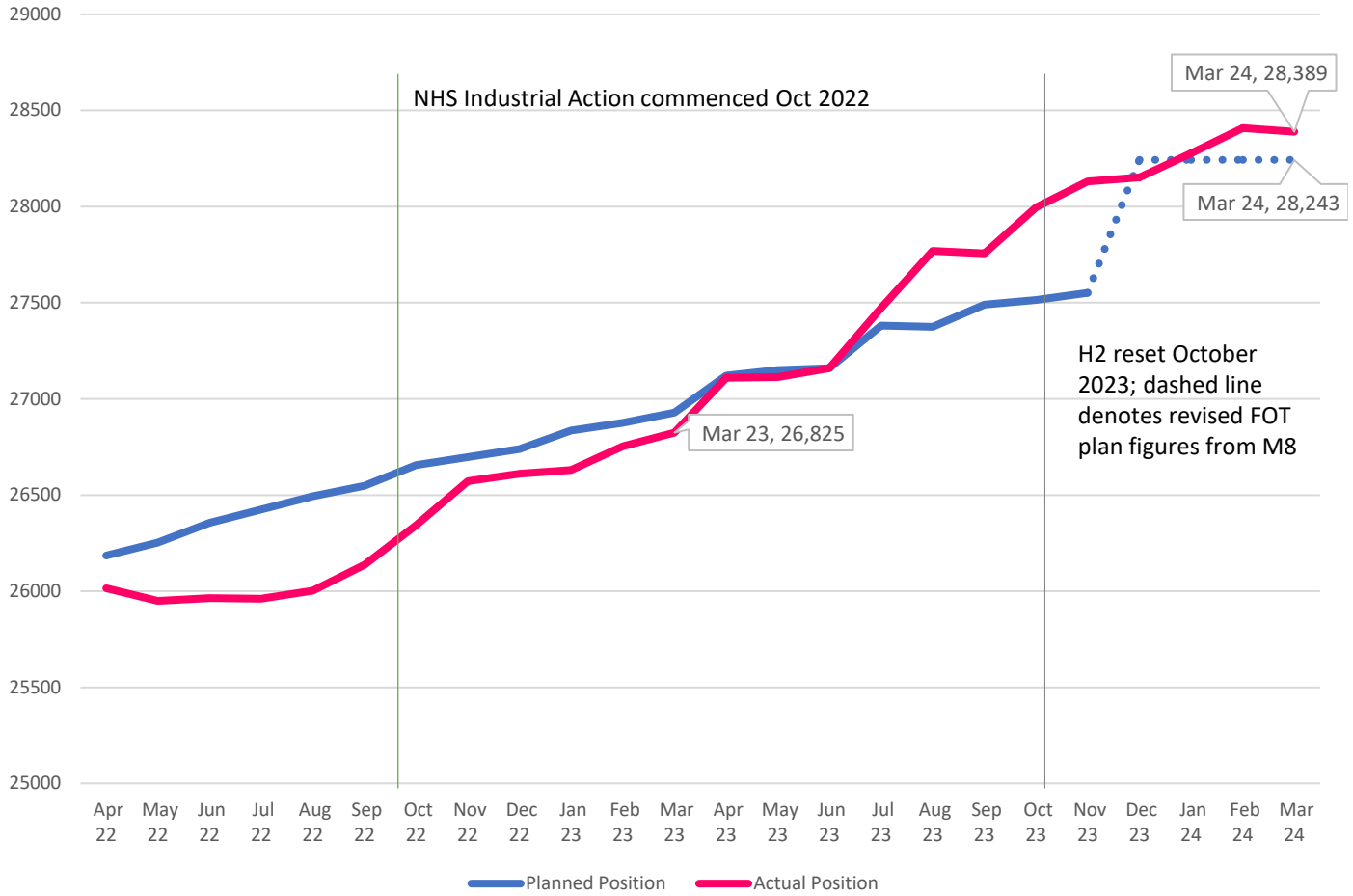
- The 2023/24 original plan was based on growth of 2.15% (615WTE).
- Between 2022/23 M12 actual and M12 2023/24 actual there has been 6.2% growth (1,783WTE).
- The plan was adjusted following the H2 reset and the variance between the revised H2 plan and M12 actual is 656WTE; if monitoring against the original plan this would have been a year-end variance of 1357.70WTE.
- The chart demonstrates the point at which the system began to observe variance to plan; notably when industrial action first commenced which was further compounded by the M12 actual out-turn position being greater than the M1 baselines. This issue has been resolved in the 2024/25 planning as all baselines are being reviewed against the M12 actual position to ensure alignment.

Workforce Total WTE	2022 - 2023												2023 – 2024											
	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12
	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Planned	27,885	27,949	27,811	27,825	27,854	27,907	27,982	28,020	28,044	28,103	28,134	28,184	28,617	28,642	28,645	28,849	28,838	28,950	28,948	28,974	29,807	29,807	29,807	29,807
Actual	27,821	27,752	27,712	27,811	28,011	27,924	27,946	28,524	28,233	28,413	28,512	28,681	29,022	29,154	29,117	29,402	30,039	29,818	30,246	30,227	30,170	30,489	30,523	30,463
Variance	-64	-197	-98	-14	158	17	-36	505	189	310	378	496	405	512	473	552	1,201	868	1,298	1,252	363	681	716	656

Table 2b: Workforce Trend (Substantive WTE)

Derby and Derbyshire Integrated Care Board

During the H2 system reset, we received a revised forecast outturn plan position for substantive workforce.



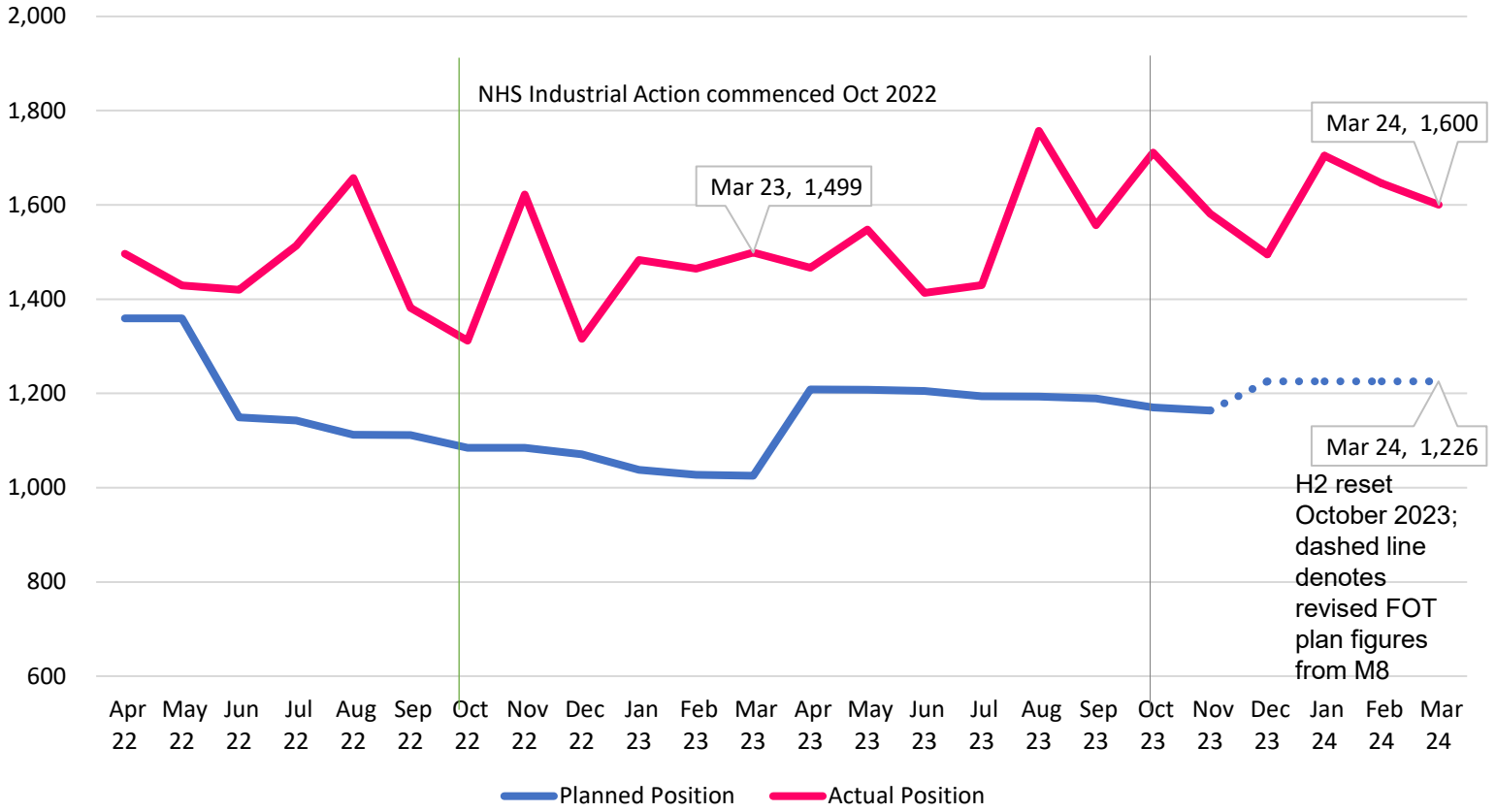
- The 2023/24 original plan was based on growth of 3.25% (871WTE).
- Between 2022/23 M12 actual and 2023/24 M12 actual there has been 5.8% growth (1,565WTE).
- The M12 actual is 0.5% greater (146.81WTE) than the revised H2 plan.

Substantive Total WTE	2022 - 2023												2023 - 2024											
	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12
	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Planned	26,185	26,253	26,356	26,425	26,493	26,548	26,656	26,697	26,739	26,835	26,876	26,929	27,122	27,150	27,159	27,381	27,375	27,490	27,514	27,551	28,243	28,243	28,243	28,243
Actual	26,016	25,950	25,963	25,961	26,003	26,138	26,344	26,572	26,611	26,630	26,754	26,825	27,110	27,114	27,160	27,472	27,769	27,757	27,997	28,131	28,152	28,276	28,243	28,243
Variance	-169	-303	-393	-464	-490	-410	-312	-125	-128	-206	-122	-104	-11	-36	1	91	395	267	483	580	-91	33	28,409	28,389

Table 2c: Workforce Trend (Bank WTE)

Derby and Derbyshire Integrated Care Board

During the H2 system reset, we received a revised forecast outturn plan position for substantive workforce. Bank and Agency have also been supplied by CRH, DCHS and DHcFT with EMAS and UHDB to follow their original plan.



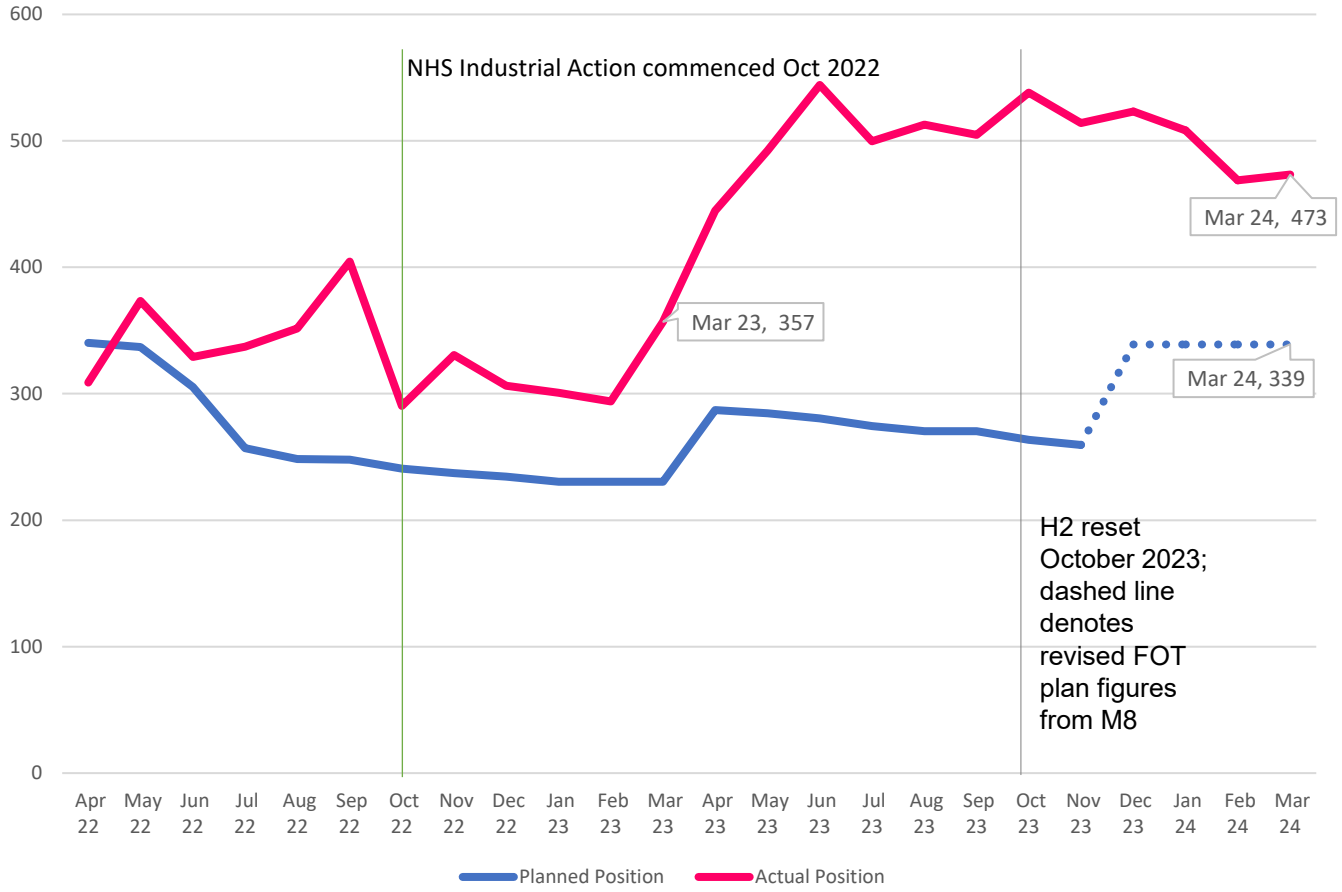
- The 2023/24 plan was based on a decrease of 22.13% (332WTE).
- Between 2022/23 M12 actual and 2023/24 M12 actual there has been 6.8% increase (101WTE).
- The M12 actual is 30.6.% greater (374.70WTE) than the revised H2 plan.

Bank Total WTE	2022 - 2023												2023 - 2024											
	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12
	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Planned	1,359	1,359	1,149	1,143	1,112	1,111	1,085	1,085	1,071	1,038	1,028	1,025	1,209	1,208	1,205	1,194	1,193	1,189	1,170	1,164	1,226	1,226	1,226	1,226
Actual	1,496	1,429	1,420	1,513	1,657	1,382	1,312	1,622	1,316	1,483	1,464	1,499	1,467	1,548	1,413	1,430	1,757	1,557	1,711	1,581	1,495	1,704	1,646	1,600
Variance	137	70	271	371	544	270	227	537	245	445	437	474	258	340	208	236	564	367	541	418	269	479	420	375

Table 2d: Workforce Trend (Agency WTE)

Derby and Derbyshire Integrated Care Board

During the H2 system reset, we received a revised forecast outturn plan position for substantive workforce. Bank and Agency have also been supplied by CRH, DCHS and DHcFT with EMAS and UHDB to follow their original plan.



- The 2023/24 plan was based on a reduction of 33.66% (109.3WTE).
- Between 2022/23 M12 actual and 2023/24 M12 actual there has been 32.6% growth (116WTE).
- The M12 actual is 39.6% greater (134.30WTE) than the revised H2 plan.
- The main reason for the significant agency increase from March 23 was due to EMAS paramedics (overtime and 3rd party) being recorded in the agency WTE due to the PWR change. However, it is noted that these have specific funding associated with the roles and not agency in the same sense as other providers.
- If EMAS was excluded from the M12 position (less 250wte) the actual position for other providers would be 223WTE, which is **116WTE below** the revised H2 plan.

Agency Total WTE	2022 - 2023												2023 - 2024											
	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12
	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Planned	340	337	305	257	248	248	241	237	234	230	230	230	287	284	280	274	270	270	263	259	339	339	339	339
Actual	309	373	329	337	352	404	290	331	306	301	294	357	445	492	544	500	513	505	538	514	523	508	469	473
Variance	-32	36	24	80	103	157	50	93	72	70	64	127	158	208	264	225	242	234	275	255	184	169	130	134

Table 3: 2023/24 Primary Care Workforce (M11)

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

Data Source: GP Commissioning Team	Baseline	Actual			Plan	Actual			Plan	Actual			Plan	Actual		Plan
Primary Care	Staff in post outturn	Q1			Q1	Q2			Q2	Q3			Q3	Q4		Q4
Joined Up Care Derbyshire STP	Year End	As at the end of			As at the end of	As at the end of			As at the end of	As at the end of			As at the end of	As at the end of		As at the end of
	(31-Mar-23)	Apr-23	May-23	Jun-23	Jun-23	Jul-23	Aug-23	Sep-23	Sep-23	Oct-23	Nov-23	Dec-23	Dec-23	Jan-24	Feb-24	Mar-24
Workforce (WTE)	Total WTE	Total WTE			Total WTE	Total WTE			Total WTE	Total WTE			Total WTE	Total WTE		Total WTE
Total Workforce	**3,378**	**3,367**	**3,377**	**3,385**	**3,439**	**3,394**	**3,434**	**3,424**	**3,548**	**3,447**	**3,469**	**3,505**	**3,614**	**3,553**	**3,571**	**3,647**
GPs excluding registrars	766	748	740	742	767	736	762	756	795	749	747	758	789	748	742	778
Nurses	364	353	354	353	365	349	343	341	363	337	337	338	363	337	342	361
Direct Patient Care roles (ARRS funded)	465	512	506	523	510	541	558	556	580	578	603	626	636	687	724	669
Direct Patient Care roles (not ARRS funded)	282	270	268	267	286	267	268	271	290	273	273	275	293	274	269	298
Other – admin and non-clinical	1,502	1,485	1,509	1,501	1,512	1,501	1,503	1,500	1,519	1,509	1,509	1,508	1,532	1,506	1,495	1,542

Summary

- At M11, the total workforce was 76WTE below M12's plan. The gap was observed mainly from GPs excluding registrars (-36WTE), Direct Patient Care roles (ARRS funded) (+56WTE), and Other – admin and non-clinical staff (-47WTE).

Caveats to the data:

- Primary Care data is up to M11 due to the data availability from GP team.
- Only quarterly plans are available, so we compare the nearest quarter end numbers for workforce gap data.
- Some months may include backdated info as PCNs tend to submit claims as and when they receive them as they have to wait for third party invoices therefore WTE fluctuates WTE on the claims include temporary, agency, CVS and trust staff – not just PCN employed staff
- The info received for ARRS is a month in arrears

Table 4a: Workforce establishment V M12 actuals (WTEs) comparison to pay-bill (£)

Derby and Derbyshire Integrated Care Board

Data Sources:

Provider Finance Returns (PFR)

Finance - Deputy DoFs (extracted from Finance Ledgers)

Provider Workforce Returns (PWR extracted from)

	M12 Pay Budget	M12 Pay Actual	M12 Pay Variance	YTD Pay Budget	YTD Pay Actual	YTD Pay Variance	Establishment (as per Finance) *	Staff in Post (Substantive) M12 Actual	Vacancy **	Vacancy Rate **	Bank M12 Actual	Agency M12 Actual	Net Staffing (Substantive, Bank & Agency Total) M12 Actual	Establishment V Actual Variance
	£'000	£'000	£'000	£'000	£'000	£'000	WTE	WTE	WTE	%	WTE	WTE	WTE	WTE
ICB Total	123,262	185,659	-62,397	1,490,018	1,599,628	-109,610	29,665	28,389	1,276	4.30%	1600	473	30,463	-798
CRH	19,410	29,421	-10,011	239,470	266,769	-27,299	4,796	4,622	175	3.64%	311	107	5,039	-243
DCHS	13,804	21,317	-7,513	164,329	175,127	-10,798	3,819	3,715	104	2.73%	99	37	3,851	-32
DHcFT	13,038	19,356	-6,319	154,172	165,721	-11,549	3,052	2,972	80	2.61%	164	24	3,161	-109
EMAS ^	17,427	26,053	-8,626	207,563	207,701	-138	4,376	4,354	22	0.50%	59	228	4,641	-265
UHDB	59,584	89,512	-29,928	724,485	784,310	-59,825	13,622	12,727	895	6.57%	967	77	13,771	-149

Notes:

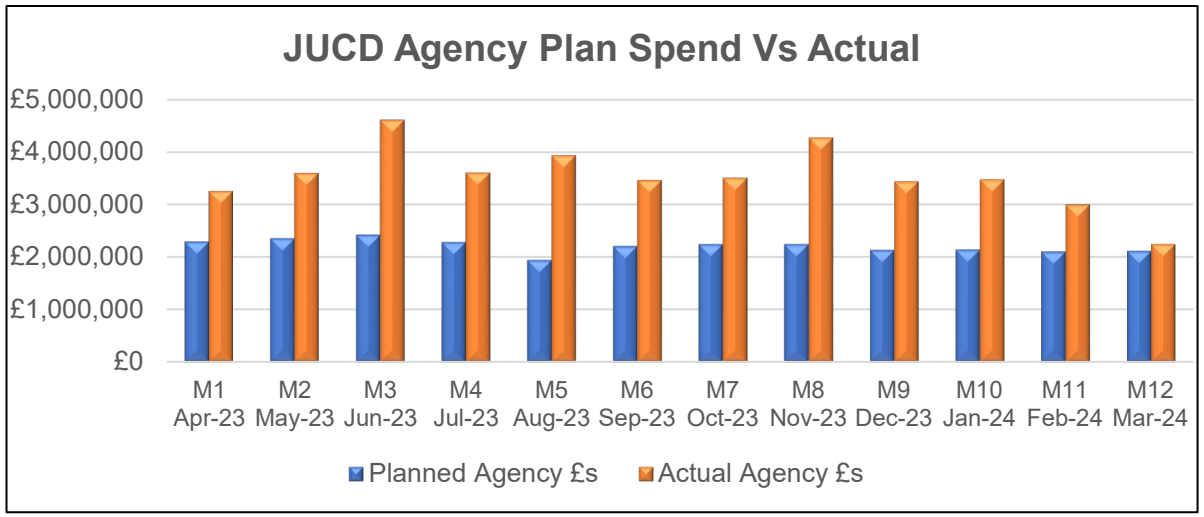
* The establishment figures do not include the full impact of all the required efficiencies and subsequent impact on workforce consistently across all Trusts

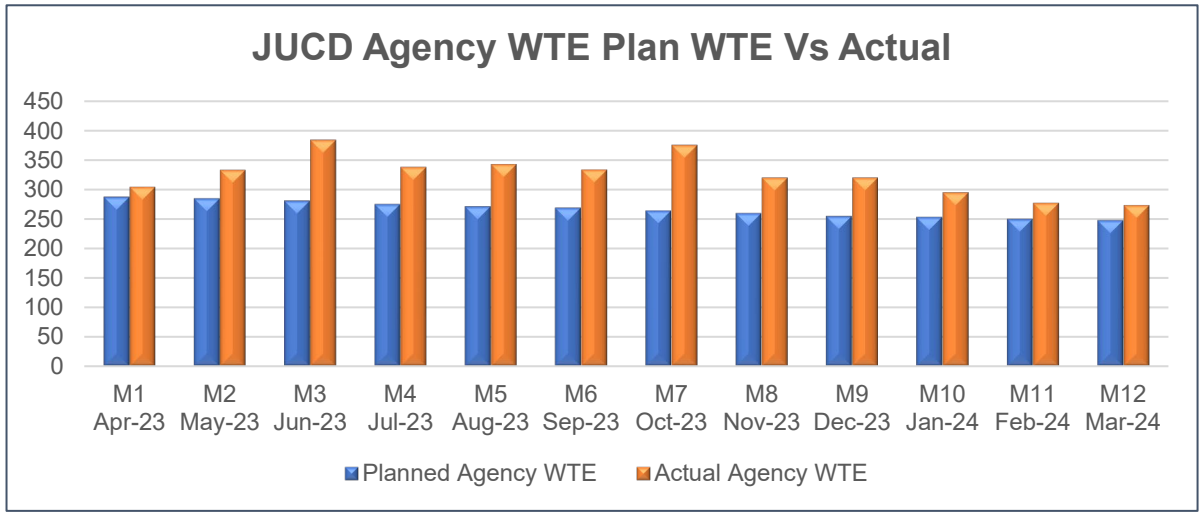
** For the purpose of this comparison exercise the vacancy numbers are based on the difference between establishment and staff in post as a proxy measure. It is recognised that there is a slight variance in the figures compared to those submitted in PWR and this is because of the establishment figures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

^ Due to PWR changes, EMAS paramedics (overtime and 3rd party) are now being recorded in the agency WTE but it is noted that these have specific funding associated with the roles and not agency in the same sense as other providers

In the absence of the national requirement for monthly establishment plans, local arrangements have been put in place, to monitor the workforce plan against the actual staffing levels that we have the budget for (i.e. costed WTE establishment). The overall YTD position is an overspend against the pay budget of £109.6m with 798WTE over-establishment at M12 (total workforce).

2023/24 M12 JUCD Agency Breakdown





Note: Does not include EMAS paramedics in the agency WTE as they are funded separately (200.08WTE)

KPI Summary:

- In M12 JUCD agency cost amounted to 1.2% of total pay costs, 2.5% under the national target of 3.7%. YTD 2.9%.
- JUCD planned to spend £2.1m on agency staff in M12. The actual spend was £2.2m. This is an overspend against plan of £100k.
- As of the end of M12, JUCD have reached 161% of planned agency spend.
- YTD JUCD have a current overspend of £16m on agency staff.
- Off framework usage was 157 shifts in M12, 3.7% of total agency shifts.
- There were 2,141 non price cap compliant shifts, 51.0% of the total agency shifts.
- Admin and Estates came to 192 shifts in M12, 4.6% of total agency shifts.

Actions:

- Further investigation is ongoing to understand the factors for the high-level of off framework and Admin and Estates usage (particularly EMAS).
- Further work is also underway to enable a more granular breakdown of the data to ensure consistency with regards to the highest paid/longest serving agency workers.
- The analysis work being undertaken to investigate the factors for agency usage and spend, is informing the targeted actions in the system Agency Reduction Plan.

Finance

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

Month 12 System Finance Summary – Financial Position

Derby and Derbyshire Integrated Care Board

As of 31st March 2024, JUCD delivered the H2 reset position of a £42.3m deficit but with technical adjustments (IFRS16 and Health Care Support Worker re-banding), the reported figure is £59.8m.

The position is based on the financial reset position of £42.3m recognised as the genuine likely position by NHSE (excluding the impact of the IFRS 16 change and health care support worker re-banding). This was an accepted deviation from the original breakeven plan due to excess inflation, underfunding of the pay award, the change in national policy on revenue support for cost of capital and insufficient funding to cover contractual obligations for Primary Care.

At month 11 it was identified a £7.2m benefit due to IFRS 16 revaluation was no longer able to be included in the position due to an NHSE policy change. The final impact of this was £9m due to an additional adjustment of £1.8m for UHDB.

In month 12 additional costs of £8.5m relating to the national Health Care Assistant claim for re-banding have been included in the position. These costs were previously included as a risk to achieving the year end position, as well as the impact of the IFRS 16 change.

			Technical Adjustments		
Forecast Outturn	Full Year Plan £m's	Full Year Actual £m's	IFRS16 £m's	HCSW £m's	Reported JUCD Position £m's
NHS Derby and Derbyshire ICB	0.0	1.0	0.0	0.0	1.0
Chesterfield Royal Hospital	0.0	(15.5)	0.0	(2.0)	(17.5)
Derbyshire Community Health Services	0.0	(2.2)	0.0	(0.4)	(2.6)
Derbyshire Healthcare	0.0	(4.4)	(0.2)	0.0	(4.6)
EMAS	0.0	0.1	0.0	0.0	0.1
University Hospital of Derby and Burton	0.0	(21.3)	(8.8)	(6.1)	(36.3)
JUCD Total	**0.0**	**(42.3)**	**(9.0)**	**(8.5)**	**(59.8)**

Month 12 System Finance Summary – Efficiencies

Derby and Derbyshire Integrated Care Board

The annual efficiency plan was to deliver £136m. The actual achievement for the year is £134.7m, a variance of £1.2m behind plan.

JUCD has delivered 99% of the plan, despite pressures from high inflation and industrial action, which has led to management and clinical leadership being directed away from the efficiency challenge.

The level of recurrent efficiencies achieved for the year were £32.7m behind plan. There is a need to identify recurrent transformational change to move the system to a financially sustainable position.

Efficiencies by Provider Month 12 Position	Full Year Plan £m's	Full Year Actual £m's	Variance £m's
NHS Derby and Derbyshire ICB	44.2	47.8	**3.6**
Chesterfield Royal Hospital	15.7	12.0	**(3.7)**
Derbyshire Community Health Services	9.2	9.2	**0.0**
Derbyshire Healthcare	8.8	8.8	**0.0**
EMAS	11.2	11.2	**(0.0)**
University Hospital of Derby and Burton	47.0	45.8	**(1.1)**
JUCD Total	**136.0**	**134.7**	**(1.2)**

Month 12 System Finance Summary – Capital

Derby and Derbyshire Integrated Care Board

The JUCD capital allocation for 2023/24 was £76.4m, of which £74m related to provider capital. The notified capital allocation was £57m, with additional in year uplifts of £17m provided for IFRS16 lease implications.

In month twelve it was identified that due to the late notification of the IFRS16 uplifts, there was allocation of up to £1.2m available for other capital programmes. Expenditure of £0.5m to support the Mental Health dormitories programme was identified.

The final year end position shows an overall underspend of £0.9m, which all relates to the £17m of IFRS16 uplift allocations received. Providers have committed expenditure in line with plan for the £57m notified capital allocation.

Provider Capital Allocation	Full Year Plan £'m	Full Year Actual £'m	Variance £'m
Chesterfield Royal Hospital	8.6	8.5	0.1
Derbyshire Community Health Services	9.0	9.0	(0.0)
Derbyshire Healthcare	19.9	20.4	(0.4)
EMAS	17.4	16.2	1.2
University Hospital of Derby and Burton	19.0	19.0	0.0
Total	**74.0**	**73.1**	**0.9**

Month 12 System Finance Summary – Cash

Derby and Derbyshire Integrated Care Board

The cash balance at month 12 includes cash held for capital commitments, this amounts to £32.6m.

Both CRH and UHDB requested cash support from NHSE/DHSC in 2023/24 to help manage cash balances.

The ICB required £20.7m more cash than the Cash Limit it was given at the start of the year due to the amount of non-recurrent balance sheet and other flexibilities used to support the 2023/24 financial position.

Month 12 Position Organisation	31st March 2024 Total Cash Balance £m's
Chesterfield Royal Hospital	24.8
Derbyshire Community Health Services	40.0
Derbyshire Healthcare	33.6
East Midlands Ambulance Service	20.2
University Hospitals of Derby And Burton	62.8
JUCD Total Surplus/(Deficit)	181.4

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 010

Report Title	Operational Plan Update 2024/25							
Author	Craig Cook, Director of Acute Commissioning, Contracting and Performance Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Presenter	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1 – ICB position against NHS England Operational Planning Priorities – 2024/25							
Assurance Report Signed off by Chair	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Which committee has the subject matter been through?	NHS Executives Meeting ICB Board Extraordinary Confidential Meeting							

Recommendations

The ICB Board are recommended to **NOTE** the report on the Operational Plan 2024/25.

Purpose

The purpose of this report is to provide a summary of our 2024/25 planning assumptions from the perspective of operational performance, workforce, and finance.

Background

NHS England formally published 2024/25 priorities and operational planning guidance on 27th March 2024.

Whilst there are many aspects and details within the planning guidance the highlighted specific areas of focus are:

- **Operational performance:** specific targets established for A&E 4 hours; RTT 65 week+ waits; cancer 62-day treatments; 28-day faster cancer diagnosis and Category 2 response times.
- **Workforce:** System workforce numbers must be aligned to the financial resources available.
- **Finance:** Deliver a balanced net system financial position for 2024/25.

Report Summary

The final version of the of the ICB's 2024/25 operational plan was submitted on 2nd May 2024 and is the result of a significant amount of work by all partners across the NHS in Derby and Derbyshire.

In this context, the purpose of this report is to provide a summary of our 2024/25 planning assumptions from the perspective of operational performance, workforce, and finance.

Operational Performance

This plan sees the NHS in Derby and Derbyshire committing to deliver operational performance that is compliant with the national ask, in most cases. For the small number of items where we are not compliant (CRH's Value Weighted Activity plan and the LD&A adult inpatient rate), we can demonstrate stretch in our improvement ambition on 2023/24 outturn.

Urgent and Emergency Care (UEC)

We have established our intent to improve 4 hr performance and have set a plan to achieve 82% in March 2025, across the ICB's entire UEC commissioning portfolio.

Planned Acute Care

We have established our intent to have no patient waiting over 65 weeks at the end of September 2024. This is underpinned by an activity plan where both acute trusts are seeking to deliver a significant amount of additional admitted and non-admitted elective activity relative to a "normalised" 2023/24 outturn position (i.e., with lost Industrial Action activity added back in).

CRH have set out a Value Weighted Activity (VWA) trajectory that will see them achieve 106% in 2024/25. Whilst we recognise that this is 1% short of the target, it is important to note that there is a significant amount of stretch within the plan to achieve 106%.

Cancer

We have established our intent to achieve the 70% 62-day treatment target by March 2025 and the 28-day faster diagnosis standard.

Community Health Services

Our planning return sets out a forecast where for adult services, the number of 52-week waits is projected to grow by 18% or 237 patients, in overall terms. This position is skewed by the effect of one service related to Derbyshire Healthcare Community Service FT. Given that there is more work to do with the Trust to agree a plan to improve this position, the forecast should be considered as a worst case at this moment in time. Indeed, when this service is "excluded" from forecast, we are planning to reduce the overall waiting list by 12% and proportion of 52 week waits by 84% in 2024/25.

From a children and young person's community health perspective, our planning return indicates that we are proposing to "hold" the number of 52 week waits at 2023/24 outturn. The long wait position is driven by Derbyshire Healthcare NHSFT's community paediatric service and more specifically within this the neurodevelopmental assessment pathway. Given the growth in referrals to this service, holding the waiting list position will be challenging but is something that we are focussed on delivering.

Primary Care

From a General Practice perspective, we have set out our intent to match the level of GP appointments delivered in 2023/24 for 2024/25, with at least 75% of patients being seen within 2 weeks on average. This is set in the context of growth in activity delivered over the last few years against the backdrop of limited growth in General Practitioners and Practice Nurses.

Enhancing access to dental care is an important objective for the Derby and Derbyshire NHS in 2024/25. As such, we have an intent to increase the proportion of adults and children who will see a dental practitioner by 2% in 2024/25.

Mental Health, Autism and Learning Disabilities

We have established our intent to hold the good performance achieved in 2023/24 throughout 2024/25 and deliver a compliant plan for most of the targets set, apart from the learning disability and/or autism inpatient rate. In our submission that we have set out a trajectory that sees 35 adults per 1m population inpatient rate by the end of 2024/25. We recognise that this exceeds the tolerance of 30 that has been set but does represent improvement given the rate that we were recording some six months ago. We will of course continue to focus on driving down this rate further.

Workforce

This plan delivers a reduction in the number of whole-time equivalents (WTEs) across the four JUCD Foundation Trusts, on a like for like basis (March 2025 plan vs. March 2024 actual). When accounting for the workforce effect arising from a set of funded initiatives the overall workforce is planned to be higher in March 25 relative to March 24.

Finance

The plan does not meet the planning ask of a break-even financial position. This plan generates an underlying trading deficit of £68.8m for the ICB and five Foundation Trusts (inclusive of EMAS) combined, with deficit plans for the CRHFT, UHDBFT and DHcFT.

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

No further risks identified.

Financial impact on the ICB or wider Integrated Care System		
[To be completed by Finance Team ONLY]		
Yes ☐	No☐	N/A☒
Details/Findings Not applicable.		**Has this been signed off by a finance team member?** Not applicable.
Have any conflicts of interest been identified throughout the decision-making process?		
None identified.		
Project Dependencies		
Completion of Impact Assessments		

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

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

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

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

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

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

NHS Derby and Derbyshire ICB position against NHS England Operational Planning Priorities – 2024/25

Area	Objective	DDICB position
Urgent and emergency care	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	We have set an objective to improve 4 hr performance on 23/24 outturn and have set a plan to achieve 84.3% in March 2025, across the ICB's entire UEC commissioning portfolio.
Primary and community services	Improve community services waiting times, with a focus on reducing long waits	Adults - we are planning to reduce the overall adult waiting list by 12% and the proportion of 52 week waits by 84%, in 2024/25 (excluding Tier 3 weight management service) Children & Young Persons - we are proposing to "hold" the number of 52 week waits at 2023/24 outturn.
	Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels	Ensure that 41% of the adult population see a dentist by the end of 24/25 (compared to 39% at the end of 23/24) and 59% of the CYP population see a dentist by the end of 24/25 (compared to 56% at the end of 23/24).
	Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	At least deliver the same level of GP appointment output in 24/25 as we did in 23/24.
Elective Care	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	Both Trusts have committed to have zero 65+week waits, by end of September 24.
	Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	107% for UHDB and 106% for the CRH
Cancer	Improve performance against the headline 62-day standard to 70% by March 2025	76% CRH; 70% UHDB
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	77% CRH; 77% UHDB
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	UHDB 95%; CRH 95%

NHS Derby and Derbyshire ICB position against NHS England Operational Planning Priorities – 2024/25

Area	Objective	DDICB position
Mental Health	Improve patient flow and work towards eliminating inappropriate out of area placements	26 in April 2024 reduced to zero by end of March 2025.
	Increase the number of people accessing transformed models of perinatal mental health to 66,000	Trajectory set at 1,111 people accessing services in March 25 which holds 23/24 outturn performance and is in line with the target set.
	Increase the number of people accessing children and young people services (345,000 additional CYP aged 0–25 compared to 2019)	14,555 people accessing by March 25 vs. 13,015 as at end of Jan 24.
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery	67% achieving a reliable improvement on average in 24/25 and 50% achieving a reliable recovery.
	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	78% of people with SMI will receive a full annual health check in Q4 24/25. This represents a significant improvement in performance when considering that 23/24 delivered ~ 62%.
	Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025	68% by March 2025
People with a learning disability and autistic people	Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025	75% by March 2025
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 12–15 under 18s for every 1 million population	14 CYP per 1 million population
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults for every 1 million population	35 adults per 1 million population

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 011

Report Title	Primary Care Access Recovery Plan							
Author	Emma Prokopiuk, Assistant Director of Primary Care							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Presenter	Clive Newman, Director of Primary Care							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Not applicable							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Population Health and Strategic Commissioning Committee – 15.04.24							

Recommendations
The ICB Board are requested to **NOTE** that the ICB has made good progress against the Primary Care Access Recovery plan in year 1 and has robust plans to deliver to target by the end date of the 31st March 2025.
Purpose
As part of the national Primary Care Access Recovery Plan, ICBs are required to take a System Level Primary Care Access Improvement Plan through their ICB Public Boards in October/November 2023 with a further update in May 2024. The ICB Board received and approved the full plan in November 2023. This report provides a summary position of the progress made since then.
Background
A joint NHS and Department of Health and Social Care plan was published on the 9th May 2023. The Primary Care Access Recovery Plan (PCARP) focuses on recovering access to general practice and supports two key ambitions: 1. **To tackle the 8am rush and reduce the number of people struggling to contact their practice.** End to patients requested to call back another day to book an appointment.

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

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

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

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

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

Report Summary

Since the release of the Primary Care Access Recovery Plan in May 2023 DDICB Primary Care Team have been working with Primary Care Networks (PCN) and their practices to deliver the initiatives contained within the plan.

Primary Care Networks developed Capacity and Access plans (CAP) which were a national requirement as part of the PCN Directed Enhanced Services (DES). PCN DES funding had been repurposed to support delivery of these plans with 70% being unconditionally paid to PCNs and a further 30% following year end and evidence of delivery. These plans focussed on 3 areas:

- patient experience of contact;
- ease of access and demand management;
- accuracy of recording in appointment books.

As part of the CAP plans the PCNs incorporated all the requirements of PCARP into these and in June 2024 the ICB will be assessing each plan to determine if achievement has been met against each of them before awarding funding.

We do know from the data that significant progress has been made during 23/24 and the slides included provide an update on the initiatives contained within the plan. This is a two-year plan and further work will be continued into 24/25.

We have made good progress in 23/24, including:

- 100% of practices have enabled patients to order repeat medications, book/cancel appointments and receive secure messaging through the NHS App;
- 47.% of practices are utilising the automatic GP registration service;
- supporting and funding (over £1m) our practices to move to digital phone systems;
- 17.9% increase in the number of online consultations since April 2023;
- 49 practices have taken part/taking part in the National General Practice Improvement Programme;
- 82% of appointments seen within 2 weeks.

Our priorities for 24/25 are:

Empower patients

- Increase use of NHS App and other digital channels to enable more patients to access to their prospective medical records (including test results) and manage their repeat prescriptions.
- Continue to expand Self-Referrals to appropriate services.
- Expand uptake of Pharmacy First services.

Implement Modern General Practice Access

- Complete implementation of better digital telephony.
- Complete implementation of highly usable and accessible online journeys for patients.
- Complete implementation of faster care navigation, assessment, and response.
- National transformation/improvement support for general practice and systems.

Build capacity

- Continue with expansion and retention commitments in the Long Term Workforce Plan (LTWP).

Cut bureaucracy

- Make further progress on implementation of the four Primary Care Secondary Care Interface Arm recommendations.
- Make online registration available in all practices.

In summary PCNs and GP practices are progressing well to deliver the Primary Care Access Recovery Plan and we have a robust plan in place to deliver on the second and final year of the plan. It should be noted that overall access remains a challenge for patients and practices due to structural issues outside of the scope of this plan, including rising demand and a static GP workforce. Outside of this plan we continue to work with General Practice to address these broader structural issues, most directly with the development and implementation of the GP strategy.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	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**	There is a risk that the system does not create and enable a health and care workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

No further risks identified.

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

Have any conflicts of interest been identified throughout the decision-making process?
None identified.
Project Dependencies
Completion of Impact Assessments

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

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

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

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

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

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

NHS
Derby and Derbyshire
Integrated Care Board

Derby & Derbyshire ICB Primary Care Access Recovery Plan

April 2024

Brief recap

- NHS England published the Primary Care Access Recovery Plan (PCARP) in May 2023 with two central ambitions:

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

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

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

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

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

- Derby & Derbyshire ICB responded to the national plan with a local implementation plan that was presented to the ICB Board in November 2023.
- Significant progress has been made during 23/24 and the following slides provide an update on the initiatives contained within the plan. This is a two-year plan and further work will be continued into 24/25.

Empowering patients

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

Commitment	Progress – April24
Improving information and NHS App functionality	• 100% of Derbyshire practices offer patients the ability to order repeat prescriptions online • 100% of Derbyshire practices offer patients the ability to book/cancel appointments online. • 100% of Derbyshire practices offer patients secure App messaging • 78% of Derbyshire practices have enable patients access to their prospective medical records. The ICB is working with the remaining practices to offer guidance and support to progress towards this target.
Increasing self-directed care where clinically appropriate	The promotion of self-referral was launched wk comm 11/03/2024. A self-referral page was created that hosts information for patients and professionals. A communications toolkit was shared with all system partners. Public facing communications was also developed including social media
Expanding community pharmacy services	• Pharmacy First was launched 31st January 2024 and 100% of Derbyshire Community Pharmacies signed up to deliver the service. • Roll out in Derby and Derbyshire has been progressing well. We are awaiting data from NHSE on the usage of the services to target areas of low uptake.
Registering with a GP service	47.% of practices are utilising the automatic GP registration service. This is an improved position; however progress is still to be made to achieve 100%

Implementing Modern General Practice Access

The plan is to change how practices work by implementing the 'Modern General Practice Access' programme. This aims to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another time. The aim is that patients know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online message

Commitment	Progress – April24
Better digital telephony	We have supported and funded (over £1m) our practices to move to digital phone systems by the end of March 2024. We are going further than this and are upgrading practices who are already on digital but don't have all the functions that they might need. We aim to ensure that all practices will have digital systems with all the functionality that they need.
Simpler online requests	There has been a 17.9% increase in the number of online consultations since April 2023
Faster navigation, assessment and response	93 practices have participated in the national Care Navigation Training.
Digital Framework	Although the national framework has been delayed our PCN Managers have been working together to develop a specification for a front-end triage tool to support the consistent navigation of patients contacting the practice
GPIP	• 21 practices have signed up/or completed the national intermediate GPIP • 15 Practices have signed up/or completed the national intensive GPIP • 7 practices are signed up to take part in the national Practice Level Support Programme (new name for the national programme, no intermediate/intensive going forward) • 6 practices have been accepted onto the local GPIP run by Hub Plus (local training hub)
GPAD (appointment data)	• Total appointments in February 24 had increased by 11.3%, 597,000 (compared to 2019) • 82% of appointments are within 2 weeks. This is an improved position for D&D but progress is still to be made to reach the lower threshold of 85% and upper threshold of 90%

Building capacity

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

Commitment	
Larger Multi-Disciplinary Teams	PCNs have spent 94.7% of their ARRS allocation in 2023/24. Spend to date is approx.. £24.9m, leaving an underspend of £1.4m. Only four PCNs are showing a significant underspend (greater than £100k). The March 2024 target has been met. There are currently 686 WTE in post (as of February 2024) against a target of 455. We expect to see a further 2.4% growth across primary care workforce during 2024/25.
More Doctors	The total permanent General Practice workforce headcount for Derbyshire as of the 31st of January 2024 is 3,869 working a Full Time Equivalent (FTE) of 2,854.54. This is an increase of 23.25 FTEs since March 2023. The General Practice workforce in Derbyshire is stable and we have seen an increase in our overall number and GP numbers. From October 2021, our GP numbers started to decline but we have seen a gradual increase over the last 12 months in headcount (HC) and FTE (from the available data via NWRS
Retention and return of experienced GPs	As of March 2024, 24 GPs were funded by the retainer scheme. Derbyshire has utilised its full allocation of £1.951m on retention in 2023/24. Elements of funding are matched to activity, which is why the overall allocation has increased. Schemes are currently supporting 173 members of general practice. However, this does not include the number of people accessing local schemes. **Fellowships:** 78 GP Fellows, 39 Nurse Fellows – Newly qualified and new to practice **Supporting Mentors**: 15 Mentors, 40 Mentees **Local Retention Schemes:** 5 schemes in place
Higher priority for PC in housing developments	Awaiting national update

Cutting bureaucracy

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

Commitment	Progress
Improving the primary/secondary care interface: • Onward referrals • Complete care (fit notes and discharge letters) • Call & recall: • Clear point of contact **Building on the Bureaucracy Busting Concordat -** Reduce the demands on practice time from unnecessary or low value asks and improve processes for only the most important requests for medical evidence.	• Working Group now established, first meeting held on 29 March 2024. • Medical Director representation from all Trusts, CPLG, LMC, GPPB and DDICB • The ICB Board will undertake assurance on the delivery of the Interface work • ToR and Governance proposed and to be agreed • Group will meet monthly to oversee programme progression • Propose Alliance for Clinical Transformation (ACT) undertake role as Reference Group • Approval of Peer Coaching & Learning programme offer for provider collaborative leadership teams • Of four key focus areas, JUCD membership propose immediate priorities as Complete Care – Fit Notes and Clear Points of Contact - Singe Point of Access

Next steps

- Continue to work with our practices to make progress against the plan.
- Meet with our PCNs to assess their year-end position against the Capacity & Access plans.
- Agree 24/25 Capacity & Access Plans with the PCNs.
- Work with the GPPB to implement the new clinical model for General Practice to ensure the two plans complement each other.
- Work with PCNs that have an ARRS underspend to maximise their allocation and recruitment in 24/25.
- Establish a baseline of permanent ARRS staff vs temporary, additional overtime etc. and look to increase the permanent WTE.
- We will apply greater flexibility to the ARRS scheme and support PCNs to recruit other direct patient care, non-nurse and non-GP MDT roles to increase capacity

Next steps

Empower patients

- Increase use of NHS App and other digital channels to enable more patients to access to their prospective medical records (including test results) and manage their repeat prescriptions
- Continue to expand Self-Referrals to appropriate services
- Expand uptake of Pharmacy First services

Implement Modern General Practice Access

- Complete implementation of better digital telephony
- Complete implementation of highly usable and accessible online journeys for patients
- Complete implementation of faster care navigation, assessment, and response
- National transformation/improvement support for general practice and systems

Build capacity

- Continue with expansion and retention commitments in the Long Term Workforce Plan (LTWP)

Cut bureaucracy

- Make further progress on implementation of the four Primary Care Secondary Care Interface Arm recommendations
- Make online registration available in all practices

Key Information

Key contacts:

Emma Prokopiuk: emma.prokopiuk@nhs.net

Clive Newman: clive.newman3@nhs.net

Link to DDICB System Improvement Plan presented to ICB Board in November 2023

Derbyshire ICB website (16 November 2023 board meeting pages, page 183 to 208)

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 012

Report Title	NHS Impact Programme							
Author	Dr Chris Weiner, Chief Medical Officer							
Sponsor (Executive Director)	Dr Chris Weiner, Chief Medical Officer							
Presenter	Dr Chris Weiner, Chief Medical Officer							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☐
Appendices	Not applicable							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Not applicable							

Recommendations
The ICB Board are recommended to **DISCUSS**: • the NHS Impact Programme; and • how the NHS Impact Programme could assist in the delivery of the strategic priorities for the Derby City and Derbyshire Integrated Care System.
Purpose
1. To increase the awareness of the developing national NHS Impact programme within the Derby and Derbyshire Integrated Care System. 2. To allow the ICB Board to provide a leadership steer in the local delivery of the NHS Impact programme. 3. To highlight the opportunities that the NHS Impact programme could have in delivering a shift towards the primary and secondary prevention in healthcare services and the delivery of more equitable services to those most in need.
Background
NHS IMPACT (Improving Patient Care Together) is the new, single, shared NHS improvement approach. The intention of this national programme is to create the right conditions for continuous quality improvement and deliver high performance in NHS services. The aim of the programme is to mainstream continuous improvement across the entire NHS in order to achieve: 1. enhanced patient outcomes; 2. increased operational efficiency; and 3. excellence in healthcare delivery.

Evidence demonstrates that a systematic approach to quality improvement will help systems and organisations respond to today's challenges, deliver better care for patients and give better outcomes for communities.

Report Summary

High quality healthcare services are:

1. safe;
2. effective;
3. a good experience for patients;
4. affordable; and
5. sustainable over the long term.

All of our NHS Services can benefit from improvement in the quality. The NHS is currently responding to the impact of an aging population, as services continue to recover from the impact of the Covid-19 pandemic, whilst also managing within a constrained resource environment (staff and financial). The delivery of continuous quality improvement is of critical importance not only for the day to day running of the NHS, but also for the communities that we serve in Derby City and Derbyshire.

The NHS in Derbyshire recognises that there is important quality improvement work required that improves:

- health outcomes across our communities;
- emphasis upon primary and secondary prevention to reduce the need for high cost intervention;
- equality in health outcomes experienced by members of our communities;
- timely access to, high quality elective, urgent and emergency care; and
- the stability and longevity of services.

Evidence demonstrates that the five components of all evidence-based improvement approaches that need to be in place in order to deliver a systematic approach to continuous quality improvement are:

1. building a shared purpose and vision;
2. investing in people and culture;
3. developing leadership behaviours;
4. building improvement capability and capacity; and
5. embedding improvement into management systems and processes.

These five components are integral in the expectations of the NHS Impact programme.

The opportunities to deliver are numerous and there will be many items touched upon in today's ICB Board meeting where people recognise that quality improvement is of value. This need for improvement will be recognised not only in services that have recognised quality concerns, but also in services that are perceived as working well or are just beginning to be implemented in the NHS. For services that are working well it will be important to ensure that there is equitable access to the services by all members of our community (e.g. there is evidence from the Midlands in the UK, that access to services such as elective hip replacement is reduced in people from more deprived backgrounds). For those services that are just beginning to be implemented in the NHS (e.g. virtual wards), it will be essential to recognise that continuous quality improvement will ensure that such services reach their full long term potential.

In order to realise the full opportunities that can be delivered through the NHS Impact and Improvement programme it is suggested that we should now:

- consider how we bring clinicians, nursing staff, allied health professionals and managers together around a shared system quality improvement agenda;
- understand the role of the Integrated Care Provider Board alongside the ICB in delivering the NHS Impact Programme;
- align the quality improvement agenda around the intentions of the five year forward view for our integrated care system in order to ensure that we are delivering improvement that is strategically important to our system;
- set an expectation of measurable improvement in our improvement approach that allows the local NHS to demonstrate to our communities that we are delivering improvement in our services; and
- recognise that the NHS Impact Programme can allow us to mobilise an improvement methodology that improves health care equity and a shift towards the delivery of the prevention agenda.

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

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

Not applicable.

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?
The NHS Impact work affords the ICB and the Integrated Care System the potential to advance the equality of opportunity between people who share a protected characteristic or have factors that increase the risk of inequalities in health, in having access to high quality services.

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

Details/Findings Not applicable.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 013

Report Title	Audit and Governance Committee Assurance Report – May 2024							
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, 2nd May 2024							

Recommendations
The ICB Board are recommended to **NOTE** the Audit and Governance Committee Assurance Report for May 2024.
Items to escalate to the ICB Board
The Internal Auditors were not in a position to give an overall indicative Head of Internal Audit Opinion for the draft annual report and financial statements because a number of reviews including 3 core reviews are not yet complete. The ICB must as a priority ensure that they respond to any Internal Audit requests in a timely and complete manner to enable the outstanding work to be completed before a final opinion is required. We also asked that going forward reviews that involve other partners should be programmed sufficiently early to allow for the longer timeframes often needed to complete such reviews. In addition, we noted the limited assurance report from Internal Audit on Operational Planning. This was based on the operational planning process for 2023/24 and scheduled for Quarter 2 to help inform the 2024/25 planning process. However, delays meant that the report was not finalised until April 2023, too late to influence the 2024/25 planning process as much as it could have done. Reflecting on the current year's planning process there was a consensus that there have been more mature discussions with partners this year along with more transparency and triangulation, whilst accepting that there remain areas for improvement.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Audit and Governance Committee on the 2nd May 2024.

Background

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

Report Summary

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

- matters of concern or key risks to escalate;
- decisions made;
- major actions commissioned or work underway;
- positive assurances received; 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 a health and care workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

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

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

No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

Appendix 1

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Audit and Governance Committee on 2nd May 2024

Matters of concern or key risks to escalate	Decisions made
The Internal Auditors were not in a position to give an overall indicative Head of Internal Audit Opinion for the draft annual report and financial statements because a number of reviews including 3 core reviews are not yet complete. The ICB must as a priority ensure that they respond to any Internal Audit requests in a timely and complete manner to enable the outstanding work to be completed before a final opinion is required. We also asked that going forward reviews that involve other partners should be programmed sufficiently early to allow for the longer timeframes often needed to complete such reviews. In addition, we noted the limited assurance report from Internal Audit on Operational Planning. This was based on the operational planning process for 2023/24 and scheduled for Q2 to help inform the 2024/25 planning process. However, delays meant that the report was not finalised until April 2023, too late to influence the 2024/25 planning process as much as it could have done. Reflecting on the current year's planning process there was a consensus that there have been more mature discussions with partners this year along with more transparency and triangulation, whilst accepting that there remain areas for improvement.	The Committee approved the: • 2023/24 accounting policies; • draft Annual Accounts for 2023/24; and • draft Annual Report for 2023/24. In approving all three of the above the Committee noted the hard work that has gone into preparing these documents within a tight timeframe to such high quality. Positive comments were also received from the external auditors in support of the draft documents approved. The Committee also approved the: • Joint Working Agreement for the East Midlands ICBs for the delegation of specialised commissioning; and • Terms of Reference for the Joint Committee of the East Midlands ICB.

Major actions commissioned or work underway	Positive assurances received
The Committee noted the regional approach and process for the ICB Annual Assessment.	The Committee took positive assurance from the: • Internal Audit's interim conclusions of significant assurance regarding the ICB's strategic risk management and BAF as well as the timely implementation of previous recommendations; • ICB Board Assurance Framework, Corporate Risk Register report and the risks responsible to the Audit and Governance Committee which confirmed that risks are being monitored and managed on an ongoing basis and that all committees are in the process of reviewing the underlying threats and associated actions; and • Month 12 financial position review which was in line with the position agreed by the system. We noted the over delivery of efficiencies but that a lower proportion than intended were recurrent which will add to the pressures in 2024/25.

Comments on the effectiveness of the meeting
The meeting was well attended and effective contributions were made by all. The presentation on the financial statements was particularly helpful, highlighting significant changes and explaining key elements of the accounts. All of the papers were well focused and provided clear explanations which enabled the Committee to focus on the key areas for discussion.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 014

Report Title	Finance, Estates and Digital Committee Assurance Report – March and April 2024							
Author	Jill Dentith, Non-Executive Member (Finance and Estates)							
Sponsor (Executive Director)	Keith Griffiths, Chief Finance Officer							
Presenter	Jill Dentith, Non-Executive Member (Finance and Estates)							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report – March 2024 Appendix 2 – Committee Assurance Report – April 2024							
Assurance Report agreed by:	Jill Dentith, Non-Executive Member (Finance and Estates)							
Which committee has the subject matter been through?	Finance, Estates and Digital Committee – 26th March and 23rd April 2024							

Recommendations
The ICB Board are recommended to **NOTE** the Finance, Estates and Digital Committee Assurance Reports for March and April 2024.
Items to escalate to the ICB Board
Please see the report at Appendix 1 and 2 for information.
Purpose
This report provides the ICB Board with a brief summary of the items transacted at the meeting of the Finance, Estates and Digital Committee on the 26th March and 23rd April 2024.
Background
The Finance, Estates and Digital Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The Finance, Estates and Digital Committee's Assurance Reports (Appendix 1 and 2) highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made; • major actions commissioned or work underway;

- positive assurances received; and
- comments on the effectiveness of the meeting.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	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 a health and care workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

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

Financial impact on the ICB or wider Integrated Care System

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

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

No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

Better health outcomes	☒	Improved patient access and experience	☒

A representative and supported workforce	☒	Inclusive leadership	☒
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?			
There are no implications or risks which affect the ICB's obligations under the Public Sector Equality Duty.			
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?			

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable to this report.

Appendix 1

NHS
Derby and Derbyshire
Integrated Care Board

Board Assurance Report

Finance, Estates and Digital Committee on 26th March 2024

Matters of concern or key risks to escalate	Decisions made
• As of 29th February 2024, the **JUCD year to date position** is a £46.7m deficit against a £2.8m planned deficit, a £43.9m overspend against the plan. The main factors driving this are excess inflation, additional pay costs and increased activity levels. • NHSE recognise a **forecast year end deficit of £44.7m** this reflects pressures that were not known at the time of planning including, inflation, a shortfall on pay award funding, shortfall in primary care funding. This was the position the position signed up to as part of the H2 reset, which also included an expected benefit of £7.2m relating to a reduction in Public Dividend Capital with the revaluation of PFI assets under IFRS16. Due to a change in national policy this benefit can no longer be recognised in the System position.(Similarly the H2 reset excluded the costs associated with the equal pay claim which is hitting the NHS nationally) . The impact of this IFRS issues is c £7m which means the final reported deficit could be c£51m. NHSE have been made fully aware of this national issues for many months. • **Additional risks** Other significant additional risks relating to health care assistant re-banding at a cost of £20.2m,(national issue across the NHS)~ and pressures on capacity and activity, and drugs costs could impact the year end further • The **system efficiency** delivery is £0.3m behind plan year to date in total, split into £28.1m behind plan on recurrent efficiencies and £27.8m over plan on non-recurrent efficiencies. Unless planned levels of recurrent efficiencies can be delivered, it will impact in future years. • **Workforce** - JUCD is reporting an overspend of £47.2m to date with a year-end forecast of £52.4m overspend.	No decisions were made at the meeting.

Major actions commissioned or work underway	Positive assurances received
• **ICS Infrastructure Strategy** – the Committee received an update on the strategy which includes sections on Estate Optimisation, Estates Utilisation, Digital and Data, Fit and Affordable, Time and Resource and Collaboration. An update on the strategy will be presented to the April or May Committee. • **Summary Transformation Plans for each Delivery Board - 2023/24** were presented to the Committee which included an outline of progress and issues year to date by delivery boards. • **System delivery and transformation programmes 2024-25** – work has begun to set out improvement and change plans for 2024/2025 and beyond. This included planning workshops for the main programme teams and key stakeholders. The main outputs of the workshops were high level objectives/priority change plans for each of the Delivery Boards. Progress will be reported to future Committee meetings. • **Cost Improvement Programmes (CIPs)** – in 2024-25 we have a 5% recurrent CIP to build into the plan. We have significant work to do to gain confidence that the system will deliver this. The Committee therefore focused on developing a fully worked up program to deliver this. A report will be presented to future meetings. • **Capital** - we have not delivered the capital plan as proposed in 2023-24, it is therefore important we understand the closing position for 2023-24 and the impact that this will have on capital and revenue as we move into 2024-25. A report will be presented to a future meeting.	• **Elective Recover Fund (ERF)** - Based on local data as at month nine the system has achieved 100.7% against a target of 100%. Due to this overperformance an allocation of £3.5m is expected to be received at the end of the year. • **Productivity at UHDB** - There has been significant progress made over the last two years to increase productivity, although this has not kept pace with peers especially when compared to 19/20. UHDB have identified opportunities for further progress to recover the position and are participating in a national pilot for improvement. Learning will also be shared with Trusts in the Derby and Derbyshire system.

Comments on the effectiveness of the meeting
The Committee was well attended by members. There were helpful discussions on the financial position 2023/24 and projections for 2024/25, infrastructure, productivity and the work of the Delivery Boards.

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Finance, Estates and Digital Committee on 23rd April 2024

Matters of concern or key risks to escalate	Decisions made
Financial position 2023-24 - As of 31st March 2024, the JUCD position hit its H2 Reset target of £42m but, with recognised exceptional items for IFRS16 and Equal Pay, the reported deficit is £58.0m. The original plan for 2023-24 was breakeven but as with all NHS organisations there were significant in year pressure caused by inflation and pay, primary care funding shortfalls, the full cost of which were reflected in the H2 reset in December 2023. **Financial planning 2024-25** – the Committee had a detailed discussion about the forecasted financial position and the work currently underway to reduce the projected deficit position prior to the submission to the Region on 2 May 2024. **System Efficiency 2023-24 recurrent vs non-recurrent split** - £32.7m behind plan on recurrent efficiencies and £31.4m over plan on non-recurrent efficiencies which will exacerbate the financial position in 2024-25 if not addressed. All organisations are populating the ePMO to ensure robust plans are in place by 2 May.	**Risk Register and Board Assurance Framework –** the Committee revied both documents to ensure that they still accurately reflected the risks, risk ratings and mitigations assigned to the Committee in 2023-24 and any changes into 2024-25. JB to work with colleagues in the Corporate Team to update.
Major actions commissioned or work underway	**Positive assurances received**
Electronic Patient Record (Acute hospitals) - University Hospitals Derby Burton (UHDB) alongside Chesterfield Royal Hospital (CRH) have procured a joint EPR solution for both organisations. The business case successfully secured the required funding investment. Work continues on the implementation of the system. **System Improvement and Transformation Plan 2024-25** - the Committee noted the emerging transformation priorities for 2024/25 and the intention to develop a cross-system approach to benefits realisation. Further work on the plans has been commissioned and will be reported to the May Committee meeting.	**Financial position 2023-24 of DDICB Regional and National comparisons** – the deficit represents 1.2% of turnover which makes DDICB the second-best performing system in the Midlands and puts the organisation below the national average. **System Efficiency 2023-24 -** delivery stands at £134.7m of the £136m plan, 99.1%. **Cyber security** – the Committee received positive assurance on the ongoing work around cyber security across the System. **Optimised Patient Tracking and Intelligent Choices Application (Optica)** - live at UHDB and CRH. Both Trusts have developed their local implementation plans.

	Derbyshire Shared Care Record (DSCR) – aims to provide health and social care professionals with health and social care information for the citizens in Derbyshire for the purpose of 'direct care'. Work continues to further engage other partner providers in submitting data to the DSCR and for single sign on access.
Comments on the effectiveness of the meeting	
There was excellent representation across the System at the meeting. The Committee noted the work within the system to deliver the 2023-24 financial position and the ongoing work on the 2024-25 financial, transformation and workforce. Committee members contributed to the confirm and challenge discussions.	

NHS
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Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 015

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

Recommendations
The ICB Board are recommended to **NOTE** the Quality and Performance Committee Assurance Report for March 2024.
Purpose
This report provides the Board with a brief summary of the items transacted at the Quality and Performance Committee on the 28th March 2024. As reported in previous reports the ICB is currently not compliant with any statutory operational targets relating to the urgent care, planned care and cancer.
Background
The February 2024 Committee meeting was a development session and there is no assurance report provided. It should be noted that 360 Assurance were present at the March meeting as part of their six monthly review of the ICB Committees. This report provides the Board with a brief summary of the items transacted at the meeting of the Quality and Performance Committee on the 28th March 2024. The subjects for the Deep Dives presented to the Committee are identified either at the request of those present to allow more detailed information to be provided on areas of concern or risk raised during the meeting or as a matter of routine to allow an in-depth review of the subject matter.
Report Summary
The System Quality and Performance Committee Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made;

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

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	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**	There is a risk that the system does not create and enable a health and care workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

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

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☐	Inclusive leadership	☐
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?			
There are no implications or risks which affect the ICB's obligations under the Public Sector Equality Duty.			
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?			

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable.

Appendix 1

NHS
Derby and Derbyshire
Integrated Care Board

Board Assurance Report

Quality and Performance Committee on 28th March 2024

Matters of concern or key risks to escalate	Decisions made
• Risk 09 on the ICB risk register relates to risk stratification and the patient harm review process. It has been on the risk register and rated at 20 for a significant amount of time with regular discussions taking place at SQG. The ICB Board had requested a review of the risk given. In December, SQG advised that the rating be dropped to 8. Although there is anecdotal evidence suggesting patient harm there is no actual evidence from the ICB's four main providers. Since June 2023 there has been sustained improvement in the implementation of the risk stratification process. Based on the reports presented to SQG there was a recommendation that the risk was reduced. • Integrated Performance Report: Sepsis – UHDBFT are not currently using the UK Sepsis bundle. It was noted that UHDBFT are reviewing their sepsis bundle against the new guidance published by NICE in January 2024. • Neuro Developmental (Children and Young People) Assessment Waiting Times and Pathway: concerns were raised regarding the ability of Providers to effectively record ethnicity to add value to reporting.	• Risk 09: The Committee asked that a further paper is presented to a future meeting (now June 24), additional information is required around thought processes and evidence to support the recommendation of reducing the risk score to an 8. • Board Assurance Framework (BAF): The Committee approved the updated to the BAF.
Major actions commissioned or work underway	**Positive assurances received**
Integrated Performance Report: CDiff and MRSA numbers are increasing in the acute trusts with breaches around CDiff. This suggests a lack of control around IPC. It would be beneficial to see that there has been a rounded approach to the management of this issue. It was agreed to bring a more in-depth deep dive to future Committee meeting and to invite Acute trust colleagues to have input into the deep dive.	• Deep Dive on Stroke Services • Deep Dive on Personal Health Budgets • Neuro Developmental (Children and Young People) Assessment Waiting Times and Pathway • Integrated Performance Report
Comments on the effectiveness of the meeting	
Those present agreed that the meeting had been effective, with sufficient opportunity for discussion and that the papers presented were appropriate.	

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 016

Report Title	Population Health and Strategic Commissioning Committee Assurance Report – April 2024							
Author	Richard Wright, Non-Executive Member (Population Health & Public Partnership)							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Presenter	Richard Wright, Non-Executive Member (Population Health & Public Partnership)							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Richard Wright, Non-Executive Member (Population Health & Public Partnership)							
Which committee has the subject matter been through?	Population Health and Strategic Commissioning Committee – 11/04/24							

Recommendations
The ICB Board is recommended to **NOTE** the Population Health and Strategic Commissioning Committee Assurance Report for April 2024.
Items to escalate to the ICB Board
As detailed within the report.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Population Health and Strategic Commissioning Committee on the 11th April 2024.
Background
The Population Health and Strategic Commissioning Committee ensures that the ICB effectively delivers the statutory functions of the ICB. It is a requirement for Committees of the ICB to produce an assurance report as set out in the Committee's Terms of Reference.
Report Summary
The Population Health and Strategic Commissioning Committee Assurance Report highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made;

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

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 a health and care workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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

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

Yes ☐	No☐	N/A☒

Details/Findings 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 raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?			
There are no implications or risks which affect the ICB's obligations under the Public Sector Equality Duty.			
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?			
Carbon reduction	☐	Air Pollution	☐
Waste	☐		
Details/Findings Not applicable to this report.			

Appendix 1

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Population Health and Strategic Commissioning Committee – 11th April 2024

Matters of concern or key risks to escalate	Decisions made

None to report.	**Commissioning Decisions**
	There were no items for a specific commissioning decision at this meeting.
	
	Board Assurance Framework (BAF)
	The Population Health and Strategic Commissioning Committee
	• Discussed the Board Assurance Framework Strategic Risks 7, 8 and 9 for quarter 4 to date;
	• Reviewed the risk score for each Strategic Risk 7, 8 and 9 for quarter 4 to date; and
	• Agreed the:
	  ○ closing Quarter 4 position for 2023/24; and
	  ○ opening Quarter 1 position for 2024/25 confirming that the risks and controls/assurances are still valid and current.
	Risk Register
	The Population Health and Strategic Commissioning Committee received and discussed the risks responsible to the Committee.

Major actions commissioned or work underway	**Positive assurances received**
Further to the development session in March the following work has been commissioned and is underway. 1. Review membership and TOR 2. Map supporting committees, working groups and sub groups 3. Develop framework for PHSCC 4. Develop commissioning plan 5. Develop procurement and contracting plan 6. Develop data insights 7. Further discussion on mandate for members and supporting groups	**Risk Register** Received and discussed the risks responsible to the Committee. **Board Assurance Framework (BAF)** Received and discussed the strategic risks responsible to the Committee. **Other items:** Primary Care Subgroup report Primary Care Access Recovery Plan update 3 other confidential items

	The following items were received for information: • CPAG updates • Derbyshire Prescribing Group report/minutes • JAPC Bulletin • CPLG minutes
Comments on the effectiveness of the meeting	
Nothing of note in terms of concerns. It was noted to be a productive meeting with good items received and good input and participation from committee members.	

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 017

Report Title	People and Culture Committee Assurance Report – April 2024							
Author	Lucinda Frearson, Executive Assistant							
Sponsor (Executive Director)	Linda Garnett, Interim ICB Chief People Officer							
Presenter	Margaret Gildea, Non-Executive Member (People & Culture)							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Margaret Gildea, Non-Executive Member (People & Culture)							
Which committee has the subject matter been through?	People and Culture Committee – 25th April 2024							

Recommendations
The ICB Board are recommended to **NOTE** the People and Culture Committee Assurance Report for April 2024.
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 25th April 2024.
Background
The People and Culture Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The People and Culture Committee's Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made; • major actions commissioned or work underway; • positive assurances received; and • comments on the effectiveness of the meeting.

Identification of Key Risks					
SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	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 a health and care workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Any risks highlighted and assigned to the 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?

No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?					
There are no implications or risks which affect the ICB's obligations under the Public Sector Equality Duty.					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable to this report.					

Appendix 1

NHS
Derby and Derbyshire
Integrated Care Board

Board Assurance Report

People and Culture Committee on 25th April 2024

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	It was decided to recommend to the ICB Board changes to the Board Assurance Framework (BAF) Strategic Risk 05 and Strategic Risk 06 which involved deleting Risk 06 and changing the wording for Risk 05.
Major actions commissioned or work underway	**Positive assurances received**
Committee were provided with a presentation about the Derbyshire Academy detailing the purpose and background along with information on the finance and efficiencies made to date and the impact the Academy has had on the ICB workforce priorities.	Through this joint working with the faculty's efficiencies are already being made. The biggest impact has been reducing organisational duplication and a saving of costs through shared admin of over £10k.
24/25 Operational Plan Workforce figures were still being collated for the final submission on the 2nd May with an extra ordinary Board meeting being held prior to that date to sign off the submission.	In terms of numbers the latest position is showing an overall growth of 0.2% which is 58 WTE, which includes EMAS. If remove planned, known and funded investment going into next year and compared like for like we are showing a reduction of 4.3%, just over 1000 people which is quite significant.
Latest Workforce Report update.	A reset was carried out for the second half of the year and finished above the target by 600 WTE but there was a noticeable slowing of growth. In terms of substantive roles there was only 146 WTE which was where we said we would be against a 30,000 workforce. The system is in a much better position this year in terms of outturn at M12 and where we expect to be in M1, which gives a much better starting point.

An Agency Reduction Steering Group has been established also an Agency Data Group to support and feed into the Steering Group.	The group is looking into 3 areas: • framework agency • over cap • admin and clerical and infrastructure agency. Once final submission received a face-to-face session will be arranged to bring together all exit plans then commence discussions on the next steps. To provide assurance Committee were informed there was a high level of scrutiny around the work being done and also national interest. We are doing well in terms of agency spend but we need to start off with things we can do quickly but there will be issues that will not be so easy.
Leadership and Organisational Development Workstream have now launched the Derbyshire Wide Leadership Development at no cost to anybody within health, social care, voluntary sector and primary care systems.	This was quite a small offer at this point, but it is a start and was fully taken up within 2 hours of going live. Which shows there was a need and people are interested. There are positives being seen in this.
Comments on the effectiveness of the meeting	
The meeting was well attended and generated a lot of discussion covering several topics.	

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 018

Report Title	Public Partnership Committee Assurance Report – April 2024							
Author	Sean Thornton, Director of Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Richard Wright, Non-Executive Member (Population Health & Public Partnership)							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Richard Wright, Non-Executive Member (Population Health & Public Partnership)							
Which committee has the subject matter been through?	Public Partnership Committee, 30th April 2024							

Recommendations
The ICB Board are recommended to **NOTE** the Public Partnership Committee Assurance Report for April 2024.
Items to escalate to the ICB Board
Members were keen to strike the correct balance between assurances against risk and assurances of engagement activity to support service change and health improvement. This will be reviewed through the Committee's next development session in June 2024.
Purpose
This report provides the ICB Board with highlights from the development meeting of the Public Partnership Committee on the 30th April 2024. The committee alternates its monthly meetings between business, through which project and programme schemes are reviewed for assurance, and development, where the committee discusses structural and process issues in greater depth to support committee establishment and role; the April meeting was a business meeting. This report provides a summary of the items transacted for assurance.
Background
The Public Partnership Committee ensures that the ICB effectively delivers the statutory functions of the ICB in relation to patient and public involvement. The committee also seeks, through its terms of reference, to drive citizen engagement in all aspects of the ICB's work to ensure that local people are central to planning and decision-making processes.

Report Summary

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

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

Identification of Key Risks

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**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

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

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Public Partnership Committee on 30th April 2024

Matters of concern or key risks to escalate	Decisions made
Members were keen to strike the correct balance between assurances against risk and assurances of engagement activity to support service change and health improvement. This will be reviewed through the Committee's next development session in June 2024.	<u>Board Assurance Framework (BAF)</u> The Committee reviewed the Q4 position against BAF Strategic Risk 3 and agreed to maintain the risk with some amendment in 2024/25. Given that the mitigations for this risk reflect ongoing delivery elements within the agreed Engagement Strategy, the work programme continues naturally; at present there was partial assurance against defined actions. The Committee ratified its recommendation from its February meeting that the risk score be reduced from a 4x4=16 to a 3x4=12, due to the stabilisation of the Communications and Engagement Team following the ICB restructure and that the engagement strategy systems and processes are in development. <u>Corporate Risks</u> The ratings for the Committee's corporate risks relating to communications and engagement team capacity was reduced from 3x3=9 to a 2x3=6. There is reduced likelihood, and it was noted that the team's capacity would begin to stabilise following the outcome of the ICB's staff restructure. The risk relating to stakeholder engagement through a period of change was maintained at 3x4=12. A public and stakeholder communications programme will be developed during May and June 2024 to deepen understanding of local financial and performance challenges, as well as to raise awareness of performance improvement in 23/24. The Committee formally adopted a new risk relating to the introduction of the new provider selection regime, and the risk that existing processes to connect PPI governance into change programmes may weaken, resulting in services not meeting needs of patients, reduced PPI compliance, risk of legal challenge and damage to NHS and ICB reputation. This risk is initially rated 3x4=12, but with mitigations in development could quickly reduce to a lower rating. <u>Fertility Policy</u> A extraordinary meeting of the committee would be arranged to review the engagement plans being developed to support the East Midlands Fertility Policy review. Timings of existing business meetings were not aligning with the planning process.

Major actions commissioned or work underway	Positive assurances received

• Board Assurance Framework action plan – ongoing delivery of mitigating actions
• East Midlands Fertility Policy Review
• Recruitment to committee lay member vacancies
• Review of approach to committee/sub-group diversity.
• Establishment of Lay Reference Group.
• Ongoing development of engagement frameworks
  ○ Insight Framework
  ○ Governance Framework
  ○ Evaluation Framework
  ○ Co-production Framework
  ○ Engagement Framework
	<u>Patient and Public Involvement Log</u>
	This log records the outcomes of all assessments of legal duty triggers where service changes are identified. The log is presented to PPC at each meeting, with the open opportunity for members to request deep dives on any schemes listed.
	
	<u>Performance Report</u>
	There are ongoing discussions to support a performance report for the committee to monitor its assurance role. The report will combine national assessment framework lines of enquiry, nationally-defined principles for working with people and communities, the Committee Terms of Reference and annual reporting requirements to articulate how performance can be assured during the course of the year.
	
	<u>Post-Covid Service Final Outcomes</u>
	The Committee received a report on the final outcomes following engagement to help determine the future provision of Post-Covid services. It was recognised that the project had fully embraced the ICB's Engagement Model, running a thorough approach from the development of a case for change through to the options appraisal and decision-making process. The committee felt it was an excellent example of the model working in practice.
	
	<u>Hypertension Case-Finding Programme</u>
	The Committee received a further report on community engagement undertaken to inform a hypertension case finding project in Derby. Working with community leaders and communities themselves, the engagement undertaken informed the service provision and the communications and resulted in significant additional blood pressure checks being undertaken in an effort to help reduce heart attacks and strokes. The project was heralded as an excellent model of community engagement.

Comments on the effectiveness of the meeting
The committee reviewed a series of assurance questions and agreed that the meeting had been effective.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 019

Report Title	ICB Board Assurance Framework – Quarter 4 2023/24 and Opening 2024/25 position							
Author	Rosalie Whitehead, Risk Management & Legal Assurance Manager							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Quarter 4 2023/24 BAF Strategic Risks 1 to 10							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Finance and Estates Committee Population Health and Strategic Commissioning Committee Quality and Performance Committee People and Culture Committee Public Partnership Committee							

Recommendations

The ICB Board are recommended to:

- **RECEIVE** the Quarter 4 23/24 closing BAF strategic risks 1 to 10 and opening Quarter 1 24/25 BAF strategic risks;
- **NOTE** the decrease in risk score for Strategic Risk 1 from a very high score of 16 to a high score of 12;
- **NOTE** the decrease in risk score for Strategic Risk 3 from a very high score of 16 to a high score of 12;
- **NOTE** the revised risk description for Strategic Risk 5;
- **NOTE** the new threat assigned to Strategic Risk 5 owned by the People and Culture Committee;
- **NOTE** the closure of Strategic Risk 6 owned by People and Culture Committee.

Purpose

The purpose of this report is to present to the ICB Board the closing Quarter 4 2023/24 Board Assurance Framework and Quarter 1 2024/25 Opening Position.

Report Summary

Quarter 4 closing BAF 2023/24

During Quarters 1 and 2, the BAF has been modified to include the cross referencing of gaps in control and assurance to the relevant actions. A significant review was undertaken of gaps in

controls and assurances to ensure they address the risk areas. Where gaps did not address the risk areas they have been removed. Actions to address gaps in controls and assurances have been reviewed, updated and marked as complete where required. Updates for Quarter 4 are highlighted in blue. Text has strikethrough applied to illustrate that this will be removed and details the replacement text where superseded.

- Appendix 1 provides the summary of the Quarter 4 BAF and the detailed Quarter 4 2023/24 BAF strategic risks 1 to 10.
- The closing quarter 4 BAF position will be agreed as the opening April 2024/25 position.

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

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

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

Risk Score

Having thoroughly reviewed the mechanisms and assurances in place and also accepting that there are still significant system concerns around maternity services, the risk score is recommended to be decreased from a very high score of 16 to a high score of 12.
This strategic risk will continue to be rigorously reviewed during 2024/25.

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

Risk Score

Following review of Strategic Risk 2, it is proposed that the risk score remains at a very high 16 until further actions are complete. There is currently insufficient progress on the actions to recommend a decrease in risk score at this time.

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

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

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

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

BAF Strategic Risk 7

Several actions have been completed during quarter 4 relating to Strategic Risk 7. One such action relates to Delivery Boards developing a process to share decisions and challenge actions enhancing transparency and shared understanding of impact. This was completed March 2024 and the Committee level of assurance has been changed from 'Partially Assured' to 'Assured' to reflect this completion.

Further completed actions are detailed in point 6, further in this report.

Following the review of actions, the Committee have agreed that the risk profile for this risk remains at risk score 12.

BAF Strategic Risk 8

This Strategic Risk is currently scored at a high 12.

Updates have been included where appropriate, with further updates to actions added where the ICB Staff re-structure agreement was previously in process. This is now nearing completion.

Following review of this strategic risk, the Committee have agreed that the risk profile for this risk remains at risk score 12.

BAF Strategic Risk 9

This Strategic Risk is currently scored at a very high 16.

A key update in respect of this risk is the recommendation that has been made to redevelop and update the ICB integrated performance report to reflect the new ICB delegated responsibilities and performance management approach. A working group is being developed to address this.

The risk profiles of risk 9 have been reviewed and considered by the Committee and have not changed during quarter 4.

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

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

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

Meetings have taken place during February and March with the relevant Leads to review and update the relevant gaps and actions.

BAF Strategic Risk 4

In November 2023 of quarter 3, Strategic Risk 4 was increased in risk score from a very high score of 16 to a very high score of 20. This remains the score for the closing position of quarter 4.

BAF Strategic Risk 10

The risk score for Strategic Risk 10 has been reviewed and the current risk score of a high 12 remains appropriate as the quarter 4 closing position. Key updates are detailed on the BAF document.

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

Strategic Risk 5: (Original description) *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.*

At the People and Culture Committee meeting held on 25th April 2024, the risk description in respect of Strategic Risk 5 was revised to reflect the most up to date position relating to workforce.

New Risk Description for Strategic Risk 5

The new risk description is respect of Strategic Risk 5 has been revised to:

There is a risk that the system is not able to maintain a sustainable workforce size and profile which meets the People Promise objectives.

New Threat for Strategic Risk 5

One additional, new threat has been identified.

Current system financial position makes the current workforce model unaffordable.

This new threat was recommended to be numbered as Threat 1 due to its prominence and the original threats are re-numbered from 2 onwards.

There are new System Controls, System Gaps in Control along with the mitigating actions for these System Gaps in Control.

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

Following a thorough review and refinement of the risk description for Strategic Risk 5, along with the strategic threats and actions, Strategic Risk 6 risk also relates to system affordability and ownership. This is now more explicitly reflected and integrated into Strategic Risk 5.

As such, it was recommended that Strategic Risk 6 now be closed. This closure was approved at the People and Culture Committee meeting held on 25th April 2024.

5. Public Partnership Committee – 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.

A reduction in risk score from a very high 16 to a high score of 12 was proposed and has been approved by the Public Partnership Committee at the meeting held on 30th April 2024. This is effective for quarter 4.

The reason for the decrease in risk score is:

- The structure is now agreed and staff structures for the communications and engagement have been retained and increased in some cases.
- The engagement strategy is in place and the systems and processes supporting the delivery of the strategy are in place including the Insights Framework.

6. Actions completed during Quarter 4

The following table details actions which have been completed during Quarter 4 across the Strategic Risks.

Action Reference Number	Action	Action date completed
1T1.5A	Production of Maternity Reporting process into the Local Maternity and Neo natal System (LMNS). Reporting monthly to Quality and Performance Committee and System Quality Group (SQG).	January 2024
1T1.7A	Integrated Care System (ICS) Quality Risk Escalation Policy ensures decisions to move quality risks through the escalation process are taken as close to the point of care as possible. Examples: Wound Care, Community Podiatry.	December 2023
1T1.8A	Maternity Recovery Action Plan to develop and report into LNMS and Q&P.	January 2024
2T1.5A	Quality governance link to Place being developed.	December 2023
3T1.2A	Evaluation Framework – PPC discussion. Co-production Framework – first scoping session. Insight Framework – pilots underway.	November 2023 June 2023 September 2023
5T4.2A	Programme of work agreed to be presented to the ICP. Attended ICP and programme of work agreed by ICP.	February 2024
6T1.1A	Electronic Training Needs Analysis to identify training gaps so that learning and development needs can be identified and prioritised for investment developed.	March 2024
7T1.3A	Delivery Boards to develop a process to share decisions and challenge actions enhancing transparency and shared understanding of impact. TCG co-ordinates overall transformation reporting and escalation of risks.	March 2024 March 2024
7T2.1A	H2 planning – first draft 25.09.23. Awaiting formal feedback. Ongoing, in progress – continuous planning approach.	November 2023
7T2.2A	Delivery Boards to develop a process to share decisions and challenge actions enhancing transparency and shared understanding of impact. TCG co-ordinates overall transformation reporting and escalation of risks.	March 2024
8T1.2A	Agree structure of ICB analytics team and role of Chief Data Analyst.	February 2024
8T1.7A	SIG reconstituted and reset.	December 2023

Each responsible Executive and the Committee reviewed and approved their final Quarter 4 2023/24 strategic risks at the Committee meetings during April 2024.

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 a health and care workforce to facilitate integrated care	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒
No further risks identified.					

Financial impact on the ICB or wider Integrated Care System		
Yes ☒	No☐	N/A☐
Details/Findings 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, *Chief Finance Officer*

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

Project Dependencies

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

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

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

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?			
There are no implications or risks which affect the ICB's obligations under the Public Sector Equality Duty.			

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings The ICB Corporate Risk register defines the risk to the achievement of Net Zero Targets and the delivery of the Derbyshire ICS Green Plan.					

Appendix 1 - ICB – Board Assurance Framework (BAF) Quarter 4 2023/24

The key elements of the BAF are:

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

Key to lead committee assurance ratings:

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

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

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

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

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

Risk scoring = Probability x Impact (P x I)

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

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

Reference	Strategic risk	Responsible committee	Executive lead	Last reviewed	Target risk score	Previous risk score	Current risk score	Risk appetite risk score	Movement in risk score	Overall Assurance rating
SR1	There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to delivery consistently safe services with appropriate levels of care.	Quality & Performance	Prof Dean Howells	15.04.2024	10	16	12	12	↓	Partially assured
SR2	There is a risk that short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	Quality & Performance	Prof Dean Howells	15.04.2024	10	16	16	12	↔	Partially assured
SR3	There is a risk that the population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	Public Partnership Committee	Helen Dillistone	19.04.2024	9	16	12	12	↓	Partially assured

Reference	Strategic risk	Responsible committee	Executive lead	Last reviewed	Target risk score	Previous risk score	Current risk score	Risk appetite risk score	Movement in risk score	Overall Assurance rating
SR4	There is a risk that the NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	Finance, Estates and Digital Committee	Keith Griffiths	12.04.2024	9	20	20	12	⟷	Partially assured
SR5	There is a risk that the system is not able to maintain a sustainable workforce size and profile which meets the People Promise objectives.	People & Culture Committee	Linda Garnett	15.04.2024	16	20	20	16	⟷	Partially assured
SR6	There is a risk that the system does not create and enable a health and care Workforce to facilitate integrated care.	People & Culture Committee	Linda Garnett	15.04.2024	9	12	12	9	**Risk Closed March 24**	Partially assured
SR7	There is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	Population Health & Strategic Commissioning Committee	Michelle Arrowsmith	12.04.2024	9	12	12	12	⟷	Partially assured
SR8	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	Population Health & Strategic Commissioning Committee	Dr Chris Weiner	11.04.2024	8	12	12	12	⟷	Partially assured
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	Population Health & Strategic Commissioning Committee	Michelle Arrowsmith	11.04.2024	12	16	16	12	⟷	Partially assured
SR10	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	Finance, Estates and Digital Committee	Jim Austin	15.04.2024	9	12	12	12	⟷	Partially assured

ICB – Board Assurance Framework (BAF)

Strategic Risk SR2 – Quality and Performance Committee

Strategic Aim – To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**
	ICB Lead: Prof Dean Howells, Chief Nursing Officer **ICB Chair** :Adedeji Okubadejo, Chair of Quality & Performance Committee	**System lead:** Prof Dean Howells, Chief Nursing Officer, Dr Robyn Dewis **System forum:** Quality and Performance Committee
		Date of identification: 17.11.2022 **Date of last review:** 15.04.2024

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

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

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

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	Performance Dashboard to include inequality measures. • All Providers are undertaking clinical harm reviews linked to long waiting lists and waits at the Emergency Department. Tier 1 oversight is in place for UHDB and processes are in place.			• Quality sub group of MHLDA Delivery Board established. Regular Integrated Assurance report is in place and reported to the Delivery Board. • UEC Board are including Quality as a regular agenda item. • Children and Young Peoples Board are looking at the model of either Quality sub group or a regular agenda item.		
Threat 2 The ICS short term needs are not clearly determined	• Agreed ICS 5 Year Strategy sets out the short-term priorities • Agreed ICB Strategic Objectives • Integrated Care Partnership (ICP) was established in shadow form and met in formally Public from February 2023. • System planning & co-ordination group managing overall approach to planning • Agreed Commissioning Intentions in place • ICP Strategy now approved.	2T2.1C 2T2.2C	Commissioning to focus on patient cohorts, with measures around services to be put in place to support reduction of inequalities. Increase Patient Experience feedback and engagement.	• The ICB Board Development Sessions provide dedicated time to agree ICB/ ICS Priorities. • ICB Board agreement of Strategic Objectives • BAF Operational Group - Regular review of the ICB BAF via established working group prior to reporting to Quality and Performance Committee.		
Threat 3 Lack of coordination across Derby and Derbyshire results in health outcomes and life expectancy improvements not being achieved	• Agreed NHSE Core20PLUS5 Improvement approach to support the reduction of health inequalities • Agreed System Quality & Performance dashboard to include inequality measures • County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Integrated Care Partnership (ICP) was established in shadow form and met in formally Public from February 2023. • Robust Citizen engagement across Derbyshire and reported through Public Partnerships Committee • Derbyshire ICS Health Inequalities Strategy has been developed and woven into the ICS Strategy and has been approved by the ICP.	2T3.3C	Alignment between the ICS and the City and County Health and Wellbeing Boards.	• County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Public Partnerships Committee Public assurance to ICB Board. • Derbyshire ICS Health Inequalities Strategy has been developed and woven into the ICS Strategy and has been approved by the ICP. • Winter Plan has been developed and is in place. • Showcase of Health Inequalities and wider Determinants of Health presented at November Quality & Performance Committee.	2T3.1AS	Public Health Summary Report to be developed and report into Quality & Performance Committee.

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

ICB – Board Assurance Framework (BAF)

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	2T1.1A	Develop the Intelligence and evidence to understand health inequalities A Quality Equality Impact Assessment is completed for all projects. •GetUBetter – MSK digital enabler to support patients to manage and prevent deterioration of conditions and ensure patients access the right local services at the right time. •Recap Health – Digital enabler secured to support Cardiac Rehab patients. •Digital Weight Management Programme – Offer of patient self-referral mechanism. •Virtual Wards – Digital enablement onboarded. SUS Outpatient data has the ability to identify F2F / virtual activity. The ICB (along with other system partners) is currently considering a Section 251 application to the Health Research Authority to enable the sharing of data across JUCD for population health management purposes. However, this requires agreement on a platform that will collate and distribute the data. The ICB is entering a proof of concept arrangement with NECS for their Axym project to assist in developing and assessing the Information Governance and Business Intelligence processes and requirements. This with focus upon two use cases – cancer and physical health checks for patients with a serious mental illness.	2T1.1C	Ged Connolly-Thompson/ Angela Deakin	June 2024	Commenced	JUCD Data & Digital Board and subsequent sub groups/Population Health & Strategic Commissioning Committee	Partially assured
	2T1.3A	Provider Collaborative Leadership Board and System Delivery Boards. The final Deloitte report outlines integrated assurance and moving forward with System Delivery Boards and provider Collaborative Leadership Boards, to be triangulated and embedded.	2T1.2C 2T1.3C	Helen Dillistone	Quarter 1 2024/2025	Commenced	ICB Board	Partially assured
	2T1.4A	Annual Review of the Integrated Care Partnership to determine alignment and relationships between ICP, Health and Wellbeing Boards and the ICS. The review will be incorporated into the system Integrated Assurance work.	2T1.4C 2T1.3C	Helen Dillistone/ICP Chair	Quarter 2 2024/25	Not yet commenced	Integrated Care Partnership	Partially assured

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
	2T1.5A	Quality governance link to Place being developed. As part of the work to understand how quality and governance links/sit in Place, a Place Quality/Governance Workshop was held in December to help identify how this will/could work in the landscape.	2T1.2AS	Phil Sugden	Complete 31.12.23	Completed 31.12.23	Place Quality/Governance Workshop	Assured
Threat 2	2T2.1A	Develop Patient Experience Plan The Patient Engagement Strategy is currently under review and the Patient Experience Plan is being incorporated the strategy going forward.	2T2.1C 2T2.2C	Elaine Belshaw / Karen Lloyd	~~31/12/2023 Draft completed Dec 23. February 2024 submission to System Quality Group~~ First Draft to PPC April 2024	Commenced	System Quality Group Public Partnerships Committee	Partially assured
Threat 3	2T3.2A	Alignment between the ICS and the City and County Health and Wellbeing Boards. A Local Government Association (LGA) facilitated workshop between Derby and Derbyshire Health and Wellbeing Boards and Integrated Care Partnership was held on 29th February 2024. The purpose of the development workshop was to develop a shared view of: • the ingredients required for success • the challenges and barriers we face • what we want to collectively achieve • the opportunities and actions to progress. In addition, the workshop aimed to improve alignment and clarification of relative roles, responsibilities and accountability. The detailed output of the workshop is currently being collated as well as proposed next steps.	2T3.3C	Dr Robyn Dewis	Work plan in development	Work plan in development	ICP, Health & Well Being Boards, ICB Board	Partially assured
	2T3.3A	Public Health Summary Report to be developed and report into Quality & Performance Committee. Population Health Core20 dashboard and a Surveillance Report being developed for the system. This second report covers various data from A&E to Waiting List, ambulance response times etc.	2T3.1AS	Dr Chris Weiner	Work plan in development	Work plan in development	Directors of Public Health meeting	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR3 – Public Partnership Committee

Strategic Aim – To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Helen Dillistone, Chief of Staff **ICB Chair:** Richard Wright, Chair of Public Partnership Committee	**System lead:** Helen Dillistone, Chief of Staff **System forum:** Public Partnership Committee	**Date of identification:** 17.11.2022 **Date of last review:** 19.04.2024

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

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

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

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

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

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started? Update**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	**3T1.2A**	Ongoing implementation of Engagement Strategy frameworks Evaluation Framework – PPC discussion Co-production Framework – first scoping session Board development session ahead of seeking pilots. Insight Framework – pilots underway Governance Framework – PPI and HOSC Guides developed. Final framework to follow conclusion of other frameworks.	3T1.3C 3T1.1AS	Karen Lloyd HM BF LK AK KL	31 March 2024 Completed 28.11.23 Completed 20.6.23 TBC Completed 15.9.23 ~~31.3.24~~ Continuous, delivery date TBC	Commenced Completed Completed Not started Completed Commenced	Public Partnership Committee	Partially assured
	3T1.3A	Ongoing implementation of Insight Framework approach Board development session Piloting of tool	3T1.4C 3T1.1AS	Karen Lloyd KL/ST/HD KL/AK	~~31 March 2024~~ Continuous, delivery date TBC TBC 31.3.24+	Commenced Not started Commenced	Public Partnership Committee	Partially assured
	3T1.4A	Programme of work to roll out PPI Guide with system partners, including general practice Clarification of PPI expectations for GP Ongoing opportunities to promote approach.	3T1.5C 3T1.1AS 3T1.2AS	Karen Lloyd KL KL	~~31 March 2024~~ Continuous Continuous	Continuous Continuous Continuous	Public Partnership Committee	Partially assured
	3T1.5A	Assess current team skills in cultural engagement and communications, including channel assessment, and devise action plan to close gaps/implement training and development. Health literacy bite-sized training (various team members and team discussion) Team skills audit and PDPs Community profiles development, including knowledge of communications preferences for population segments. Confirm pilot areas. Internal channels benchmarking and evaluation External channels benchmarking and evaluation	3T1.6C 3T1.1AS 3T1.3AS	Sean Thornton Various MH ST/KL DLB CC/MH	31.03.24+ 30 September 2023+ 31.03.24+ 31.05.24 31.03.24 Continuous – Delivery Date TBC ~~31.03.24~~ 30.06.24	Commenced Commenced Complete 6.2.24 Continuous Re-commenced 1.2.24 Re-commenced 1.2.24 Re-commenced 1.2.24	Communications and Engagement Team	Partially assured
	3T1.6A	Completion of ICB self-assessment and submission to NHSE	3T1.4AS 3T2.1AS 3T3.1AS	Helen Dillistone	~~End of Quarter 4~~ Quarter 1 2024/25	Commenced	Corporate Delivery Team/Public Partnership Committee/Audit and Governance Committee	
Threat 2	**3T2.1A**	Delivery of Communications and Engagement Strategy Stakeholder chapter to scope processes on relationship managing and stakeholder perceptions, resulting in business case.	3T2.1C 3T2.1C 3T2.2C 3T2.4C	Sean Thornton	31 March 2024+	Commenced	Public Partnership Committee	Partially assured

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		Configuration of tool for ICB purposes		GC-T	TBC	Recommenced Mar 24	Communications and Engagement Team	Partially assured
		Population of tool with local data, inc. GDPR compliance		DLB	31.3.24	Not started.		Partially assured
		Use of tool for distribution purposes		DLB	31.3.24+	Not started.		
		Development of tool for stakeholder management purposes, including profiling		DLB	31.3.25			
	3T2.3A	Delivery of Communications and Engagement Strategy Internal Communications chapter to create platform for engagement with ICB and system staff, building on existing mechanisms.	3T1.1C	David Lilley-Brown	~~31 March 2024~~ 31.12.24	Commenced	Communications and Engagement Team	Partially assured
		Internal channels benchmarking and evaluation		DLB	31.3.24	Delay	Communications and Engagement Team	Partially assured
		Team Derbyshire programme continues		DLB	Ongoing	In progress		
		Scope communications support for GP Provider Board (inc. PCNs) and GP Task Force		ST	31.03.24			
		System leader key message briefings to start		DLB/ST	29.02.24	Commenced 1.4.24		
		Roll out of online engagement platform tool for staff		DLB/HofC	1.2.24	Not started.		
	3T2.5A	Completion of ICB self-assessment and submission to NHSE	3T2.1AS	Helen Dillistone	~~End of Quarter 4~~ Quarter 1 2024/25	Commenced	Corporate Delivery Team/Public Partnership Committee/Audit and Governance Committee	Partially assured
Threat 3	**3T3.1A**	Allied to ePMO programme review, implement scoping exercise across system/ICB delivery boards and other groups to establish baseline of work.	3T3.1C	Sean Thornton	30 September 2023+	Commenced	Communications and Engagement Team	Partially assured
		System C&E leads undertake delivery board and committee scoping		System C&E	31.03.24	Delay		
		Collation of all priorities and capacity assessment		ICB/System C&E	29.2.24	Delay		
		Resource/capacity assessment presented to NHS Executive Team		ST	29.2.24	Delay		
	3T3.2A	Programme of work to roll out PPI Guide with system partners, including general practice.	3T3.2A	Karen Lloyd	31 March 2024+	Continuous	Public Partnership Committee	Partially assured
	3T3.3A	Completion of ICB self-assessment and submission to NHSE	3T3.1AS	Helen Dillistone	End of Quarter 4	Commenced	Corporate Delivery Team/Public Partnership Committee/Audit and Governance Committee	Partially assured
Threat 4	**3T4.1A**	Allied to ePMO programme review, implement scoping exercise across system/ICB delivery boards and other groups to establish baseline of work.	3T4.1C	Sean Thornton	~~30 September 2023~~ Delivery Date TBC	Commenced	Communications and Engagement Team	Partially assured
	3T4.3A	Implement remaining elements of Communications and Engagement Strategy chapters.	3T4.1C 3T4.3C	Sean Thornton & team	31 March 2024+	Commenced	Public Partnership Committee	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR4 – Finance, Estates and Digital Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Keith Griffiths, Chief Finance Officer **ICB Chair:** Jill Dentith, Finance, Estates and Digital Committee Chair	**System lead:** Keith Griffiths, Chief Finance Officer **System forum:** Finance, Estates and Digital Committee	**Date of identification:** 17.11.2022 **Date of last review**: 12.04.2024

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.**	**Risk appetite: target, tolerance and current score**	**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee **12**	**16**	**20**	**9**

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

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

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

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

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	**4T1.1A**	Development of Triangulated Activity, Workforce and Financial plan for 24/25 Financial Sustainability Group continues to oversee progress of efficiency progress for the wider system. Financial reset has given further clarity over both workforce and operational performance with the finances. Each organisation within the system has been asked to produce a 5 year Financial Sustainability plan.	4T1.1C 4T1.2C 4T1.6C	Michelle Arrowsmith	Continuous process	Commenced	Finance/Performance/Quality Committees ICB Board Financial Sustainability Group	Partial assurance given the transparency and debate at Board level, recognising the socio-economic environment the health and care sectors are currently navigating and the scale of the tasks that lie ahead – both operationally and culturally.
	4T1.2A	Benchmark exercise and Report against pre covid levels of activity	4T1.1C 4T1.4C	Linda Garnett, Keith Griffiths	Continuous	Commenced	People and Culture/Finance Estates and Digital Committee	
	4T1.3A	Develop management processes to deliver plans and level of productivity required Implementation and maintenance of the e-PMO to track efficiencies. E-PMO now consistently populated with efficiencies including productivity and CIP. Plans to set up a productivity sub-group of the	4T1.1C 4T1.3C 4T1.5C	Chair of Provider Collaborative/ Tamsin Hooton/Provider DOFs	Continuous - 2024/25	Commenced	PCLB/ Finance, Estates and Digital Committee	

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
		ICB Finance and Estates Committee. Providers working on productivity plans as part of 24/25 planning in addition to Delivery Board/PCLB plans. Delivery boards looking at efficiency and productivity in addition to internal provider actions e.g. planned care board and Get it right first time (GIRFT). Work has been done to look at 'value' across all Delivery Boards. Pipeline schemes/opportunities being recorded on ePMO, workshops with trust and programme teams to develop 2024/2025 plans.						
	4T1.4A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met The Integrated Assurance and Performance Report is in place and will continue to be developed further as reported to ICB Board. Recommendation has been made to redevelop and update our ICB integrated performance report to reflect the new ICB delegated responsibilities and performance management approach. A working group is being pulled together to: - codify performance management approach - agree what data goes into the integrated performance report; and - agree the process to provide the narrative/explanatory information for the report.	4T1.1C 4T1.1AS	Executive Team Sam Kabiswa	~~Ongoing – 2024/25~~ This will be a continuous process with key review points/dates. The next key date will be Mid-June 2024	Commenced	ICB Board	
Threat 2	**4T2.1A**	Develop the workforce planning approach to inform the 2024/25 plan and future projections Examples - Clinical Models Plan: Cardio Vascular plan currently being developed to target population health management and health inequalities across Derby and Derbyshire on a PLACE based approach. Socialising plan is now with system partners and will be presented at PHSCC in January for ratification. At the December CPLG meeting, the concept was agreed.	4T1.2C 4T2.2C 4T2.4C 4T1.2C 4T2.2C 4T2.4C	Linda Garnett/ Chris Weiner Chris Weiner/ Scott Webster	Q1 2024/25 Q1 2024/25 – plans to be developed at a PLACE level. Q2 onwards anticipated delivery	Commenced Commenced	People and Culture Committee/ CPLG CPLG and PHSCC	Partial assurance given the transparency and debate at board level, recognising the socio-economic environment the health and care sectors are currently navigating and the scale of the tasks that lie ahead – both

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
		Added to the planning round 24/25 awaiting confirmation of acceptance and finance apportioned to it.						operationally and culturally
	4T2.2A	Development of Triangulated Activity, Workforce and Financial plan Financial Sustainability Group continues to oversee progress of efficiency progress for the wider system. Financial reset has given further clarity over both workforce and operational performance with the finances. Each organisation within the system has been asked to produce a 5 year Financial Sustainability plan.	4T2.1C 4T2.3C	Executive Team	Continuous process	Commenced	People and Culture Committee/ Finance Estates and Digital Committee	
	4T2.3A	Benchmark exercise and report against pre covid levels of activity	4T2.1C 4T2.5C	Executive Team/Michelle Arrowsmith	Continuous	Commenced	People and Culture/Finance Estates and Digital Committee	
Threat 3	**4T3.1A**	Develop and embed EPMO System The system e-PMO continues to develop. At quarter 4 e-PMO was fully recording all provider and ICB CIP plans and being used to track delivery via the FSB and SFEDC. Work to further develop the e-PMO functionality and ease of use is ongoing, led via Director of PMO and Improvement. The system is being used to record all CIP plans and pipeline transformation plans for 2024/2025.	4T3.3C 4T3.4C 4T3.5C	Tamsin Hooton	Continuous – Q4 2023/24 / substantially completed	Commenced	Finance, Estates and Digital Committee / PCLB	Partial assurance through evidence of improving reporting and accountability, although real delivery is yet to be seen
	4T3.3A	Development of a consistent approach to measuring productivity is ongoing. Benchmarking work on corporate efficiencies, work underway on people supply, digital and procurement. Work to identify additional opportunities for savings underway. Procurement, HR and digital are current priority workstreams within corporate efficiencies. There are plans to establish a sub group of SFEDC on productivity (end date Q1 2024/2025). Work on 'value' opportunities, supported by Regional analytics team has also been completed (end of Q3). PCLB to establish	4T3.2C	Tamsin Hooton	Quarter 1 2024/2025	Commenced	Delivery and Trust Boards, PCLB, SFEDC, System PMO Leads Group	Partially assured

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
		a shared programme on productivity (end date Q1 2024/2025).						
Threat 4	**4T4.1A**	National Allocations unclear	4T4.1C 4T4.1AS	Executive Directors / NEMs	Continuous – 2024/25	Commenced	SFEDC	Not assured
Threat 5	**4T5.1A**	The ICB will continue to lobby the Regional and National teams	4T5.1C 4T5.1AS	Keith Griffiths	Continuous – 2023/25	Commenced	SFEDC	A significant change in allocation policy at National level will need to take place to rectify this issue.

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR5 – People and Culture Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Linda Garnett, Interim Chief People Officer **ICB Chair:** Margaret Gildea, Chair of People and Culture Committee	**System lead:** Linda Garnett, Interim Chief People Officer **System forum:** People and Culture Committee	**Date of identification:** 17.11.2022 **Date of last review:** 15.04.24

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the system is not able to maintain a sustainable workforce size and profile which meets the People Promise objectives.**	**Risk appetite: target, tolerance and current score**	**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee. **16**	**20**	**20**	**16**

Strategic threats (what might cause this risk to materialise)	**Impact** (what are the impacts of each of the strategic threats)
1. Current system financial position makes the current workforce model unaffordable 2. Lack of system alignment between activity, people and financial plans 3. Staff resilience and wellbeing across the health and care workforce is negatively impacted by environmental factors e.g. the industrial relations climate and the financial challenges in the system. 4. Employers in the care sector cannot attract and retain sufficient numbers of staff to enable optimal flow of service users through the pathways and the scale of vacancies across health and care and some specific professions.	1. Workforce model developed to meet system finances as opposed to population need. 2. There is an under supply of people to meet the activity planned and the funding available. 3. Increased sickness absence, deterioration in relationships and higher turnover particularly people retiring early leading to gaps in the staffing required to deliver services. 4. People are going to better paid jobs in other sectors which means that patients cannot be discharged from hospital due to lack of care packages causing long waiting times in the Emergency pathways, poorer quality of care.

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 Current system financial position makes the current workforce model unaffordable	• Organisational vacancy controls • Agency Reduction plan	5T1.1C 5T1.2C 5T1.3C 5T1.4C	• System Vacancy control processes • System level control total • Development of a Health and Care Strategy which delivers an affordable workforce model. • Workforce implications of Transformations programmes including CIP not fully understood.	• Monthly monitoring of workforce numbers and temporary staffing spend vs budget and agency spend. • Approved System Workforce Strategy and Workforce plan • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce.		Pending discussion at the next P&CC (27 June 2024)
Threat 2 Lack of system alignment between	• An Integrated planning approach has been agreed across the system covering finance activity and workforce.	5T2.3C	Develop 24/25 workforce plan.	• Monthly monitoring of workforce numbers and temporary staffing spend vs budget and agency spend. • Approved System Workforce Strategy	5T2.1AS	Work is progressing to develop an integrated performance assurance report which includes Quality, Performance, Workforce and Finance.

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
activity, people and financial plans	• Agreed System level SRO for Workforce Planning supported by Workforce Strategy and Planning Assistant Director • The System People and Culture Committee provides oversight of workforce across the system.			and Workforce plan • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce.	5T2.2AS	Activity delivered should be informing everything but there remain further issues requiring resolution in that area. Consistent escalation reporting across the system to be agreed (NA).
Threat 3 Staff resilience and wellbeing across the health and care workforce is negatively impacted by environmental factors e.g. the industrial relations climate and the financial challenges in the system	• A Comprehensive staff wellbeing offer is in place and available to Derbyshire ICS Employees • Engagement and Annual staff opinion surveys are undertaken across the Derbyshire Providers and ICB • The System People and Culture Committee provides oversight of workforce across the system. • Enhanced Leadership Development offer to support Managers and promoting Health and Wellbeing.	5T3.1C 5T3.3C	Funding for wellbeing offer is not recurrent. The Leadership Development offer is not yet fully embedded in each organisation.	• Monthly monitoring of absence and turnover • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce. • System Wellbeing Group provides performance information to the People Services Collaborative Delivery Board. • Health Assessments continue to provide impact and now embedded within People Services to support long-term sickness.	5T3.1AS 5T3.2AS	Work is progressing to develop an integrated performance assurance report which includes Quality, Performance, Workforce and Finance. Activity delivered should be informing everything but there remain further issues requiring resolution in that area. Despite measures being in place the situation is deteriorating in terms of staff health and being due to a range of factors (NA).
Threat 4 Employers in the care sector cannot attract and retain sufficient numbers of staff to enable optimal flow of service users through the pathways and the scale of vacancies across health and care and some specific professions	• Promotion of social care roles as part of Joined Up Careers programme. • The System People and Culture Committee provides oversight of workforce across the system. • Integrated Care Partnership (ICP) was established in shadow form and now meets in Public (February 2023 onwards)	5T4.1C 5T4.2C 5T4.3C	More work required to understand how the NHS can provide more support to care sector employers. Lack of Workforce representation on the ICP. Insufficient connection with People and Culture and the ICP	• Monthly monitoring of vacancies via Skills for Care data • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce. • Approved Integrated Care Partnership (ICP) Terms of Reference by the ICP and ICB Board. • County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Better Care funding supports the Joined Up Careers team to work in partnership with Health and Social Care. • Action Plan including range of widening participation and resourcing proposals to support with DCC Homecare Strategy 23/24	5T4.1AS 5T4.2AS	Work is progressing to develop an integrated performance assurance report which includes Quality, Performance, Workforce and Finance. Activity delivered should be informing everything but there remain issues requiring resolution in that area. Insufficient connection with People and Culture and the ICP (NA).

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ICB – Board Assurance Framework (BAF)

Actions to treat threat.								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Subgroup Assurance	**Committee level of assurance**
Threat 1	5T1.1A	Develop System Vacancy control processes.	5T1.1C	Linda Garnett	TBC	TBC	People & Culture Committee	Partially assured.
	5T1.2A	System level control total.	5T1.2C	Linda Garnett	TBC	TBC	People & Culture Committee	Partially assured.
	5T1.3A	Develop Health and Care Strategy which delivers an affordable workforce model.	5T1.3C	Sukhi Mahil	TBC	TBC	People & Culture Committee	Partially assured.
	5T1.4A	Workforce implications of Transformations programmes including CIP not fully understood.	5T1.4C	Tamsin Hooton	TBC	TBC	PH&SCC	Partially assured.
Threat 2	5T2.3A	Develop the workforce planning approach to inform the 2024/25 plan and future projections	5T2.3C 5T2.1AS 5T2.2AS	Sukhi Mahil	Q1 2024/25	Commenced	People & Culture Committee	Partially assured.
Threat 3	5T3.1A	Continue to spread and embed well-being offer. Review and evaluate feedback from Health and Wellbeing survey to continue to develop and improve wellbeing service offering. Work is ongoing with good levels of engagement across JUCD Health and Care workforce in activities. Over 4000 colleagues participating in activities each month. The evaluation from the HNA has been completed and will inform future planning. A new timetable of support is implemented quarterly along with the development of specialist groups, interventions for emotional and physical health.	5T3.3C 5T3.2AS	Nicola Bullen	Continuous from quarter 3 2023/24	Continuous	People & Culture Committee People Services Collaborative Delivery Board	Partially assured.
	5T3.2A	Review Occupational Health Services to ensure they are focused on promoting health and wellbeing. The health promotional activity largely sits within the JUCD Wellbeing programmes of work including activity timetable, lifestyle and wellbeing and health inequalities, with Occupational Health supporting the health Surveillance programmes. There is a significant programme of work around health surveillance as well as a quarterly activity programme that is produced for all staff across Derbyshire.	5T3.2AS	Nicola Bullen	Quarter 2 2024/25	Continuing	People & Culture Committee People Services Collaborative Delivery Board	Partially assured.
	5T3.3A	Pursue alternative funding sources, consider measures to mitigate impact of services	5T3.1C 5T3.1AS	Nicola Bullen	Continuous from Quarter 2 2023/24	Commenced	People & Culture Committee	Partially assured.

Actions to treat threat.								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Subgroup Assurance	**Committee level of assurance**
		reducing, utilise wellbeing support in place across the system. Funding will be received through NHS Midlands, a combined bid with Northants ICB, this will provide mental health hub activity across the East Midlands. Commitment to finance secured within Primary Care, Local Authority and City Council.					People Services Collaborative Delivery Board	
Threat 4	5T4.1A	Continue to develop system wide recruitment campaigns to meet demand for health and care across Derbyshire.	5T4.1C 5T4.2C 5T4.3C 5T4.1AS	Susan Spray	System Recruitment campaigns planned as a rolling programme.	Commenced	People & Culture Committee	Partially assured.
	5T4.2A	Programme of work agreed to be presented to the ICP. Attended ICP and programme of work agreed by ICP.	5T4.1C 5T4.2C 5T4.3C 5T4.2AS	Linda Garnett/ Susan Spray	Completed February 2024	Complete	People & Culture Committee	Assured.

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR6 – People and Culture Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Linda Garnett, Interim Chief People Officer **ICB Chair:** Margaret Gildea, Chair of People and Culture Committee	**System lead:** Linda Garnett, Interim Chief People Officer **System forum:** People and Culture Committee	**Date of identification:** 17.11.2022 **Date of last review:** 15.04.2024

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

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

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control Ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
<u>Threat 1</u> There is insufficient funding to undertake skills and cultural development needed to support integration	• A system wide training needs analysis is to be carried out so that learning and development needs can be identified and prioritised for investment. • The System People and Culture Committee provides oversight of workforce triangulation across the system. • Agreement to develop a system OD programme.	6T1.1C	Agreement needed that any education and training funding will be invested in accordance with the priorities identified.	• The outcome of the training needs analysis and decisions on investment of education and training funding will be overseen by the Workforce Advisory Group. • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • The Workforce Advisory Group brings together all component part to discuss workforce and planning and system engagement of the plan. • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce. • Commitment to develop a system OD programme.	6T1.1AS 6T1.2AS	The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. Consistent escalation reporting across the system to be agreed.

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 2 Lack of system ownership and commitment to an integrated Workforce	• Work is underway to develop a Workforce Strategy and plan aligned to the Integrated Care Strategy and Joint Forward Plan involving all system partners	6T2.1C	Development and implementation of the Workforce Strategy will be overseen by the People and Culture Committee	• Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • People and Culture Committee assurance to the Board via the ICB Board Integrated Assurance Report and Integrated Assurance and Performance Report which includes workforce.	6T2.2AS 6T2.3AS	The Integrated Assurance and Performance Report is in place and will continue to be developed further as reported to ICB Board. Consistent escalation reporting across the system to be agreed.

Actions to treat threat.

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Subgroup Assurance	Committee level of assurance
Threat 1	6T1.1A	Electronic TNA to identify training gaps so that learning and development needs can be identified and prioritised for investment developed. This has been implemented across 50% of JUCD Organisations. Remaining organisations are fully involved in discussions regarding training gaps and needs to support prioritisation and investment across the full system and will be added to the electronic TNA once consistent ESR access is available to ensure consistency across the system. An operational project lead was freed up to work on this and the electronic TNA is now in place.	6T1.1C	Faith Sango	Quarter 4 2023/24	Completed March 2024 pending whole system adoption of ESR	People Services Collaborative Delivery Board	Assured
Threat 2	6T2.1A	Develop Workforce Strategy in response to the Integrated Care Strategy, JFP and anticipated People plan.	6T2.1C 6T2.1AS 6T1.1AS 6T1.2AS 6T2.2AS 6T2.3AS	Sukhi Mahil	Initial draft to be aligned to JFP timescales	Commenced	ICS Executive	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR7 – Population Health and Strategic Commissioning Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Michelle Arrowsmith, Chief Strategy and Delivery Officer **ICB Chair:** Richard Wright, Chair of PHSCC	**System lead:** Michelle Arrowsmith, Chief Strategy and Delivery Officer **System forum:** Population Health and Strategic Commissioning Committee	**Date of identification:** 17.11.2022 **Date of last review:** 12.04.2024

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

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

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

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Gap Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Gap Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	'system think' via system-wide cost: impact analysis • Delivery Boards engagement with JUCD Transformation Board. • Provider Collaborative Leadership Board in place overseeing Delivery Boards and other delivery groups. • System planning & co-ordination group managing overall approach to planning • Formal risk sharing arrangements in place across organisations (via Section 75s/ Pooled Budgets) • Health Oversight Scrutiny Committees (HOSCs)/ Health and Wellbeing Boards are in place with an active scrutinising role • Dispute resolution protocols jointly agreed in key areas e.g. CYP joint funded packages – reducing disputes • Currently the system part funds the GP Provider Board (GPPB) which provides a collective voice for GP practices in the system at a strategic and operational level • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023.	7T1.4C 7T1.5C	Scoping, baselining, strategic overview, and solution choice to be carried out to ensure right solution is adopted to fit the business problem Understand impact of changes, how they support operational models, how best value can be delivered, and prioritised.	Board minutes • Health and Well Being Board minutes • ICB Scheme of Reservation and Delegation • Agreed process for establishing and monitoring financial and operational benefits • GPPB proposal for future operating model and funding planned for ICB Board discussion in April 23. • 2023/24 Operational Plan in place Integrated Care Strategy approved by the ICB Board and ICP. • Joint Forward Plan, Derby and Derbyshire NHS Five Year Plan 23/24 to 27/28 in place and published		
Threat 2 Demand on organisations due to system pressures/restoration may impact ability to focus on strategic aims.	**As above and:** • System performance reports received at Quality & Performance Committee will highlight areas of concern. • ICB involvement in NOF process and oversight arrangements with NHSE. • As above – GPPB and LMC both provide some resourced 'headspace' giving GP leaders time and opportunity to focus on strategic aims. • PCN funding gives GP Clinical Directors some time to focus on the development of their Primary Care Networks • System Planning and Co-ordination Group ensuring strategic focus alongside operational planning	7T2.1C 7T2.2C	Prolonged operational pressures ahead of winter and expected pressures to continue / increase. Level of maturity of Delivery Boards	• NHSEI oversight and reporting (EA) • Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • System Quality Group assurance to the Quality and Performance Committee and ICB Board. • System Quality and Performance Report • Monthly reports provided to ICB/ ICS Executive Team/ ICB Board and NHSE • Measurement of relationship in the system: embedding culture of partnership across partners • Coproduction • Workforce resilience • Demand in the system • Audit and Governance Committee oversight and scrutiny • Board Assurance Framework • 2023/24 Operational Plan in place Integrated Care Strategy approved by the ICB Board and ICP. • Joint Forward Plan, Derby and Derbyshire NHS Five Year Plan 23/24 to 27/28 in place and published	7T2.1AS 7T2.2AS	The Integrated Assurance and Performance Report is in place and continues to be developed further as reported to ICB Board. Consistent management reporting across the system to be agreed.

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Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Gap Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Gap Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 3 Time for system to move more significantly into "system think".	• SOC/ICC processes – ICCs supporting ICB to collate and submit information • As above – GPPB and LMC both provide some resourced 'headspace' giving GP leaders time to focus on system working • Development and delivery of Integrated Care System Strategy • Embedded Place Based approaches that focus partners together around community / population aims not sovereign priorities	7T3.1C	As above, extent of operational pressures and time required to focus on reactive management.	• Daily reporting of performance and breach analysis – identification of learning or areas for improvement • Measurement of relationship in the system: embedding culture of partnership across partners • Resilience of OCC in operational delivery including clinical leadership • Coproduction • Workforce resilience • Demand in the system • NHSE oversight and daily reporting (EA) • 2023/24 Operational Plan in place Integrated Care Strategy approved by the ICB Board and ICP. • Joint Forward Plan, Derby and Derbyshire NHS Five Year Plan 23/24 to 27/28 in place and published	7T3.1AS	The Integrated Assurance and Performance Report is in place and continues to be developed further as reported to ICB Board.
Threat 4 Statutory requirements on individual organisations may conflict with system aims.	• Strategic objectives agreed at ICB Board; dissemination will occur via Board members who represent system partners. • ICB and ICS Exec Teams in place • JUCD Transformation Co-ordinating Group in place with responsibility for delivery of transformation plans across system. • System Delivery Boards in place - providing a mechanism to share decisions and challenge actions enhancing transparency and shared understanding of impact • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis • Delivery Boards engagement with JUCD Transformation Board. • Provider Collaborative Leadership Board in place overseeing Delivery Boards and other delivery groups. • GPPB and LMC both provide some resourced 'headspace' giving GP leaders time and opportunity to focus on strategic aims. • PCN funding gives GP Clinical Directors some time to focus on the development of their Primary Care Networks • System Planning and Co-ordination Group ensuring strategic focus alongside operational planning	7T4.1C 7T4.2C 7T4.3C 7T4.4C 7T4.5C	Process to ensure consistent approach is adopted to share outputs from ICS and ICB Exec team meetings. Lack of process to measure impact of agreed actions across the system. Prolonged operational pressures ahead of winter and expected pressures to continue / increase. Level of maturity of Delivery Boards System Oversight of Individual boards decisions which may be against system aims.	• Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE • Audit and Governance committee oversight and scrutiny • ICB Strategic objectives and strategic risks • System Delivery Board agendas and minutes • Provider Collaborative Leadership Board minutes • Health and Well Being Board minutes • Measurement of relationship in the system: embedding culture of partnership across partners • Coproduction • 2023/24 Operational Plan in place Integrated Care Strategy approved by the ICB Board and ICP. • Joint Forward Plan, Derby and Derbyshire NHS Five Year Plan 23/24 to 27/28 in place and published		

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	7T1.1A	Produce and embed the use of a universal prioritisation framework to guide resource allocation decisions. *(Also 7T3.1A).* This is being carried out as part of the development of the Joint Forward Plan implementation and 24/25 operational planning.	7T1.1C 7T1.3C 7T1.4C 7T1.5C	Michelle Arrowsmith Sam Kabiswa	~~Quarter 4 2023/24~~ Quarter 1 2024/25	Commenced	PHSCC	Partially Assured
	7T1.2A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met. *(Also 7T3.2A).* This is progressing, the first elements are in place, currently systemising the process. This is ongoing and any subsequent changes are reflected in the report. Recommendation has been made to redevelop and update our ICB integrated performance report to reflect the new ICB delegated responsibilities and performance management approach. A working group is being pulled together to: - codify performance management approach - agree what data goes into the integrated performance report; and - agree the process to provide the narrative/explanatory information for the report.	7T1.1AS	Michelle Arrowsmith Sam Kabiswa	This will be a continuous process with key review points/dates. The next key date will be Mid-June 2024	Reported to Board Bi monthly	ICB Board	Partially Assured
	7T1.3A	Delivery Boards to develop a process to share decisions and challenge actions enhancing transparency and shared understanding of impact.	7T1.2C	Tamsin Hooton	~~Quarter 4 2023/24~~ Completed March 2024	Completed	Delivery Boards/ Provider Collaborative Leadership Board	Assured
		TCG co-ordinates overall transformation reporting and escalation of risks. Summary reports are presented to PCLB and escalations to NHS Executive. Reports and deep dives also go to SFEDC. Further work is being done to develop a benefits realisation plan across Delivery Boards.			~~Quarter 4 2023/24~~ Completed March 2024	Completed	TCG/PCLB/SFEDC	Assured
		Workshop session held 27/9/23, to agree a process to develop programme plans in a co-ordinated way, proposal for a system wide benefits realisation approach to understand impact, and interface with a system prioritisation approach. Benefits realisation and triangulation has been embedded in planning process for 24/25 but there is more work to do to fully complete this piece of work.			~~Quarter 4 2023/24~~ Quarter 2 2024/25	Commenced	TCG/System Planning Group	Partially assured

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 2	7T2.1A	H2 planning – first draft 25.09.23. Awaiting formal feedback. Ongoing, in progress – continuous planning approach. Planning completed and submitted to NHS England in November 2023.	7T2.1C	Sam Kabiswa	Completed November 2023	Completed	UECC Board	Assured
	7T2.2A	Delivery Boards to develop a process to share decisions and challenge actions enhancing transparency and shared understanding of impact. TCG co-ordinates overall transformation reporting and escalation of risks. Summary reports are presented to PCLB and escalations to NHS Executive. Reports and deep dives also go to SFEDC. Further work is being done to develop a benefits realisation plan across Delivery Boards.	7T2.2C	Tamsin Hooton	~~Quarter 4 2023/24~~ Completed March 2024	Completed	Delivery Boards/ Provider Collaborative Leadership Board	Assured
		Workshop session held 27/9/23, to agree a process to develop programme plans in a co-ordinated way, proposal for a system wide benefits realisation approach to understand impact, and interface with a system prioritisation approach. This now needs to be aligned with system planning approach. Benefits realisation and triangulation has been embedded in planning process for 24/25 but there is more work to do to fully complete this piece of work.			Quarter 2 2024/25	Commenced	TCG/System Planning Group	Partially assured
	7T2.3A	Consistent management reporting across the system to be agreed. System wide performance report compiled jointly with the Quality Team. The Joint Forward Plan has an agreed Outcomes Framework to drive the activities and interventions to include measurable System Objectives and development in key areas. Recommendation has been made to redevelop and update our ICB integrated performance report to reflect the new ICB delegated responsibilities and performance management approach. A working group is being pulled together to: - codify performance management approach - agree what data goes into the integrated performance report; and - agree the process to provide the narrative/explanatory information for the report.	7T2.2AS	Sam Kabiswa	This will be a continuous process with key review points/dates. The next key date will be Mid-June 2024.	Commenced	Quality and Performance Committee ICB Board	Partially assured

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 3	7T3.1A	Prioritisation process agreed in the system to better manage our time and use of resource. This is being carried out as part of the development of the Joint Forward Plan implementation and 24/25 operational planning.	7T3.1C	ICB / ICP Sam Kabiswa	~~Quarter 4 2023/24~~ Quarter 1 2024/25	Commenced	PHSCC	Partially assured
	7T3.2A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met. This is progressing, the first elements are in place, currently systemising the process. This is ongoing and any subsequent changes are reflected in the report. Recommendation has been made to redevelop and update our ICB integrated performance report to reflect the new ICB delegated responsibilities and performance management approach. A working group is being pulled together to: - codify performance management approach - agree what data goes into the integrated performance report; and - agree the process to provide the narrative/explanatory information for the report.	7T3.1AS	Michelle Arrowsmith	This will be a continuous process with key review points/dates. The next key date will be Mid-June 2024.	Reported to Board Bi-monthly	ICB Board	Partially assured
Threat 4	7T4.1A	Development of log System ICB/ICP Board decisions	7T4.1C	Chrissy Tucker	Quarter 2 2024/25	Commenced	ICB Board/ICP Board	Partially assured
	7T4.2A	Develop a process to measure impact of agreed actions across the system. To be delivered as part of the Joint Forward Plan implementation – System wide Evaluation Strategy of the impact of the Joint Forward Plan and the Integrated Care Strategy.	7T4.2C	Sam Kabiswa	~~Quarter 4 2023/24~~ Quarter 3 2024/25	Commenced	ICB Board/ICP Board	Partially assured
	7T4.4A	Delivery Boards to develop a process to share decisions and challenge actions enhancing transparency and shared understanding of impact. Transformation report and escalation report produced monthly and shared with TCG/PCLB. Workshop session held 27/9/23, to agree a process to develop plans in a co-ordinated way, including a system wide benefits realisation approach to understand impact, and interface with a system prioritisation approach. This has now been embedded in the planning approach for 24/25.	7T4.4C	Tamsin Hooton	~~Quarter 4 2023/24~~ Quarter 1 2024/25	Commenced	Delivery Boards/ Provider Collaborative Leadership Board	Partially Assured
	7T4.5A	Development of a process to support system oversight and delivery of system aims and Joint Forward Plan.	7T4.5C	Chrissy Tucker	Quarter 1 2024/25	Not yet commenced	ICB Board/ICP Board	Partially Assured

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
		The final Deloitte report outlines integrated assurance and moving forward with System Delivery Boards and provider Collaborative Leadership Boards, to be triangulated and embedded.						

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR8 – Population Health and Strategic Commissioning Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Chris Weiner ICB Chief Medical Officer **ICB Chair:** Richard Wright, Chair of PHSCC	**System lead:** Chris Weiner, ICB Chief Medical Officer **System forum:** Population Health and Strategic Commissioning Committee	**Date of identification:** 17.11.2022 **Date of last review:** 11.04.24

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

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

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 Agreement across the ICB on prioritisation of analytical and BI activity is not realised and therefore funding and associated resources are not identified to deliver the analytical capacity	• Agreed and publicly published Digital and Data Strategy • Digital and Data Board (D3B) in place. This provides board support and governance for the delivery of the agreed Digital and Data strategy. • D3B responsible for reporting assurance to ICB Finance and Estates Committee and assurance and direction from the Provider Collaborative Leadership Board. • Strategic Intelligence Group (SIG) established with oversight of system wide data and intelligence capability and driving organisational improvement to optimise available workforce and ways of working • Analytics and business intelligence identified as a key system enabler and priority for strategic planning and operationally delivery in the Digital and Data strategy • NHSE priorities and operational planning guidance 23/24 requires the right data architecture in place for population health management • Digital and Data identified as a key enabler in the Integrated Care Partnership strategy	8T1.1C 8T1.2C 8T1.3C 8T1.4C 8T1.5C	Senior system analytical leadership role to be created within ICB structures Senior analytical leadership role to co-ordinate: - Delivering value from NECS contract - Co-ordinating work across SIG - Identifying opportunities for more effective delivery of PHM Identified three priority areas of strategic working: - System surveillance intelligence - Deep dive intelligence - Population Health Management. Strategic Intelligence Group (SIG) needs formalising and structured reporting through to D3B and direct link to ICB Strategic Intent function and ICB planning cell JUCD Information Governance Group needs formalisation and work required on using data for planning purposes.	• Data and Digital Strategy • CMO and CDIO from ICB executive team are vice chairs of the D3B. • Regional NHSE and AHSN representation at D3B provide independent input. • D3B minutes demonstrating challenge and assurance levels • Provider Collaborative Leadership Board Minutes demonstrating challenge and assurance levels • Monthly Reporting to Finance and Estates Committee, ICB Board, NHSE and NHS Executive Team • Evidence of compliance with the ICB Scheme of Reservation and Delegation • A staffed, budgeted establishment for ICB analytics (workforce BAF link required) • Data Sharing Agreements in place across all NHS providers, ICB, hospices and local authorities for direct care purposes.	8T1.1AS	The Integrated Assurance and Performance Report is in place and continues to be developed further as reported to ICB Board.

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	8T1.2A	Agree structure of ICB analytics team and role of Chief Data Analyst	8T1.1C 8T1.2C	Chris Weiner	~~December 2023~~ February 2024	Completed	Executive Team	Assured
	8T1.3A	Recruitment of analytics team	8T1.2C	Chris Weiner	~~Quarter 4 2023/24~~ Quarter 1 2024/25	Commenced	Executive Team	Partially assured
	8T1.4A	Co-ordination and local prioritisation through SIG with leadership provided by internal business intelligence team	8T1.3C 8T1.4C	Chris Weiner	April 2024	Commenced	Business Intelligence Team	Partially assured

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
	8T1.5A	SIG is looking at health inequalities, population health management and how this data can be shared across the whole system. Senior analytical leadership role to be confirmed due to structures.	8T1.4C	Chris Weiner	New structure to be implemented by end of Q1 2024	Commenced	Strategic Intelligence Group (SIG)	Partially assured
	8T1.6A	Execution of planned investment in analytical skills development in line with ICB new structure Formalise JUCD IG group and draft data sharing agreements for using data for purposes other than direct care. A paper is currently being reviewed prior to presentation to the ICB's Executive Team which identifies options for implementation of an Information Governance framework – for direct care and secondary uses – a proof of concept for two user cases (cancer and serious mental illness) to test the principles and commissioning of NECS to provide access to their Axym product to collate and store the data. If approved, this will help to unlock some of the issues currently being experienced across the system and put in place the necessary agreements between the GP Practices, the ICB, JUCD partners and NECS. Legal advice is currently being sought on the necessary contract variations and the work will need to be funded and resourced by colleagues with the appropriate skills and experience, co-ordinated through the ICB.	8T1.5C	Helen Dillistone/ Ged /CT	Moved from Q4 to Q1 2024/25 as work in progress, but has not been completed.	Commenced	Business Intelligence Team JUCD IG Group	Partially assured Partially assured
	8T1.7A	SIG reconstituted and reset	8T1.4C	Chris Weiner	December 2023	Complete	Strategic Intelligence Group	Assured
	8T1.8A	Continue to strengthen the ICB Board Integrated Assurance and Performance Report data and information. This is progressing, the first elements are in place, currently systemising the process. This is ongoing and any subsequent changes are reflected in the report. Recommendation has been made to redevelop and update our ICB integrated performance report to reflect the new ICB delegated responsibilities and performance management approach. A working group is being pulled together to: - codify performance management approach - agree what data goes into the integrated performance report; and - agree the process to provide the narrative/explanatory information for the report.	8T1.1AS	Executive Officers Sam Kabiswa	This will be a continuous process with key review points/dates. The next key date will be Mid-June 2024	Commenced Presented to ICB Board bi monthly	Quality and Performance Committee, ICB Board	Partially assured

ICB – Board Assurance Framework (BAF)

Strategic Risk SR9 – Population Health and Strategic Commissioning Committee

Strategic Aim – Reduce inequalities in health and be an active partner in addressing the wider determinants of health.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Michelle Arrowsmith, Chief Strategy and Delivery Officer **ICB Chair:** Richard Wright, Chair of PHSCC	**System lead:** Dr Robyn Dewis, Derby City Director of Public Health **System forum:** Population Health and Strategic Commissioning Committee	**Date of identification:** 17.11.2022 **Date of last review:** 11.04.2024

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

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

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

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

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

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	9T1.1A	Monthly monitoring of financial position and the ICB requirement to break-even.	9T1.1C	Jason Burn	~~Quarter 4 2023/24~~ Continuous process	On-going – Annually	Finance, Estates and Digital Committee/ ICB Board	Partially assured
	9T1.2A	Prioritisation of actions needed to implement strategy. There are three areas to the strategy; Start Well, Stay Well, Age/Die Well. This is being routinely reported to the Integrated Partnership Board including updates on actions, therefore the gap is closed on the assurance element. Capacity is still an issue and the strategy is being utilised to prioritise actions.	9T1.2C	Kate Brown	In progress – 2024/25	Commenced	ICB Board/ICP Board	Partially assured
	9T1.3A	Review alternative funding formula to Carr Hill – scope cost and logistics Initial discussion held with Leicester, Leicestershire and Rutland ICB (LLRICB) who completed this work during quarter 3. Significant additional costs likely if ICB is to 'level up' to support new formula which gives greater weighting to deprivation. Would be challenging given current system financial position. Further work needed to scope but not prioritised for 23/24. Will reconsider in action plan for 24/25.	9T1.3C	GPPB/Clive Newman/Finance	April 2025	Commenced	GPPB/PHSCC	Partially assured
	9T1.4A	NHS England Regional Prevention Group monitor Core 20 plus 5 performance and review and agree any mitigations should targets fall below threshold. National targets have been circulated to each ICB. NHSE will review the data from providers and advise the ICB should any performance falls below the threshold.	9T1.4C	Scott Webster	In Progress – continual 2024/25	Commenced	Long Term Plan Prevention Programmes Working Group meeting	Partially assured
	9T1.5A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met. This is progressing, the first elements are in place, currently systemising the process. This is ongoing and any subsequent changes are reflected in the report. Recommendation has been made to redevelop and update our ICB integrated performance report to reflect the new ICB delegated responsibilities and performance management approach. A working group is being pulled together to: - codify performance management approach - agree what data goes into the integrated performance report; and	9T1.1AS	Michelle Arrowsmith Sam Kabiswa	This will be a continuous process with key review points/dates. The next key date will be Mid-June 2024	Commenced Presented to ICB Board bi monthly	Quality and Performance Committee, ICB Board	Partially assured

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
		- agree the process to provide the narrative/explanatory information for the report.						
Threat 2	9T2.1A	Prevention and Health Inequalities Board being set up. Derby City Council has partnered with Community Action Derby to create the Derby Health Inequalities Partnership (DHIP) and is led by the voluntary sector. First meeting commenced currently reviewing Terms of Reference and membership of group.	9T2.1C	Chris Weiner / Scott Webster	~~In the process of being confirmed.~~ Will be fully implemented during Quarter 1 2024/25	Monthly	Population Health Strategic Commissioning Committee	Partially assured

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ICB – Board Assurance Framework (BAF)

Strategic Risk SR10 – Finance, Estates and Digital Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Jim Austin, Chief Digital Technology Officer **ICB Chair:** Jill Dentith, Chair of Finance, Estates and Digital Committee	**System lead:** Keith Griffiths, Chief Finance Officer **System forum:** Finance and Estates Committee Data and Digital Board	**Date of identification:** 17.11.2022 **Date of last review:** 15.04.2024

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.**	**Risk appetite: target, tolerance and current score** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **12**		**Initial** **12**	**Current** **12**	**Target** **9**

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

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

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

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Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance (eg assured, partially assured, not assured)**	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	10T1.2A	Develop and roll out staff digital literacy programme. Linked to Project Derbyshire (Digital HR) – no resource allocated / prioritised at this time. Planning work commenced	10T1.2C	Jim Austin / Workforce lead/AR	From 24/25 financial year	Commenced	D3B , Digital Implementation Group	Partially assured
	10T1.3A	Adopt ICB prioritisation tool to enable correct resource allocation	10T1.1C	Jim Austin / Darran Green	TBC – requires prioritisation tool	Part of 23/24 and 24/25 planning activity	D3B	Not assured
Threat 2	10T2.2A	Work with ICB communications team and Provider communications teams to integrate digital strategy messaging into current engagement programme.	10T2.3C	Jim Austin /Sean Thornton	Continuous – 2024/25	Commenced	Public Partnership Committee	Partially assured
	10T2.3A	Deliver digital (and data) messaging through ICB communications plan. JUCD NHS Futures site established that provides detail on specific digital projects across the ICS.	10T2.3C	Jim Austin /Sean Thornton	June 2023+	Commenced	Public Partnership Committee/ DB3	Partially assured
	10T2.4A	Meetings with Rural Action Derbyshire completed. Derbyshire County Council agreed on-going funding support for 24/25. ICB Digital Programme team and engagement team to develop joint engagement strategy.	10T2.4C	Jim Austin /Sean Thornton	Continuous – 2024/25	Commenced	Public Partnership Committee/ DB3	Partially assured

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Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th May 2024

Item: 020

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

Recommendations

The Board are requested to:
• **RECEIVE** and **NOTE:**
  ○ the Risk Register Report at Appendix 1;
  ○ Appendix 2, as a reflection of the risks facing the organisation as at 30th April 2024;
  ○ Appendix 3, which summarises the movement of all risks in April 2024; and
• **APPROVE** the **CLOSURE** of risk 05 relating to Emergency Preparedness, Resilience and Response (EPRR).
•

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

Report Summary

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

Identification of Key Risks

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

The report covers each strategic risk.

Financial impact on the ICB or wider Integrated Care System

Yes ☒	No☐	N/A☐

Details/Findings
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,
Chief Finance Officer

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

No conflicts of interest have been identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

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

CORPORATE RISK REGISTER REPORT

INTRODUCTION

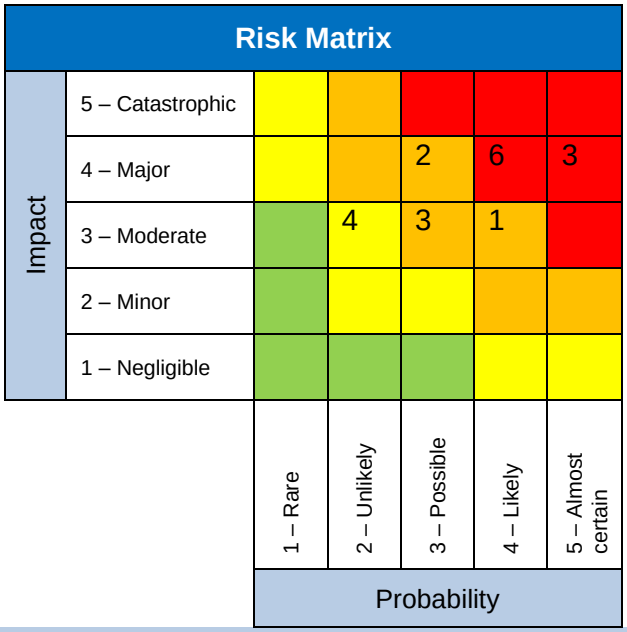
The purpose of this report is to present the ICB Board with the very high (red) operational risks from the ICB's Corporate Risk Register in order to provide assurance that robust management actions are being taken to mitigate them.

VERY HIGH OPERATIONAL RISKS

The ICB currently has 9 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 2.

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



Very High (Red) Operational Risks

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
Risk 01	*The Acute providers may not meet the new target in respect of 78% of patients being seen, treated, admitted or discharged from the Emergency Department within 4 hours by March 2025, resulting in the failure to meet the ICB constitutional standards and quality statutory duties, taking into account the clinical impact on patients and the clinical mitigations in place where long waits result.* **Update:** • The target has increased from 76% to 78% of patients being seen, treated, admitted or discharged from the Emergency Department within 4 hours by March 2025 (updated from 2024); • Shrewd has been deployed across the system and offers real time oversight of the UEC system using real time data. Data quality is still being worked through but the aim is for Shrewd to offer a real time view of system pressures, enable the	Overall score 20 **Very High** (5 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	OCC to identify trends and support system reporting. <u>March performance:</u> • CRH reported 73.2% (YTD 75.9%) and UHDB reported 78.0% (YTD 73.7%); • CRH: The Type 1 attendances and Type 3 streamed attendances remain high, with an average of 236 Type 1 and 57 streamed attendances per day; • UHDB: The volume of attendances remains high, with Derby seeing an average of 208 Type 1 adult attendances per day, 126 children's Type 1s and 148 co-located UTC. At Burton there was an average of 219 Type 1 attendances per day and 10 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 13 Resuscitation patients and 195 Major patients per day and Burton seeing 72 Major/Resus patients per day. • On 27 March, NHS England (NHSE) published the 2024/25 priorities and operational planning guidance. The guidance restates the focus on delivering the urgent and emergency care (UEC) recovery plan, focused on improving A&E waits and category 2 ambulance response times. This includes an ask that a minimum of 78% of patients are seen in A&E within 4 hours in March 2025. • Both acutes are still under performing against the target and fluctuating daily due to high demand, there is currently a focus on the 78% 4 hour target from NHSE and a lot of focused work was undertaken throughout March with both of our acute sites and other system providers to work to improve our performance.		
Risk 03	*There is a risk to the sustainability of individual GP practices (due to key areas detailed) across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.* **Update:** • OPEL reporting has been reduced to once weekly with resilience meetings and support to general practice continuing. • The Quality and Outcomes Framework (QOF) template was approved at the Primary Care Sub Group (PCSG) in March 2024. • There is no change to the risk score due to the ongoing pressures in general practice, imposition of national GP contract for 24/25 and financial pressures in staff costs due to increases in the	Overall score 16 **Very High** (4 x 4)	Population Health and Strategic Commissioning Committee

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	national living wage that are not fully covered through the national contract uplift. • A separate risk is being considered to be added relating to the threat of industrial action by GP's during 24/25 due to the imposition of the national GP contract.		
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:** • The 23/24 financial position has delivered a £58.0m, consisting of the £42.3m NHSE stretch target and pressures outside of the System's control (namely IFRS 16 lease asset revaluation, and health care support pay dispute). There are a number of consequences in delivering a deficit position, including financial impact on future years. • The Estates Strategy is to be presented at the next meeting. • The 24/25 plan is at its final stages, with shared ownership. A focus remains on the identification of improvement and transformation across all partners; governance reviews must follow in the coming weeks. NHS Providers are to commence a peer learning and coaching programme; focusing on productivity to identify opportunities for improvement. • Liquidity remains a concern. A number of funding requests were received during 23/24, and a further application has been made for Quarter 1 24/25.	Overall score 20 **Very High** (5 x 4)	Finance, Estates and Digital Committee
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:** • At the Quality and Performance Committee meeting held on 28th March 2024, the Chair and Committee members asked for a further paper to be to be submitted to the May Quality and Performance Committee meeting outlining further detailed evidence to support the recommendation to decrease the risk score.	Overall score 16 **Very High** (4x4)	Open Risk
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*	Overall score 20 **Very High** (5 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	waiting in the community for an ambulance response, resulting in potential significant levels of harm. **Update:** • Due to the recognised pressures and delays of hospital discharges through several factors, there has been a request to separate and develop a new risk from Risk 19 to ensure that ongoing discharge work is captured as its own risk with ownership from system partners. • The risk description for this risk will be revised following agreement on the new, proposed discharge risk. This is being discussed at the Strategic Discharge Group planned for 26th April 2024. • A number of mitigations include work being undertaken by the Strategic Discharge Group to improve the flow out of hospitals.		
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:** • In total there have been two hotels that have been closed - one in the city and one in the county; • In July the Home office and Serco intend to close another hotel in the county - this will leave a total of 4 contingency hotels open in the city and the county. • Until this point the concerns are ongoing for the remaining settings.	Overall score 16 **Very High** (4 x 4)	System Quality Group
22	*National funding for the 23/24 pay award and 22/23 one off payments excluded all staff who were not on NHS payrolls. Consequently staff employed by DHU, NHS subsidiary bodies, in PFI arrangements and Primary care were not eligible. Consequently there is an increasing risk of legal challenge as well as real, emerging loss of morale for over 4500 staff across the Derbyshire system which could affect recruitment and retention of critical frontline colleagues.* **Update:**	Overall score 16 **Very High** (4 x 4)	Finance, Estates and Digital Committee

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	• The recommendation is to roll this risk over into 2024/25.		
23	*There is a risk to Joined Up Care Derbyshire (JUCD) performance against the Cancer Standards, including 28 Day Faster Diagnosis Standard, 62 Day Waits and 104+ days due to an increase in referrals from Staffordshire into UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.* *New risk description:* *There is an ongoing risk to performance against the cancer standards due to an increase in referrals into UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.* **Update:** • The change in referral over the last 18 months is as a result of a range of factors - including Staffs practices focusing on early cancer diagnosis, changes in how services are configured/offered across west midlands and the increased use of Tamworth/Lichfield, all of which influence patient/GP choice of providers. • UHDB is in tier 1 for cancer performance therefore plans are being managed through national oversight to develop recovery action plans. • The risk description has been revised to reflect these wider challenges in terms of capacity to meet the cancer standards, impacting the whole of the County, not only Staffordshire.	Overall score 16 **Very High** (4 x 4)	System Quality Group
25	*There is a risk of significant waiting times for moderate to severe stroke patients for community rehabilitation. This means, patients may have discharges from acute delayed, be seen by non-stroke specialist therapists and require more robust social care intervention.* **Update:** • Case for Change development is ongoing and will be completed this month. • NHSE have requested to review the document.	Overall score 16 **Very High** (4x4)	Open Risk

RISK MOVEMENT

Appendix 3 details the movement of risk scores during April 2024 and the graphs detail the movement since April 2023.

Two risks were decreased in score in April:

1. 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.*

   The risk score was proposed to be decreased from a high score of 9 (probability 3 x impact 3) to a moderate score of 6 (probability 2 x impact 3).

   This is because the ICB is now progressing through the restructure and posts within the team are being appointed to. Therefore the likelihood is reduced, but the impact remains the same until the restructure is complete.

   The decrease in risk score was approved by the Public Partnerships Committee at the meeting held on 30th April 2024.

2. Risk 16: *With the review of ICB structures there is a risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.*

   This risk was proposed to be decreased from a high score of 12 (probability 4 x impact 3) to a moderate score of 6 (probability 2 x impact 3).

   The reason for the decrease in risk score is that the appeals have now largely been completed and we are supporting the staff who are 'at risk' of redundancy or have selection or other processes, therefore the risk has largely been mitigated. Following the proposed decrease in risk score, a view to closing the risk in a further 1 or 2 months if the staffing position remains stable is recommended.

   The decrease in risk score was approved by the Audit and Governance Committee at the meeting held on 2nd May 2024.

NEW RISKS

One new risk was proposed in April.

1. Risk 27: *As a result of the introduction of the new provider selection regime, existing processes to connect PPI governance into change programmes may weaken. This may result in services not meeting needs of patients, reduced PPI compliance, risk of legal challenge and damage to NHS and ICB reputation.*

   This new risk is scored at a high 12 (probability 3 x impact 4) and was approved by the Public Partnership Committee at the meeting held on 30th April 2024.

CLOSED RISKS

One risk is recommended to be closed:

1. 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.*

   Following the restructure the EPRR team is now fully established, a number of processes are now in place also to support EPRR delivery across the ICB. As such, it is therefore recommended that this risk is now closed.

   The proposed closure of this risk was approved by the Audit and Governance Committee at the meeting held on 2nd May 2024.

CONCLUSION

The Board are requested to:

- **RECEIVE** and **NOTE:**
  - the Risk Register Report;
  - Appendix 2, as a reflection of the risks facing the organisation as at 30th April 2024;
  - Appendix 3, which summarises the movement of all risks in April 2024; and

- **APPROVE** the **CLOSURE** of risk 05 relating to Emergency Preparedness, Resilience and Response (EPRR).

Appendix 2 - Derby and Derbyshire ICB Risk Register - as at April 2024

NHS
Derby and Derbyshire
Integrated Care Board

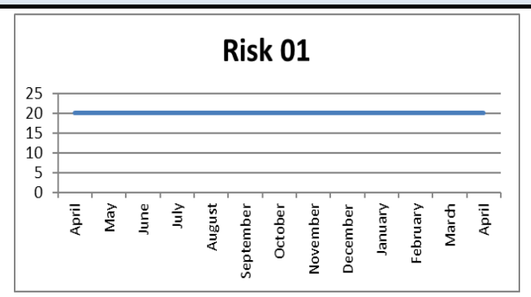
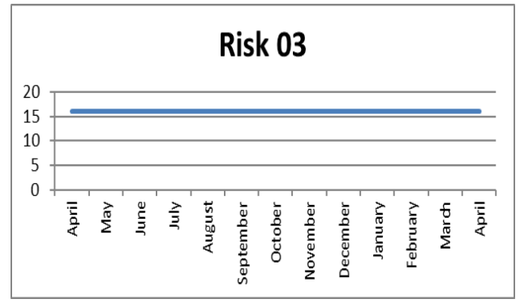
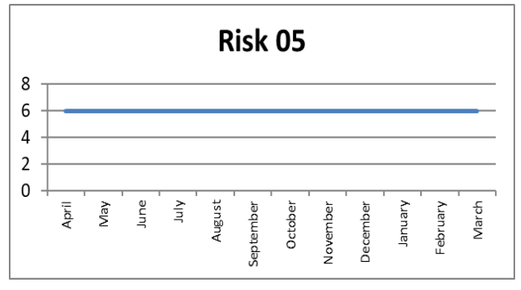
Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating			Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)
					Probability	Impact	Rating		
01	24/25	The Acute providers may not meet the new target in respect of 78% of patients being seen, treated, admitted or discharged from the Emergency Department within 4 hours by March 2024, resulting in the failure to meet the ICB constitutional standards and quality statutory duties, taking into account the clinical impact on patients and the clinical mitigations in place where long waits result.	System Quality Group	Constitutional Standards/ Quality	3	4	12	- 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 reviewed at each board meeting focusing on key standards such as the ED performance, C2 Performance, Ambulance Handovers, VW Utilisation etc. The report is a being further developed to allow the group to focus on trends and areas of improvement. This will provide greater scrutiny of performance areas of concern to be highlighted and acted upon accordingly - The System Operational Coordination centre (OCC) was established on 1st December 2022, operation 7/7 8am-6pm with on-call cover to support out of hours. The updated Minimal Viable product for the OCC was released by NHSE on 18/07/2023 and is currently being reviewed and actioned by the UEC team. The OCC have established daily system calls to check in with the system every morning at 9.30 this includes getting an operational update from each provider and raise any concerns and/or issues. When the system and/or a provider is in a state of escalation an update is shared with UEC leads, execs and on-call directors. - 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. - Shrewd has been deployed across the system and offers realtime oversight of the UEC system using real time data. Data quality is still being worked through but the aim is for Shrewd to offer a real time view of system pressures, enable the OCC to identify trends and support system reporting. - All providers across the Derbyshire Health and Social Care System participate in the System Tactical Group (silver command/tactical) and System Strategic Calls (gold command/strategic). These meetings are stood up by exception only. The purpose of this silver command level group is to co-ordinate and deliver the actions necessary to respond to significant issues which are affecting, or likely to affect, the functioning of an effective operation at a intra and inter sector level across the Health and Social Care System. This group reports into the System Escalation Group (SEC) which represents Gold Command. - ECIST have visited both UHDB sites, the team are working through the recommendations - 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 - NHSE colleagues visited CRH in November to conduct a peer review on their processes and pathways. Awaiting the report from NHSE - Non Elective Improvement Group reinstated at RDH, this forum reviews the performance and trajectories internally and also focuses on alternative pathways to improve the ED position. - Ambulance Handover Improvement Group (UHDB/EMAS/ICB) is in place weekly to review handover data trends, review pathways/processes and alternative pathways to ED such as direct to UTC/SDEC. This will support reducing the demand on our emergency departments. The direct to UTC pathway has been signed off and went live on 19/02/2024. CRH: 1. Discussions are ongoing with system partners with regards to increasing the discharge flow for patients who no longer have the right to reside, with a specific focus on P1 delays 2. The Executive Team (Medical Director, Chief Nurse & Chief Operating Officer) are having further discussions with the ED Senior Team to support Ambulatory Flow, with agreed key actions 3. Focused work continues to maximise capacity within SDEC, Frailty and co-located UTC, this is expected to reduce presentations to ED and increase flow within the department by fast tracking patients to these locations. UHDB: 1. Dailly data Breach validation process - currently saving c. 18 breaches / day. 2. Development and consistent operation and staffing of co-lo UTC on the QHB site launch 3/3. 3. Senior Decision maker / GP streamer in ED. Avoid ED disposition and see and treat wherever possible - current saving c. 5-15 breaches / day	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. The Derby & Derbyshire Clinical Navigation Hub (CNH) / Single Point of Access (SPoA) will be live from 20th November following on from the one year pilot which started 1 December 2022. - Improving ambulance handover times through increased senior ownership within EDs and applying Releasing Time To Care principles in EMAS. - The HALO role is no longer in place due to the post holder moving on to a new opportunity. Alternative options are being explored to support ambulance handover times. - Taking a system-wide approach to Same Day Emergency Care working to increase same-day discharges to improve patient flow. - Same day emergency care (SDEC) and urgent treatment centre (UTC) pathways have been developed and continue to increase for EMAS to access, in order to reduce the number of patients directed to ED. Discussions have started through Team Up on SDEC flow to community services to avoid inappropriate admissions through. - The OCC regularly review the OPEL dashboard to support their operational discussion and to give a full picture on their operational resilience, which supports the system to understand where the pressures are, the impact this has and actions required to support. The new Opel framework reporting is now in place, both acutes are working on data accuracy of the metrics with the support of the UEC and OCC team (on track). - Daily regional 10am calls continue as Operational Coordination Centre (OOC) and Regional Control Centre (RCC) calls. - As a result of the SORG refresh work, the weekly SORG meetings have been stood down and will be stood up when required going forward (process for escalation has been agreed and shared). A new specification for the OCC has been released by NHSE and is being worked through currently. Part of this will be improving reporting by implementing a smart system which is currently be explored by the UEC and OCC team. The OCC have re-established the daily check in calls with system partners to support managing the day to day operations, improve system working and relationships. A highlight report is being developed alongside BI and performance colleagues as an output of this meeting. - DDCNH+/SPoA went live on 20th November 2023. Wider communications being disseminated across the system. Co-ordinating, monitoring and reporting commenced. - NHS UTC Standards have been published. The ICB is now working with UTC providers to develop a range of KPI's which will monitor UTC performance against these standards. Conversations are ongoing between UEC Team and UTC Providers to ensure that business continuity processes are in place to support the system during times of pressure. - NHS UTC Standards have been published. KPI's for all UTCs have been agreed, and work is ongoing to support the data collection which will monitor UTC performance against these standards. - From 18th March joint face to face working at EMAS Specialist Practitioners Hub in Ripley with CNH+SPoA MDT approach. Right Care First Time for patients, maximise community services and prevent inappropriate conveyancing and attendance at ED. - The CNH is reducing between 900 and 1200 ambulances and ED attends per month being approx. 14,000 ambulances and ED attends per year with capacity to do more. 83.9% of patients through the CNH have found appropriate alternative pathways to ED. Including ongoing increases in Hear, Treat and Discharge to over 13%, 10% received care through community services including UCR, 9% seen by primary care and 58% booked into or referred to UTCs. The CNH continues to contribute to Improvement to CAT 2 response times by reducing CAT 3 and 4 conveyances and contributing to meeting 78% 4-hour target by reducing the number of ED attends as well as maximising community services capacity for example Falls Recovery Services. - The ambulance handover group has planned a walk through of the ambulance handover process with EMAS, UHDB and ICB colleagues at RDH to identify improvements/efficiencies within the pathway.
03	24/25	There is a risk to the sustainability of individual GP practices (due to key areas detailed) across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.	Population Health & Strategic Commissioning Committee	Primary Care	5	4	20	Governance processes to enable identification of potential practices requiring support. Development of Primary Care sub-group to fulfil the ICB delegation requirements in relation to Primary Medical care services. CQC and ICB summit/routine meetings to review and provide assurance re: individual practices who are due to or have had a CQC inspection resulting in a rating of requires improvement or special measures. Quality Assurance programme including development of data dashboard, triangulation of information, practice highlight report and Quality Assurance / system level framework development. Clinical Governance Leads network for sharing best practice. Primary Care Networks The Primary Care Networks will provide a way that practices can support each other in smaller groups and deliver services at scale. Over time this will provide a safe forum for practices to seek help from peers and another route for help for struggling practices. Primary Care Assurance and Delivery Board Establishment of Primary Care Assurance and Delivery Board to oversee the delivery of the Primary Care Transformation programme inclusive of estates, IT, workforce - additional roles, access. General Practice Provider Board Establishment of General Practice Provider Board to support a single, unified, appropriate representative and learned Derbyshire GP voice into the Integrated Care System.	Workforce: Increasing numbers of GP's choosing salaried or locum roles rather partnership due to the additional workload and responsibilities expected. Changing population health needs: Growing population generally, as well as increasing number living over 65 with multiple complex medical conditions combined with changing public expectations around immediacy of service provision. Access: the ICB is supporting the General Practice Improvement Programme and Modernising General Practice Programmes. GPIP has an intermediate and intensive programme supported by the System Level Framework (internal quality assurance plan) ICB representative on the Midlands Region Primary Care (Access) Board. Patient expectations and the impact of modernising general practice may have a negative impact on practice stability. Estates: Development of a System Estates forum. Inadequate estates (esp. PCN), The expansion of ARRs roles is causing significant pressure on general practice estate with many practices / PCNs unable to house the number of staff employed. Information Technology: Transition funding is available to support the move to Modern General Practice Access Model (MGPAM). As per the National delivery plan for recovering access to primary care MGPAM has 3 components: Better digital telephony, Simpler online requests, Faster navigation, assessment and response Cloud Based Telephony Systems - 33 practices within DDICB have been identified as having analogue telephony systems in place ,NHSE/I funding to move to CBT to support patient access (15 practices agreed to upgrade to Cloud Based Telephony, 4 practices declined to upgrade, 11 practices had already upgraded to Cloud Based Telephony and 3 practices missed deadline) Integration in general practice and system partners to use data consistently and constructively to help practices and the system understand patient need/behaviours and system response. Winter Resilience: ICB are implementing a process where PCN's are able to challenge their achievements which is in line with the commitment from the ICB to ensure that PCN income is maintained as a result of the support provided to the system during the challenging winter period, the ICB will aim to jointly understand and agree the position with the PCN. Practices ability to support winter system pressures. Cloud Based Telephony Systems – 15 practices within DDICB were included in phase 1 for CBT funding due to analogue telephony systems being in place. All 15 practices have signed new contracts with suppliers approved on the Better Purchasing Framework and are in the process of installing their new CBT systems. NHSE have asked that all installations for Phase 1 practices be completed by 25th March 2024. 29 practices were included in Phase 2 Cohort B for CBT funding. All 29 practices have now signed new contracts with suppliers approved on the Better Purchasing Framework.
05	24/25	If the ICB does not sufficiently resource EPRR and Business Continuity functions and strengthen emergency preparedness policies and processes it will be unable to effectively act as a Category 1 responder which may lead to an ineffective response to local and national pressures.	Audit and Governance Committee	Corporate	4	4	16	• ICB active in Local Health Resilience Partnership (LHRP) and relevant sub groups • On-call staff are required to receive Met Office Weather Alerts. These will be cascaded to relevant teams who manage vulnerable groups • Executive attendance at multi agency exercises. • Internal Audits have evaluated Business Continuity preparedness. • Derbyshire-wide Incident Plan in existence • Joint Emergency Services Interoperability Protocol (JESIP) training made available to on-call staff • Staff member trained in Business Continuity and member of professional body • Staff member competent to train Loggists internally and there are sufficient number now trained • Derby and Derbyshire ICB represented on LHRP and LRF sub-groups including, HEPOG, Training and Exercising sub-group. Risk Assessment Working Group, LRF Tactical, Human Aspects and Derbyshire Health Protection Response Group. • On-call rota being revised to introduce two tier system with improved resilience • Comprehensive training undertaken for On-call staff to National Standards	• The On Call Forum has met regularly and has provided an opportunity to share experience and knowledge •The former CCG fully participated in the response to the COVID pandemic and submitted evidence to NHSEI as part of the 2020/21 EPRR National Core Standards • Continued collaborative working with Provider organisations and other stakeholders including the LRF and NHSEI Regional teams
06	24/25	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.	Finance, Estates and Digital Committee	Finance	4	4	16	March Update: Actions are continually being taken against the detailed risk log to take smaller actions to mitigate the overriding risk. System strategies surrounding estates and digital plans, sharing risk across the System, and engagement into the ePMO to improve reporting, all play a part. Development of clear governance flows and ownership of transformation programmes have been identified. Assurance of delivery to be reported to PCLB, Place and SFEDC. Multidisciplinary ICS Planning Subgroup ensures full triangulation of plan with clinical input; allowing senior decision making and prioritisation of strategy. The System's liquidity position is considered; this period of financial challenge results in cash risks. A number of mitigating options have been provided including national solutions, enhanced management of working capital and PDC.	April Update: Finance, HR and Operational colleagues to work closer to understand the financial impacts of performance targets on a long-term planning model, alongside a strategy for estates and infrastructure. The need to focus on transformation and improvement going forward, alongside performance management; requiring System data intelligence. The System committed to the use of the ePMO to facilitate the management of ideas, schemes and transformations, which should be reinforced to ensure continued share of ownership. There is an increasing urgency to identify recurrent cost out transformation in order to move closer to financial sustainability.
07	24/25	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.
09	24/25	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
11	24/25	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

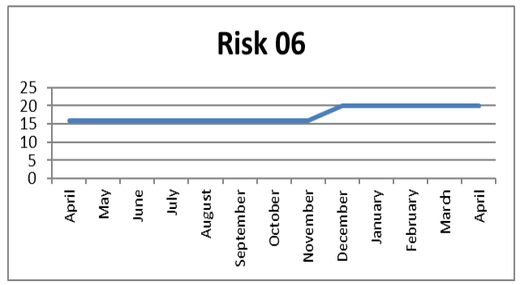
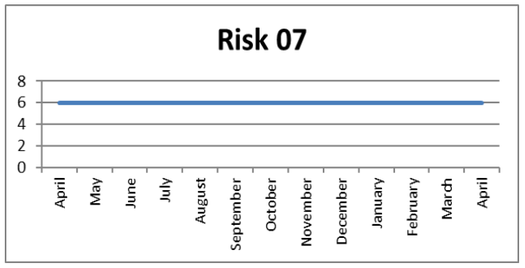
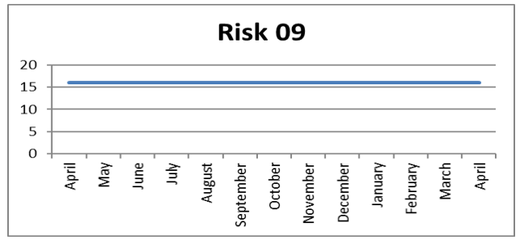
Risk Reference	Progress Update	Previous Rating			Residual/ Current Risk			Target Risk			Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
		Probability	Impact	Rating	Probability	Impact	Rating	Probability	Impact	Rating						
01	March 2024 performance CRH reported 73.2% (YTD 75.9%) and UHDB reported 78.0% (YTD 73.7%). CRH: The Type 1 attendances and Type 3 streamed attendances remain high, with an average of 236 Type 1 and 57 streamed attendances per day. UHDB: The volume of attendances remains high, with Derby seeing an average of 208Type 1 adult attendances per day, 126 children's Type 1s and 148 co-located UTC. At Burton there was an average of 219 Type 1 attendances per day and 10 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 13 Resuscitation patients & 195 Major patients per day and Burton seeing 72 Major/Resus patients per day. On 27 March, NHS England (NHSE) published the 2024/25 priorities and operational planning guidance. The guidance restates the focus on delivering the urgent and emergency care (UEC) recovery plan, focused on improving A&E waits and category 2 ambulance response times. This includes an ask that a minimum of 78% of patients are seen in A&E within 4 hours in March 2025.NHSE will also operate an incentive scheme (with details to be set out separately), rewarding providers with a Type 1 A&E department achieving the greatest level of improvement and/or delivering 80% against the four-hour target by the end of 2024/25. Both acutes are still under performing against the target and fluctuating daily due to high demand, there is currently a focus on the 78% 4 hour target from NHSE and a lot of focused work is being undertaken throughout March with both of our acute sites and other system providers to work to improve our performance.	5	4	20	5	4	20	3	3	9	On going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Apr-25	May-25	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Amy Ward Senior Operational Resilience Manager Dan Merrison Senior Performance & Assurance Manager Jasbir Dosanjh
03	August/September: Primary Care Resilience meeting took place end of July 23 and a meeting is planned for September 23, this is to develop a system plan with a focus on primary care intelligence, core offer and support for practices in crisis. Further work is taking place prior to the September meeting to develop a more advanced quality dashboard to support the early identification of practices who would benefit from additional support. October/November: Resilience meetings in place both looking at supporting individual and system resilience across general practice, Early warning score development progressing and will be discussed within upcoming resilience meeting. General Practice Improvement programme take up improving with a mixture of individual practice and PCN involvement of which completion of the Support Level framework is integral. Winter plan developed using scenario of funding/ no funding and options for both for consideration. December/January: OPEL Scoring and winter resilience meetings in place, representation including ICB, GP Provider Board, Derbyshire Local Medical Committee and links with the GP Task Force (Hub+). Local communication plan in place - Toolkit of national & local resources e.g., graphics, key messages, guides for staff and patients & Media launch led by ICB communications team. Winter funding allocated to operationalise PCN-run Acute Respiratory Infection hubs December 2023 – March 2024. February/March 2024. Continuing winter resilience meetings and support to general practice. Non recurrent funding identified to support 111 cover for Practice QUEST from April 2025. QOF template developed to support practice discussions for 23/24 achievement. Paper to PCSG in March 2024. FFP3 training offer for PCNs agreed and to be communicated to practices during March 2024 with training to commence April 2024. Change in provider of Clinical Waste for all practices in place to commence March 2024 and ensure no gap in provision. Practice resilience forum established with LMC and GPPB to scope approach for 24-25. There is no change to the risk score due to the pressures in general practice, uncertainty around the GP contract and financial pressures as a result of increases in staff costs that are not covered through the national contract uplifts. April 2024: OPEL reporting reduced to once weekly with resilience meetings and support to general practice continuing. QOF template approved at PCSG in March 2024. There is no change to the risk score due to the ongoing pressures in general practice, imposition of national GP contract for 24/25 and financial pressures in staff costs due to increases in the national living wage that are not fully covered through the national contract uplift. A separate risk is being considered to be added relating to the threat of industrial action by GP's during 24/25 due to the imposition of the national GP contract.	4	4	16	4	4	16	4	3	12	On going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Apr-25	May-25	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care
05	November Core Standards Submission has been made to NHS England and approved as partially compliant, workplan has now been formed. Further testing and training planned for 2024. Full EPRR workplan for 2024 being drawn up against key identified EPRR risks. December Continued work is ongoing with EPRR, team is now in place for the completion of the core standards process, workplan continues to be delivered. Training programme confirmed for 2024. Industrial Action again pressuring the EPRR team and completion of tasks. January Awaiting finalisation of ICB Restructure to confirm ICB EPRR Team in place, work continues to be delivered as above albeit hampered by Industrial Action Response. February Awaiting finalisation of ICB Restructure to confirm ICB EPRR Team in place, work continues to be delivered as above albeit hampered by Industrial Action Response, new dates have now been announced for Junior Drs IA that EPRR have been requested to lead on planning and assurance for the system. March/April: Following the restructure the EPRR team is now fully established, a number of processes are now in place also to support EPRR delivery across the ICB, would therefore **recommend that this risk is now closed.**	2	3	6	2	3	6	2	2	4	On going	SR4 SR5 SR6 SR8	Apr-25	May-25	Helen Dillistone - Chief of Staff	Chris Leach Head of EPRR
06	April Update: The 23/24 financial position has delivered a £58.0m, consisting of the £42.3m NHSE stretch target and pressures outside of the System's control (namely IFRS 16 lease asset revaluation, and health care support pay dispute). There are a number of consequences in delivering a deficit position, including financial impact on future years. Estates strategy is to be presented at the next meeting. 24/25 plan is at its final stages, with shared ownership. A focus remains on the identification of improvement and transformation across all partners; governance reviews must follow in the coming weeks. NHS Providers are to commence a peer learning and coaching programme; focusing on productivity to identify opportunities for improvement. Liquidity remains a concern. A number of funding requests were received during 23/24, and a further application has been made for Q1 24/25.	5	4	20	5	4	20	2	3	6	On going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Apr-25	May-25	Keith Griffiths, Chief Financial Officer	Darran Green, Acting Operational Director of Finance Donna Johnson Acting Assistant Chief Finance Officer
07	January - Review of files to transfer to Scarsdale and leavers for storage commenced. February - Review of files to transfer to Scarsdale and leavers for storage continuing. Additional administrative resource identified and planned completion by 31 March 2024. March: Slight delay due to logistical issues. April: Additional support was provided by the Corporate team and the review of staff files to transfer to Scarsdale and leavers for storage has been completed. The current staff files are to be transferred to Scarsdale this week. Leavers files have been boxed and sent for storage. Further scanning work to be carried out.	2	3	6	2	3	6	1	2	2	Jun-24	SR8	Apr-25	May-25	Helen Dillistone - Chief of Staff	James Lunn, Head of People and Organisational Development
09	October update: It should be noted there is significant 'lag' in the submission of information to the ICB in advance of the report submission; on occasion a delay of 2 Quarters. The Providers advise that these delays are due to their internal governance processes. Assurances have been received from all Providers that they have established processes to regularly reassess clinical pathways in alignment with local and national guidelines. DCHS currently holds an Amber rating for this KPI due to the ongoing refinements of their SOPs. Nevertheless, there is an overarching SOP in place for the Trust, and all planned care and specialist services have formulated their draft clinical harm SOP. The development of service specific SOPs is underway, starting with key services, and the plan is to gradually implement them across other services. No moderate or severe harms were reported in Q1 and Q2 across the Derbyshire System. November: The lag continues due to internal governance processes. This will be highlighted in a report to System Quality and Performance Committee in December for additional support. Dec 2023 - Q1 and Q2 report to be shared at Q&P Dec 2023 meeting. There has been significant strides made by our healthcare providers, their adherence to the quality standards and the measures taken to address identified harms and complaints. The report highlights that each provider has been assessed (some previously) and all key performance indicators are either on track or completed, with no indicators as not on track. This demonstrates a commitment to delivering high quality care even during the pressures they face with the increasing numbers of long waits. We are not seeing the amount of harm originally thought and we are assured that the harm processes in place are robust and are being monitored at Provider Board level. To be downgraded to 9 – Probability 3, likelihood 3. *Decrease in risk score approved at System Quality Group on 2nd January 2024, however the decrease in risk score not agreed at ICB Board meeting on 18th January 2024 and risk description needs re-wording.* ICB Board have requested further re-working on the description for this risk. Linking with risk owner to work on this. As February 2024 Quality & Performance Committee is a planned Development Session, at the Quality and Performance Committee to be held on 28th March 2024, there will be further discussions around the risk, description and challenge regarding the risk score. In light of the risk re-wording requirement and ICB Board not approving the decrease in risk score, the risk score will remain at a very high score of 16 until these issues are resolved. April - At the Quality and Performance Committee meeting held on 28th March 2024, the Chair and Committee members asked for a further paper to be to be submitted to the May Quality & Performance Committee meeting outlining further detailed evidence to support the recommendation to decrease the risk score.	4	4	16	4	4	16	3	2	6	TBC	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Apr-25	May-25	Prof Dean Howells Chief Nursing Officer	Letitia Harris Assistant Director of Clinical Quality Lisa Falconer Head of Clinical Quality (Acute)
11	Quarter 3 - Highlight Reports are being collated in readiness for reporting to NHSE SRO Review Meeting with NHSE take place quarterly, next meeting is scheduled for January 2024. Derby and Derbyshire ICB implemented the Net Zero mandatory training on ESR to all ICB staff on 1st October 2023. 20% of staff have now completed the training and there will be a communication to increase this number in December, uptake continues to be monitored by the central ESR team Travel and transport Survey – intention is to run the survey in the next 12 months Joint working with Local Authority – ICB are members of and work together on the Air Quality Group – links to ICB wellbeing strategy Green Maturity Matrix Self Assessment completed, deadline for completion 8 January 2024. 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. February: The Derbyshire ICS Green Plan is supported by the Green Action Plan which details the key priorities and actions for 2023/24. The ICS is making good progress in the achievement of the zero targets and as part of the NHSE Greener NHS Maturity self assessment, has been assessed as a Tier 3, maturing organisation. Although we have received this level of assurance, the ICS is still required to deliver a further 50% achievement of 2023/24 priorities. Delivery of this will continue into 2024/25 and beyond. Therefore, we consider the risk score of a high 9 to be appropriate and realistic. March: No change. April: Travel and transport Survey – intention is to run the survey in Quarter 1 24/25.3 The Derbyshire ICS Green Plan is supported by the Green Action Plan which details the key priorities and actions for 2023/24. The ICS is making good progress in the achievement of the zero targets and as part of the NHSE Greener NHS Maturity self assessment, has been assessed as Tier 3, a maturing organisation. Although we have received this level of assurance, the ICS is still required to deliver a further 50% achievement of 2023/24 priorities. Delivery of this will continue into 2024/25 and beyond. The risk score of a high 9 is currently appropriate and realistic.	3	3	9	3	3	9	3	2	6	Mar-25	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Apr-25	May-25	Helen Dillistone - Chief of Staff	Suzanne Pickering Head of Governance

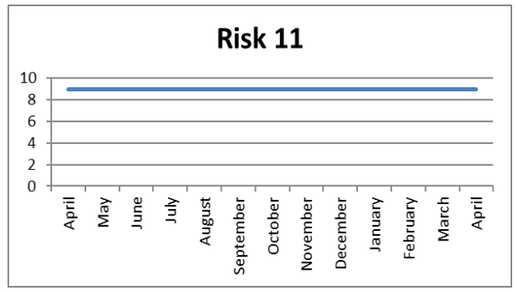
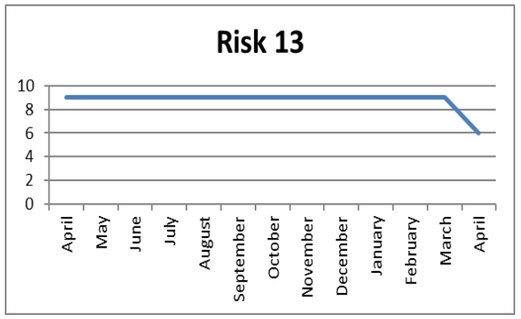
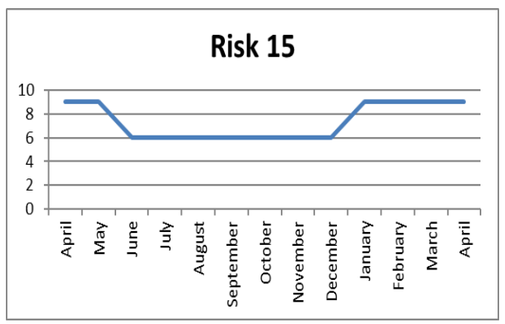
Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or 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	24/25	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 Partnership Committee	Corporate	4	4	16	• Detailed work programme for the engagement team • Clearly allocated portfolio leads across team to share programmes * Assessment of transformation programmes in ePMO system underway to quantify engagement workload. January: Ongoing assessment of ePMO programmes nearing conclusion. January: System comms leads have agreed distributed leadership approach to assessing work programmes within delivery boards and other system groups. Mapping to take place January & February, with review session planned for 2 March. September: Team has agreed portfolios and business partner arrangements to help horizon scan and plan for future work.	•Implementation of planning tool to track and monitor required activity, outputs and capacity •Links with e-PMO to embed PPI assessment and EIA processes into programme gateways •Distributed leadership across system communications professionals being implemented to understand delivery board and enabler requirements •Establishment of workstream approach to main programme areas to take place July/August 2022 to ensure prioritisation of projects is clear across system.	•Wrike planning tool in training phase (31.5.22); implementation during July/August 2022 •Agreement (8.6.22) on positioning of PPI assessment and EIA tools within e-PMO gateway processes, for implementation July 2022. Access to system granted to engagement team; training on system and assessment of activity to start August 2022. •Distributed leadership agreement among system communications group; paper to System Leadership Team (8.7.22) to confirm arrangements and flag risks deferred to future meeting. PPI Guide agreed at Engagement Committee, Senior Leadership Team and presented at Team Talk - will be developed into training programme with the aim of standardising the approach to engagement progression and equipping project teams to progress their own schemes with technical expertise provided from the engagement team. Revision and refresh of Communications and Engagement Team portfolios and priorities undertaken July 2022. July/August 23: Ongoing assessment of priorities, in line with newly emerging 5-year plan and IC strategy. Ongoing anticipation of ICB structure outcomes to seek to stabilise team and confirm roles. Temporary appointments within the engagement team risk adding to the capacity challenge, with ongoing instability due to delays with the ICB structures development. There is a risk of loss of staff in the autumn/winter 2023 period which will compound the capacity risk. Similarly, vacancies arising within the Communications Team cannot be advertised whilst the ICB structure discussions continue, further compounding capacity risk. The combination may result in the need to increase the score of this risk. February: Staff structures approved. Head of Communications position appointed to, start date mid-April 2024. Temporary appointments within the engagement team remain, awaiting understanding of final destination of existing, substantive post holders. Temporary mitigations in place until 31 March. March: Approval in place to substantively appoint to two engagement team roles currently occupied on temporary basis. Further post subject to expression of interest process for separate position. Campaigns Manager post appointed to permanently; remaining team vacancies processed as part of ICB restructure HR framework. Risk score proposed to be decreased. This is because we are not progressing through the restructure and posts within the team are being appointed to. Therefore the likelihood is reduced, but the impact remains the same until the restructure is complete. April: Appointments being made to Communications and Engagement Team posts following restructure, now nearing completion. Experienced member of engagement staff returned from external secondment. New Head of Communications commences 7/5/24 and already onboarding into ICB team and business.	3	3	9	2	3	6	2	2	4	Jun-24	SR3 SR4 SR5 SR6 SR8 SR9	Apr-25	May-25	Helen Dillistone - Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement
15	24/25	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.	January - Delegation agreement between NHSE and ICBs, Collaboration Agreement between ICBs, and Operating Framework documents all currently in draft and awaiting final versions for signature. Meeting scheduled for early Feb between ICB and NHSE Senior Programme Director to better understand exactly what will come to the hosting ICB for management, and what the responsibilities of the remaining ICBs will be. Risk score increased slightly due to the complexity of services transferring and the lack of clarity as to the operational model February - The delegated functions to be transferred from 1 April 24 are 57 of the Specialised Commissioning services. For the first year, the operational team working in this area will continue to be hosted and managed by NHSE, with staff transferring from 1 April 2025. Current work is focussed on the formal documentation required prior to 1 April 2024, namely the Delegation Agreement, the Collaboration Agreement and the Standard Operating Framework, all of which are going through final drafts prior to being issued to ICBs at the end of February for sign off. Governance will be via a Joint Committee. As much of the detail as to how this will work operationally and it is not yet clear what the individual responsibilities of ICBs will be, the score is appropriate at a 9. March/April: The ICB Board was requested at its March meeting to approve formal signature of the delegation documentation; the Board were advised that this was with the caveat that further work was required between NHSE and ICBs to be clear on the operating model and quality and finance risk management. The risk score cannot be decreased until this work is complete and impacts on ICB resources are clarified.	3	3	9	3	3	9	2	2	4	Apr-24	SR4 SR5 SR7 SR9	Apr-25	May-25	Helen Dillistone - Chief of Staff	Chrissy Tucker - Director of Corporate Delivery
16	24/25	With the review of ICB structures there is risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.	Audit and Governance Committee	Corporate	4	3	12	Regular communication with staff. Sharing information with staff as soon as this became available. Continuation of regular 1 to 1 wellbeing checks. Compliance with Organisation Change & Redundancy Policy.	No significant change in sickness absence.	January: The formal collective consultation period ended on 7th January 2024. A significant amount of feedback has been received by ICB colleagues and this has been considered by Executive Team when making their final decisions, which will be presented to the Remuneration Committee on 26th January 2024. An all staff briefing has been arranged for 8th February 2024 with any individual 'heads up' meeting taking place beforehand. ICB colleagues receive regular updates via Team Talk and the weekly staff bulletin. HR team continue to promote wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider. Sickness absence levels increased in December to 3.4% (last year for December = 3.6%). February: All staff close of consultation briefing held on 8th February 2024, Following this structures and job descriptions published and individual letters confirming position sent. ICB to commence filling posts in the new structure with priority status for colleagues 'at risk' of redundancy. HR team to support individual 'at risk' to find suitable alternative employment within the ICB and wider NHS. HR team continue to promote wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider. Sickness absence levels reduced slightly in January to 3.3% (last year for January = 3.32%). April: The appeals have now largely been completed and we are supporting the staff who are 'at risk' of redundancy or have selection or other processes the risk has largely been mitigated. As such, the recommendation is that the risk score is decreased from probability 4 x impact 3 to probability 2 x impact 3 with a view to closing the risk in a further 1 or 2 months if the staffing position remains stable.	4	3	12	2	3	6	3	2	6	Jun-24	SR4 SR5 SR6	Apr-25	May-25	Linda Garnett Interim ICB Chief People Officer	James Lunn, Head of People and Organisational Development
17	24/25	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 Partnership Committee	Corporate	4	3	12	The system has an agreed Communications & Engagement Strategy which continues to be implemented. This includes actions supporting broadening our communications reach across stakeholders, understanding current and future desired relationships and ensuring we are reaching deeper into the ICB and components parts to understand priorities and opportunities for involvement. The Public Partnership Committee is now established and is identifying its role in assurance of softer community and stakeholder engagement. Communications and Engagement Team leaders are linked with the emerging system strategic approach, including the development of place alliances, seeking to understand the relationships and deliver an improved narrative of progress. April: Engagement approach in IC Strategy underway with sessions during May. JFP engagement and stakeholder management approach now in development. August: JFP engagement approach remains in development.	*- Continued and accelerated implementation of the Communications and Engagement Strategy actions plan priorities across stakeholder management, digital, media, internal communications and public involvement. *- Continued formation of the remit of the Public Partnership Committee *- Key role for C&E Team to play in ICB OD programme *- Continued links with IC Strategy development programme *- Continued links with Place Alliances to understand and communicate priorities	June: Briefing to City HOSC secured; progression on stakeholder management database; CEO MP briefings to recommence summer 2023. Ongoing engagement planning to support IC Strategy and NHS JFP. July/August: JFP published; engagement approach in development with aim to commence foundation discussions on change with wider stakeholder groups in autumn. Place Alliance communications and engagement approach progressing with case study development. Engagement frameworks development progressing, most notably insight framework pilots to inform change programme and strengthen decision-making. January: Continuing to seek to align engagement approach with 24/25 planning. Update paper to January PPC meeting. Also requirement to refresh JFP as set out in statute; will require review of associated engagement activity. February: Continuing to seek alignment to 24/25 and priority setting. March: Linked to 24/25 planning and priority setting processes. JFP refresh deadline extended to 30.6.24. Risk rating remains the same as we await progress with ICB and team programmes. April: Ongoing connection to 24/25 planning processes, including Board. Public information and engagement programme being developed to set out 23/24 closing and 24/25 opening positions to broaden awareness and involvement in current programme requirements. For agreement by NHS Executive Team in May 2024.	4	3	12	4	3	12	3	2	6	Jun-24	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Apr-25	May-25	Helen Dillistone - Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement
19	24/25	Failure to deliver a timely response to patients due to excessive handover delays and transfer of patients to the appropriate care setting from Acute Hospitals. Risk of leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential significant levels of harm.	System Quality Group	Clinical	5	5	25	Discharge 1. ASCDF funded home care through CHS till end oct 23, plan to continue at current level till Feb 24 for discharge and flow support 2. DCHS led CRT providing reablement care for P1, increased investment through ASCDF to increase provision 2. P1 Strategy to be finalised Oct 23 3. Transport : Clinical Nav ensuring transport to community bedded care is booked to reduce incomplete discharges out and lost bed days in community beds, started CRH to be rolled out across all wards and to UHDB 4. Community Health Therapists working closely with County Adult Care and Community Response Teams to ensure P1 clients have clear goals and a planned date of discharge. This will help reduce the intensity and duration of care packages thus freeing up capacity 5. ASCDF funding VCSE 'home and settle from hospital' scheme to transport and support P0 discharges home plus county schemes coming on line in Oct / Nov : will reduce delays for P0/P1 patients awaiting discharge and reduce readmission rates as patients supported once discharged. 6. County ASC transformation to provide increased and improved P1 capacity. Launch date Jan 24 7. ASCDF funding staff to improve discharges out of CRH and UHDB, focus on weekend discharges 8. Care transfer hub process improvement work 9. OPTICA to provide IT solution for discharge planning identifying delays and supporting with prioritisation of tasks (aim to reduce duplication and better decision making) 10. Integration in City of health and social care delivery to one reablement model of care 11. ASCD to mental health to improve flow through MH beds to enable increased capacity 12. CRH and UHDB focused work on ward processes to improve flow. Roll out of UHDB strength based approach to discharge (started ward 311) 13. Jan 24 work launched to deliver a care transfer Hub in Derbyshire, this work will start from Feb 24 to define the vision and approach as well as identify staffing and outcomes 14 Project of work to deliver a true 'trusted assessor' way of working. Requires changes to training and ways of working with agreed framework from health and social care UEC interventions 1. SEC and SORG interventions. 2. Overview of HHO delays and robust scrutiny of progress to delivery improvement trajectories. 3. Performance management of workforce and abstraction rates to ensure necessary resources are in place to respond to demand 4. Implementation of EMAS Hospital Handover Harm Prevention Tool at Acute Trusts. 5. Ongoing work in commissioning Same Day Emergency Care and direct access to specialties such as surgery, gynaecology and urology and community providers implementing urgent two-hour community response to suitable patients, thereby increasing the number of patients who can be safely treated in their own homes. 6. Regular monitoring of Actions and risk by CQRG. 7. Local system governance structures to manage difficult decisions: Derbyshire System pressures quality review panel. Decisions and discussions held at SORG. 8. HALO - recruited to support both Acutes and crews with handover delays, directing appropriate patients to SDEC, supporting pinning off etc	Discharge 1. accept discharge to assess is a joint responsibility of health AND social care to deliver 2. Accept discharge out of P2 beds will have parity of impact with acutes as will create flow (25% P2b beds have patients in delay) 3. Reduce the number of handoffs within our pathways and improve faster access to pathways through joint improvement work 4. Accept OPTICA will lead to improved transparency of system delays and enable prioritisation of patient needs for discharge. All system partners to support embedding of tool 5. accept largest gain is in providing more pathway 1 access to support discharge flow, avoid use of temporary beds to place patients into who are in delay and acknowledge this leads to poor outcomes for patients and higher costs for the system 6. Accept there is limited care home capacity to accept needs of patients who have complex needs, where these are sought for discharge there will likely be delays to source 7. Reduce the delays caused by patients awaiting discharge letters / meds for discharge. 8. reduce the number of patients being discharged after midday and increase early morning discharges, this is achieved through improved discharge planning and decision making and access to transport 9. Accept decisions regarding discharge need to be made as a system with no one provider making unilateral changes to delivery without consulting with others through governance route of SDG 9. accept that process work around care transfer hubs requires transformation support of the system to enable true change to occur 10. transfer the learning from ward 311 strength based approach to UHDB so learnings can be used by the wider hospital 11. Provide assurance that ASCDF is delivering additional discharge capacity to the system through monitoring of impact and outcomes 12 accept there is a large decrease in weekend discharges due to reduced weekend staffing on wards and some providers. Unless there is significant investment in workforce across wards and community this will continue 13 accept there is a large opportunity to focus on P0 discharges which are 90+% of all flow which will likely not be supported by the care transfer hubs. UEC System actions to reduce hospital handover delays. System urgent care improvement action plans. ECIST - will be visiting the RDH site and providing recommendations and supporting the trust to improve their Type 1 performance, handover delays and reduce their bed occupancy levels Work ongoing to develop a memorandum of understanding (MOU) which sets out the commitment between ICB, Acute Providers, NHSE and Ambulance Trusts to support ambulance crews ending their shift on time, when in attendance at busy emergency departments with ambulance handover delays. Recruited 1 x HALO, start date to be agreed.	Sept 23 : Identification of P1 gap of approx. 49 discharges per week if CHS care ends in Nov, paper to execs to approve extension of CHS until ASC transformation is embedded (Feb 24), POG development support and agreement of system flow meeting, twice weekly, with all system partners to unblock flow from all providers. TOR agreed and to be shared with SDG. Require system support to facilitate this shift in meetings to outcomes, challenge and delegated decision making. Care transfer hub work to commence Oct 23 at CRH, request transformation support into these meetings Oct/Nov 23 : extension of home care provision to support discharge out of RDH and UHDB, contract negotiations due to start Nov. Connex VCSE launched supporting 10 discharges per week into high peak Dec: There is no update at this time due to managing system pressures. Jan : P1 transformation in county commenced, this will deliver more capacity and strength based reviews for pathway 1. Daily flow meetings in place with CHS /CRT/county LA to look at demand and capacity. PDSA review held at UHDB to review discharge process and capture learning and improvement. More sessions planned in January. Workshop on Care transfer hubs held Jan 24 with system stakeholders to describe the shift in delivery and scope out next steps. Workshop on 'trusted assessor' held Jan 16 to outline process to move to truely trusted model of delivery. Recruitment to CRT (DCHS led team delivering P1 capacity) successful and onboarding of new staff starting from Jan to deliver more P1 capacity and enable flow. Oct 23 ASCDF funded additional patient transport vehicles to support with discharge and patient flow. February: Following a recent discussion at the Strategic Discharge Group in relation to the Corporate Risk Register and this risk, a small Working Group has been established to develop the wording, mitigations, risks score, etc. to reflect the current issues/risks. Work is currently being carried out to finalise the wording for this risk and at the next Strategic Discharge Group planned for 8th March, the revised wording will be discussed. March/April: The risk description for this risk will be revised following agreement on a new, proposed discharge risk. This is being discussed at the Strategic Discharge Group planned for 26.04.24. Risk 19 currently relates to excessive handover delays and the transfer of patients to the appropriate care setting from Acute Hospitals. With the risk of significant response times for patients whilst waiting in the community. A number of mitigations include work being undertaken by the Strategic Discharge Group to improve the flow out of hospitals. Due to the recognised pressures and delays of hospital discharges through several factors, there has been a request to separate and develop a new risk from Risk 19 to ensure that ongoing discharge work is captured as its own risk with ownership from system partners.	5	4	20	5	4	20	2	5	10	TBC	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Apr-25	May-25	Dr Chris Weiner Chief Medical Officer	Jo Warburton Dan Webster
20	24/25	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.	20/09/23 - There are no planned reductions in the use of contingency hotels in the city or the county. Concerns also regarding the number of unaccompanied asylum seeking children arriving in the city and county. October/November: No plans to reduce the number of contingency hotels within the city or county - therefore no change in risk 17/12/23 there is no planned reduction in the use or the number of contingency hotels at this point in Derby or Derbyshire - therefore there is no change in the risk. 16/1/24 update there is no planned reduction in the use or the number of contingency hotels at this point in Derby or Derbyshire - therefore there is no change in the risk. 12/02/24 - The Home Office/ and Serco has now closed two of the 7 hotels - one in the city and one in the county and they are looking to close the other hotels but no timeframe at this stage. This is a positive move of change. The risk remains for the residents in relation to the other hotels and the residents living in a hotel setting for a lengthy period of time and impact on services still remains an issue. Therefore, no change to the risk score. 19/03/24 There have been no further hotel closures since the last update - and we have had some concerns raised by the Police which has led to meetings with the Home Office and Serco and local partners to ensure relevant support is in place for the residents. 18/4/24 In total there have been two hotels that have been closed - one in the city and one in the county. In July the Home office and Serco intend to close another hotel in the county - this will leave a total of 4 contingency hotels open in the city and the county. Until this point the concerns are ongoing for the remaining settings.	4	4	16	4	4	16	3	3	9	July 2024	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Apr-25	May-25	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children
21	24/25	There is a risk that contractors may not be able to fulfil their obligations in the current financial climate. The ICB may then have to find alternative providers, in some cases at short notice, which may have significant financial impact.	Finance, Estates and Digital Committee	Finance	4	4	16	Understand financial pressures facing our providers. Maintain Contract Database Proactive Procurement November: Work with colleagues in the ICB and wider GP community to pick up early warning signs for practices at risk of handing in their contracts and, if it does happen, work rapidly with the same group to intervene and secure cover.	Contractors will at short notice inform the ICB that they can no longer fulfil their contractual obligations. This risk should cover a wide range of contracts from the supply of health care (General Medical practitioners and Individual care packages) to the supply of goods and services. Maintain a close working relationship with key with providers. Use contract database to understand which contracts are due for renewal and plan well ahead. Work closely with colleagues in A&GEM Procurement team to ensure we are aware of latest information available in the various markets the ICB works in	September/October: The ICB is close to agreeing all contracts perceived to be at risk of inflation/cost of living, the ICB would expect to have been notified or assessed the probability of this occurring. A more robust link between contract expiry and procurement planning has been established. November: A deep dive is scheduled to take place in November to clearly understand the current processes that are in place in respect to expiry of contracts where key decisions need to be made, the output of which is to be reported to the Audit and Governance Committee. December: Deep dive has commenced with further actions to complete which is being overseen via the Governance Team for example exploring software which may aid with maximising efficiencies re: contract lifecycle management. In addition to note that contracts with the 4 NHS JUCD providers still remain unsigned along with out of area NHS provider contracts where DDICB is an associate. January/February 2024: process set up to identify and intervene with GP practices at risk of handing in contracts. Group established co-ordinated by GP Provider Board and supported by the ICB Primary Care / Quality Team March/April: From a General Practice perspective the ICB expects the risk of practice failure to remain unchanged. The ICB is currently working with a small number of practices on their future plans to ensure their ongoing sustainability. Fortunately we have not experienced any GP practice closures recently, however this has happened in other areas and remains a potential risk in Derbyshire. With the recent publication of the GP contract for 2024/25 the ICB will continue to work with GP practices to ensure their continued stability. From a dental perspective we have experienced dental practices handing back their NHS contracts in the recent past and it remains a real risk in the future. However we are working to implement the new dental recovery plan which we hope will have a positive impact in this area, and we will update the register when plans are complete.	3	4	12	3	4	12	2	3	6	Ongoing	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Apr-25	May-25	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Craig Cook Director of Acute Commissioning, Performance and Contracting & Clive Newman Director of Primary Care
22	24/25	National funding for the 23/24 pay award and 22/23 one off payments excluded all staff who were not on NHS payrolls. Consequently staff employed by DHU, NHS subsidiary bodies, in PFI arrangements and Primary care were not eligible. Consequently there is a an increasing risk of legal challenge as well as real, emerging loss of morale for over 4500 staff across the Derbyshire system which could affect recruitment and retention of critical frontline colleagues.	Finance, Estates and Digital Committee	Finance	5	5	25	The only mitigation rests with Treasury as the funds required to equalise pay across the system have not been made available to the NHS nationally; it is not just a Derbyshire problem but rather a national one.	As the ICB cannot mitigate against this risk it must be accepted. The organisations which are affected are aware of this decision and the further risk to the health and care system is that staff may be demotivated, feel undervalued, feel that they are being treated unfairly and may leave the organisations, therefore increasing the risk of inadequate workforce in Derbyshire to support our patients.	Feb/March: Individual organisations were now able to apply for payments. It is uncertain whether the applications, if successful, would cover all the nuances in the shortfall in the pay awards, but it would cover some of them. System Finance, Estates and Digital Committee agreed to decrease the score of this risk to 4 x 4 on the matrix. We have now received some requests for information from the national team as several organisations who provide services to the System have appealed for this funding. April: Recommendation to roll this risk over into 2024/25	4	4	16	4	4	16				Sept/Nov 2024	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Apr-25	May-25	Keith Griffiths, Chief Financial Officer	Keith Griffiths / Darran Green
23	24/25	There is a risk to Joined Up Care Derbyshire (JUCD) performance against the Cancer Standards, including 28 Day Faster Diagnosis Standard, 62 Day Waits and 104+ days due to an increase in referrals from Staffordshire into UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment. Revised Risk Description: There is an ongoing risk to performance against the cancer standards due to an increase in referrals into UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.	System Quality Group	Clinical	4	4	16	The change in referral over last 18mth a result of a range of factors - including Staffs practices focusing on early cancer diagnosis, changes in how services are configured/offered across west midlands and increased use of Tamworth/Lichfield all of which influence patient/GP choice of providers. UHDB in tier 1 for cancer performance so plans being managed through national oversight to develop recovery action plans.	•Recruitment to range of posts funded through EMCA to support recovery. •Prioritisation of Best Practice timed pathways across key tumour sites – LGI, Urology, Skin and Gynae •Development of UHDB tumour site recovery action plans (with support from NHSEI IST team) due – Oct-23 •Development of referral triage functions: Gynae, LGI and Urology •Work underway to understand drivers for variance in Histology TAT at tumour site level. •Work going to enhance access to PET scanning (Longer term ambition to develop PET service within Derbyshire) •Oncology challenges supported through regional alliance support – longer term workforce development	December - Turnaround lead in place at UHDB to deliver recovery programme (managed through ICB chaired Elective and Cancer Recovery Group) January - Turnaround lead in place at UHDB to deliver recovery programme (managed through ICB chaired Elective and Cancer Recovery Group). Work ongoing supported through JUCD Elective and Cancer Recovery weekly calls. No change expected in referrals from Staffordshire. Current focus is how we develop existing services to meet sustained demand on UHDB capacity and work to develop primary care pathways across DDICB and SSICB. February: The risk is currently being reviewed and the risk description will be revised for March reporting. There is a challenge in re-wording the risk description to ensure all aspects are captured that impact the risk and also the specific challenges and cancer recovery plan. March - Turnaround lead continuing to develop and plan productivity actions to support productivity, improved performance and access/outcomes for patients. 2425 planning underway to confirm actions that will support delivery of performance and improved patient outcomes. April - Risk description revised to reflect the wider challenges in terms of capacity to meet the cancer standards, impacts the whole of the County, not only Staffordshire.	4	4	16	4	4	16	2	4	8	Sept/Nov 2024	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Apr-25	May-25	Prof Dean Howells Chief Nursing Officer	Monica McAlindon Head of Cancer

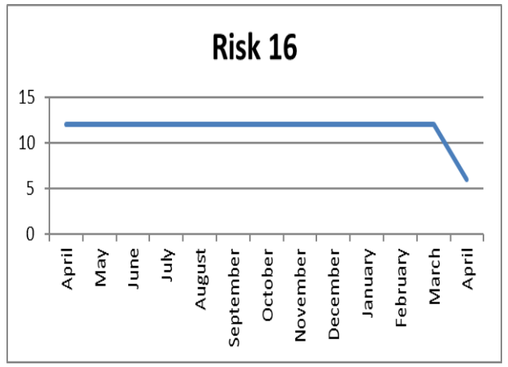
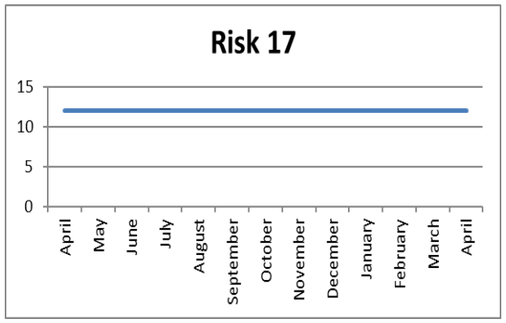
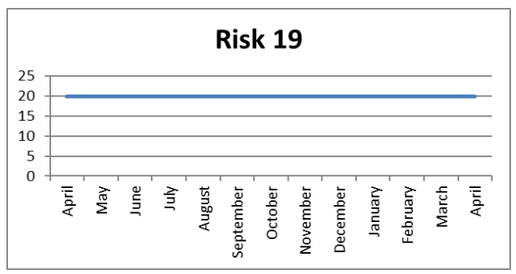
Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating			Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating			Residual/ Current Risk			Target Risk			Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
					Probability	Impact	Rating				Probability	Impact	Rating	Probability	Impact	Rating	Probability	Impact	Rating						
24	24/25	There is a risk that the ICB is non-compliant with the requirement to commission and have in place a Designated Doctor for looked after children as this is a statutory role.	System Quality Group	Clinical	4	3	12	The Designated Doctor for looked after children for Derby City is a statutory role. DDICB are responsible in ensuring that this role is in place. DDICB fund the post via Derbyshire Healthcare Foundation Trust who we commission to provide the Looked after children service for Derby City. The role equates to 1 pa session a week (4 hours a week) If we are inspected in regard to our looked after children's functions, we would need to declare we have this gap- both OFSTED and CQC inspectors expect that these statutory roles are in place and fulfilling their roles and responsibilities. DHCFT are in the process of going out to advert for a number of community paediatricians. One of these roles will have the role of the Designated Doctor for looked after children – Derby City aligned to the role - 1 PA session a week. The DHCFT Clinical Director and Consultant Community Paediatrician on a short-term basis is addressing any issues that arise with the support of the Designated Nurse for looked after children.	If the ICB or the local authority is inspected around its safeguarding /looked after children provision we would be required to inform the regulators that there is a gap and what are mitigations are to cover this vacancy and its functions until its appointed to. •DHCFT are in the process of preparing for the job advert to go out for Community paediatricians – one of which will include the function of the Designated Dr for looked after children – 1 pa session a week. •DHCFT Clinical Director and Consultant Community Paediatrician to keep the ICB updated on recruitment process via the Designated Nurse for Looked after children. •DHCFT looked after children Named Nurse / Manager to also keep the Designated nurse for looked after children updated with any issues that arise that the ICB need to be made aware of.	•Due to the vacancy in this statutory function – this has been added onto the DDICB risk register. •DHCFT who we commission and hold the funds for this post are in the process of preparing for the job advert to go out for Community paediatricians – one of which will include the function of the Designated Dr for looked after children – 1 pa session a week. •DHCFT Clinical Director and Consultant Community Paediatrician to keep the ICB updated on recruitment process via the Designated Nurse for Looked after children. •DHCFT looked after children Named Nurse / Manager to also keep the Designated nurse for looked after children updated with any issues that arise that the ICB need to be made aware of. 16/01/24 update - post remains vacant. interviews took place in early January 24 but applicant not successful, therefore post will need to be readvertised. Post is being covered as an interim by the Clinical director/ Consultant Paediatrician 12/02/24 The post remains vacant - the interviews that took place recently did not lead to a successful appointment- therefore the post has needed to be readvertised. the post is being covered as an interim period by the Clinical Director / Consultant Paediatrician March - No change. 18/04/24 the designated Dr for child death remains vacant but continues to be covered as an interim arrangement. Post is out for advert again - there is no interest at this point.	3	3	9	3	3	9	2	3	6	June 2024	SR3	Apr-25	May-25	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children
25	24/25	There is a risk of significant waiting times for moderate to severe stroke patients for community rehabilitation. This means, patients may have discharges from acute delayed, be seen by non-stroke specialist therapists and require more robust social care intervention.	System Quality Group	Clinical	4	5	20	•Risk matrix in community services is used to triage referrals- this addresses risk and clinical need and is used to prioritise waiting lists •Regular waiting list reviews are conducted in community to ensure patient needs/risk continue to be managed. This is done every 12 weeks to ensure patients are in the right place from a triage decision perspective. •When referral is accepted the service, patients receive condition specific resources which includes signposting to services and wider resource packs. Guidance is given on when to contact services, which is based on the risk matrix. •Staffing resource is redeployed/flexed across the county to manage staffing shortfalls. •Advice clinic has been established to allow non-specialists to bring Stroke and Neuro cases for advice from stroke specialists. •Provider Collaboration Leadership Board (Nov 23) and NHSE (Jan 24) have agreed to provide oversight and assurance to the project.	•Undertake a review of current service provision to better understand the patient level impact of the current service •Explore opportunities alongside the Stroke and Neuro Rehabilitation task and finish group partners for rapid service improvement measures. •Develop business case for enhanced funding to move the service in line with regions best practice. August: The Integrated Stroke Delivery Network have identified recommendations for improvement that relate to commissioning, access, service gaps, low staffing levels, psychology provision and life after stroke.	•A plan for a rehabilitation review has been developed •Key system partners have been engaged at Chesterfield Royal hospital, Royal Derbyshire Hospital, Derbyshire Community Health Service, Derbyshire Mental health Foundation Trust and the Stroke Association. •Work is ongoing to extract service level data from the system to describe the current system challenges •Patient experience leads have developed and implemented a plan to engage patients and carers across Derbyshire to understand their experiences of the stroke rehabilitation pathway •Staff engagement sessions are planned to explore opportunities for service development, integrated working and service efficiency. •A paper outlining current service provision will be presented to the Stroke Delivery Board on the 15th may with recommendations to develop a business case for enhanced Clinical Psychology input and to review VCSE provision alongside the core rehabilitation review. •Commenced the data extraction and patient engagement activity. The priority is to understand in greater detail the impact of current service provision on patients. •Escalated issue to the Stroke Delivery Board Nov- PCLB have agreed to provide oversight and assurance of the project. The task and finish group are working on the Case for Change document to support the engagement process. Dec- Revised project plan agreed by providers. Case for change development is ongoing. Jan: Revised project plan agreed by providers. Case for change development is ongoing expected to be completed by mid Feb. Complex pathway improvement project. NHSE Regional team proving assurance. Pathway development and implementation will not be complete until March 25. Feb/March/April- No update. Case for Change is ongoing and will be completed this month. NHSE requested to review the document.	4	4	16	4	4	16	2	4	8	July 2024	SR1 SR2 SR7 SR8	Apr-25	May-25	Dr Chris Weiner Chief Medical Officer	Scott Webster Head of Strategic Clinical Conditions and Pathways
NEW RISK 27	24/25	As a result of the introduction of the new provider selection regime, existing processes to connect PPI governance into change programmes may weaken. This may result in services not meeting needs of patients, reduced PPI compliance, risk of legal challenge and damage to NHS and ICB reputation.	Primary Care Committee	Clinical	3	4	12	•PPI Assessment Form included in ePMO gateway process. •Establishment of ICB Procurement Group, with C&E Team membership. •C&E staff directly connected to procurement process. •Portfolio/BP relationships with directorates and teams to understand workload.	•Establish and strengthen role within ICB Procurement Group to understand business timetable and contracts register. Understand opportunities for horizon scanning and compliance. •Raise awareness of PPI Governance Guide with ICB Procurement Group membership and other key figures to build capacity to spot, challenge and raise risks. •Continue links with ePMO team, including new lead, to maintain PPI assessment process.	New risk	3	4	12	3	4	12	2	3	6	March 2026	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9 SR10	Apr-25	May-25	Helen Dillistone - Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement

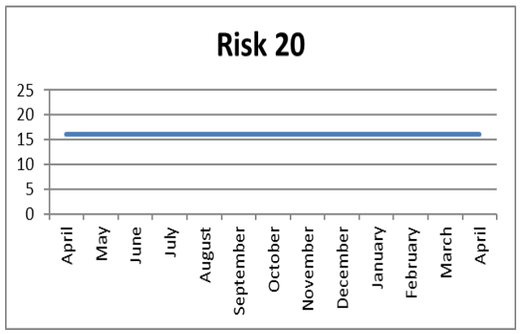
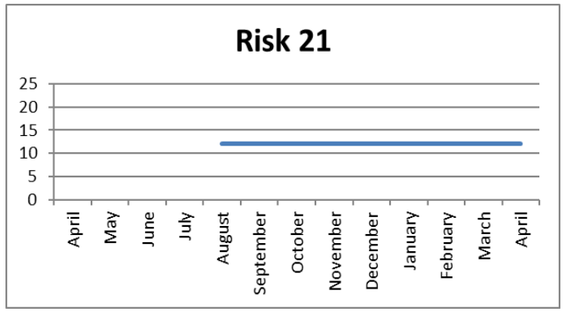
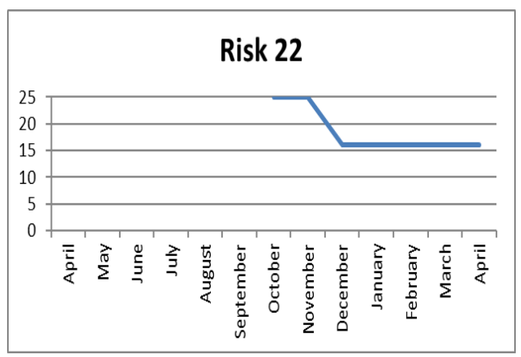
Appendix 3 - ICB Risk Register - Movement - April 2024

Risk Reference	Risk Description	Previous Rating (March)			Residual/ Current Risk Rating (April)			Movement - April	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
01	The Acute providers may not meet the new target in respect of 78% of patients being seen, treated, admitted or discharged from the Emergency Department within 4 hours by March 2025, resulting in the failure to meet the ICB constitutional standards and quality statutory duties, taking into account the clinical impact on patients and the clinical mitigations in place where long waits result.	5	4	20	5	4	20	⟺	Both acutes are still under performing against the target and fluctuating daily due to high demand	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager	
03	There is a risk to the sustainability of the individual GP practices across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.	4	4	16	4	4	16	⟺	There is no change to the risk score due to the ongoing pressures in general practice, imposition of national GP contract for 24/25 and financial pressures in staff costs due to increases in the national living wage that are not fully covered through the national contract uplift. A separate risk is being considered to be added relating to the threat of industrial action by GP's during 24/25 due to the imposition of the national GP contract.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care	
05	If the ICB does not review and update existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known and unknown risks to the Derby and Derbyshire ICB, which may lead to an ineffective response to local and national pressures.	2	3	6	2	3	6	**RISK PROPOSED FOR CLOSURE**	The EPRR team is now fully established, a number of processes are now in place also to support EPRR delivery across the ICB.	Helen Dillistone - Chief of Staff	Chris Leach, Head of EPRR	

Risk Reference	Risk Description	Previous Rating (March)			Residual/ Current Risk Rating (April)			Movement - April	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
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.	5	4	20	5	4	20	⟺	The 24/25 plan is at its final stages, with shared ownership. A focus remains on the identification of improvement and transformation across all partners; governance reviews must follow in the coming weeks. NHS Providers are to commence a peer learning and coaching programme; focusing on productivity to identify opportunities for improvement.	Keith Griffiths, Chief Financial Officer	Donna Johnson, Associate Director of Finance (ICB Reporting and Governance)	
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	⟺	Leavers files have been boxed and sent for storage. Further scanning work to be carried out.	Helen Dillistone Chief of Staff	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.	4	4	16	4	4	16	⟺	At the Quality and Performance Committee meeting held on 28th March 2024, the Chair and Committee members asked for a further paper to be to be submitted to the May Quality and Performance Committee meeting outlining further detailed evidence to support the recommendation to decrease the risk score.	Prof Dean Howells Chief Nursing Officer	Letitia Harris Clinical Risk Manager	

Risk Reference	Risk Description	Previous Rating (March)			Residual/ Current Risk Rating (April)			Movement - April	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
11	If the ICB does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	3	3	9	3	3	9	⟺	The ICS is still required to deliver a further 50% achievement of 2023/24 priorities. Delivery of this will continue into 2024/25 and beyond. The risk score of a high 9 is currently appropriate and realistic.	Helen Dillistone Chief of Staff	Suzanne Pickering Head of Governance	
13	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.	3	3	9	2	3	6	↓	The ICB is now progressing through the restructure and posts within the team are being appointed to. Therefore the likelihood is reduced, but the impact remains the same until the restructure is complete.	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	3	3	9	⟺	The ICB Board was requested at its March meeting to approve formal signature of the delegation documentation; the Board were advised that this was with the caveat that further work was required between NHSE and ICBs to be clear on the operating model and quality and finance risk management. The risk score cannot be decreased until this work is complete and impacts on ICB resources are clarified.	Helen Dillistone Chief of Staff	Chrissy Tucker - Director of Corporate Delivery	

Risk Reference	Risk Description	Previous Rating (March)			Residual/ Current Risk Rating (April)			Movement - April	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
16	Risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.	4	3	**12**	2	3	**6**		The appeals have now largely been completed and we are supporting the staff who are 'at risk' of redundancy or have selection or other processes, therefore the risk has largely been mitigated.	Helen Dillistone Chief of Staff	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 connection to 24/25 planning processes, including Board.	Helen Dillistone Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement	
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**		Due to the recognised pressures and delays of hospital discharges through several factors, there has been a request to separate and develop a new risk from Risk 19 to ensure that ongoing discharge work is captured as its own risk with ownership from system partners.	Dr Chris Weiner Chief Medical Officer	Jo Warburton Dan Webster	

Risk Reference	Risk Description	Previous Rating (March)			Residual/ Current Risk Rating (April)			Movement - April	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
20	Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.	4	4	**16**	4	4	**16**	⟷	In July the Home office and Serco intend to close another hotel in the county - this will leave a total of 4 contingency hotels open in the city and the county. Until this point the concerns are ongoing for the remaining settings.	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children	
21	There is a risk that contractors may not be able to fulfil their obligations in the current financial climate. The ICB may then have to find alternative providers, in some cases at short notice, which may have significant financial impact.	3	4	**12**	3	4	**12**	⟷	With the recent publication of the GP contract for 2024/25 the ICB will continue to work with GP practices to ensure their continued stability.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Lana Davidson Senior Contract Manager	
22	National funding for the 23/24 pay award and 22/23 one off payments excluded all staff who were not on NHS payrolls. Consequently staff employed by DHU, NHS subsidiary bodies, in PFI arrangements and Primary care were not eligible. Consequently there is a an increasing risk of legal challenge as well as real, emerging loss of morale for over 4500 staff across the Derbyshire system which could affect recruitment and retention of critical frontline colleagues.	4	4	**16**	4	4	**16**	⟷	The recommendation is to roll this risk over into 2024/25.	Keith Griffiths, Chief Financial Officer	Donna Johnson, Associate Director of Finance (ICB Reporting and Governance)	

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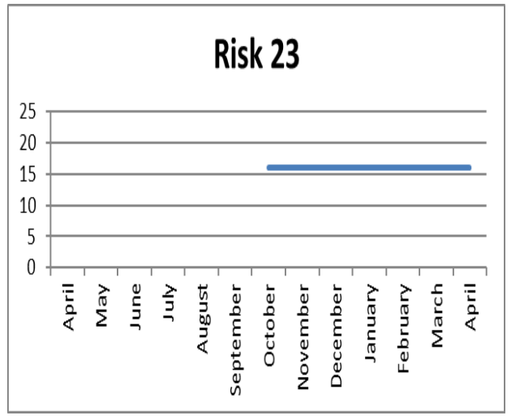
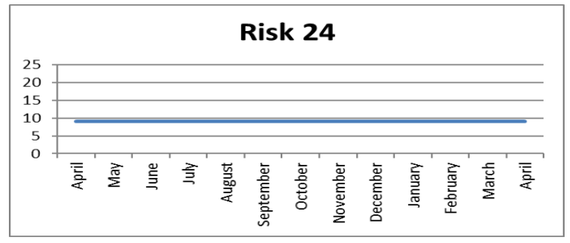
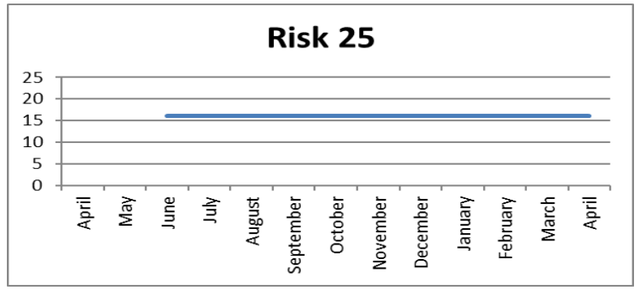
23	There is a risk to Joined Up Care Derbyshire (JUCD) performance against the Cancer Standards, including 28 Day Faster Diagnosis Standard, 62 Day Waits and 104+ days due to an increase in referrals from Staffordshire into UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment. New risk description: There is an ongoing risk to performance against the cancer standards due to an increase in referrals into UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.	4	4	16	4	4	16	⟺	The risk description has been revised to reflect the wider challenges in terms of capacity to meet the cancer standards, impacting the whole of the County, not only Staffordshire.	Prof Dean Howells Chief Nursing Officer	Monica McAllindon Head of Cancer	
24	There is a risk that the ICB is non-compliant with the requirement to commission and have in place a Designated Doctor for looked after children as this is a statutory role.	3	3	9	3	3	9	⟺	The designated Dr for child death remains vacant but continues to be covered as an interim arrangement. Post is out for advert again - there is no interest at this point.	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children	
25	There is a risk of significant waiting times for moderate to severe stroke patients for community rehabilitation. This means, patients may have discharges from acute delayed, be seen by non-stroke specialist therapists and require more robust social care intervention.	4	4	16	4	4	16	⟺	Case for Change development is ongoing and will be completed this month. NHSE have requested to review the document.	Dr Chris Weiner Chief Medical Officer	Scott Webster Head of Strategic Clinical Conditions and Pathways	

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NEW RISK 27	As a result of the introduction of the new provider selection regime, existing processes to connect PPI governance into change programmes may weaken. This may result in services not meeting needs of patients, reduced PPI compliance, risk of legal challenge and damage to NHS and ICB reputation.	3	4	**12**	3	4	**12**	**NEW RISK**	**NEW RISK**	Helen Dillistone - Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement	**NEW RISK**

NHS
Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board

Meeting in Public

Forward Planner 2024/25

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

ICB Key Areas	Apr	16 May	Jun	18 Jul	Aug	19 Sep	Oct	21 Nov	Dec	16 Jan	Feb	20 Mar
Welcome / Apologies and Quoracy		X		X		X		X		X		X
Declarations of Interests • Register of Interest • Summary register of interest declared during the meeting		X		X		X		X		X		X
Minutes and Matters Arising												
Minutes of the previous meeting		X		X		X		X		X		X
Action Log		X		X		X		X		X		X
Leadership												
Chair's Report		X		X		X		X		X		X
Chief Executive Officer's Report		X		X		X		X		X		X
Patient Stories				X		X		X		X		X
Annual Report and Accounts						X						

ICB Key Areas	Apr	16 May	Jun	18 Jul	Aug	19 Sep	Oct	21 Nov	Dec	16 Jan	Feb	20 Mar
Strategy												
ICB Strategic Aims & Objectives, and Strategic Framework		X										
Primary Care Strategy		X										X
Research Strategy				X								
Delivery & Performance												
Performance Report • Quality • Performance • Workforce • Finance		X		X		X		X		X		X
Primary Care Access Recovery Plan		X										
NHS Impact and Improvement		X										
Financial Plan		X										X
NHS Long Term Workforce Plan				X								X
Green NHS Plan and Progress								X				
Medium Term Financial Planning (part of the planning round and submission)										X		
Organisational Development and People – ICB Staff Survey Action Plan				X								

ICB Key Areas	Apr	16 May	Jun	18 Jul	Aug	19 Sep	Oct	21 Nov	Dec	16 Jan	Feb	20 Mar
Innovation & Information • Digital Development Update • Research				X								
Winter Plan								X				
Operational Plan 2024/25 and 2025/26								X				X
Corporate Governance, Assurance & Risk												
Risk Register		X		X		X		X		X		X
Board Assurance Framework		X		X				X				X
Constitution						X						
Audit and Governance Committee Assurance Report		X		X		X		X		X		X
Finance, Estates and Digital Committee Assurance Report		X		X		X		X		X		X
People and Culture Committee Assurance Committee		X		X		X		X		X		X
Population Health and Strategic Commissioning Committee Assurance Report		X		X		X		X		X		X
Public Partnership Committee Assurance Committee		X				X		X		X		X
Quality and Performance Committee Assurance Report		X		X		X		X		X		X
Corporate Committees' Annual Reports				X								
Update and review of Committee TORs								X				X

ICB Key Areas	Apr	16 May	Jun	18 Jul	Aug	19 Sep	Oct	21 Nov	Dec	16 Jan	Feb	20 Mar
For Information												
Delegation of Specialised Commissioning Services Update						X						
Derbyshire County Council Director of Public Health Annual Report 2023						X						
Derby City Council Director of Public Health Annual Report 2023				X								
Ratified Minutes of ICB Corporate Committees		X		X		X		X		X		X
Ratified Minutes of Health & Wellbeing Boards				X		X		X		X		X
Closing Items												
Forward Planner		X		X		X		X		X		X
Glossary		X		X		X		X		X		X
Any Other Business		X		X		X		X		X		X
Any risks identified during the course of the meeting		X		X		X		X		X		X
Questions received from members of the public		X		X		X		X		X		X

Abbreviations & Glossary of Terms

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

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

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

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

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

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

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

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