NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC AGENDA

Thursday, 21st November 2024 at 9:15am to 11:15am

Joseph Wright Room, Council House, Derby

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
09:15	**Introductory Items**			
	ICBP/2425/073	Welcome, introductions and apologies: Michelle Arrowsmith	Dr Kathy McLean	Verbal
	ICBP/2425/074	Confirmation of quoracy	Dr Kathy McLean	Verbal
	ICBP/2425/075	Declarations of Interest • Register of Interests • Summary register for recording interests during the meeting • Glossary	Dr Kathy McLean	Paper
09:20	**Minutes and Matters Arising**			
	ICBP/2425/076	Minutes from the meeting held on 19th September 2024	Dr Kathy McLean	Paper
	ICBP/2425/077	Action Log – September 2024	Dr Kathy McLean	Paper
09:25	**Leadership**			
	ICBP/2425/078	Chair's Report – October 2024	Dr Kathy McLean	Paper
	ICBP/2425/079	Chief Executive Officer's Report – October 2024	Dr Chris Clayton	Paper
09:40	**Strategy, Commissioning and Partnerships**			
	ICBP/2425/080	Joint Forward Plan Update (For Assurance)	Dr Chris Clayton	Paper
	ICBP/2425/081	Seasonal Plan (For Approval)	Dr Chris Weiner	Paper

Time	Reference	Item	Presenter	Delivery
	ICBP/2425/082	Strategic Update from the Provider Collaborative (For Assurance)	Stephen Posey Tamsin Hooton	Paper
10:15	**Delivery and Performance**			
	ICBP/2425/083	Progress against Plan (H1 strategic review) (For Assurance)	Dr Chris Clayton	Paper
	ICBP/2425/084	Review of Intensive & Assertive Community Treatment within Community Mental Health Teams (For Approval)	Prof Dean Howells	Paper
	ICBP/2425/085	Integrated Performance Report (including level of assurance from the relevant Committee) • Quality • Performance • Finance • Workforce Performance	 Deji Okubadejo, Prof Dean Howells Margaret Gildea, Craig Cook Jill Dentith, Keith Griffiths Margaret Gildea, Lee Radford	Papers
10:35	**People and Culture**			
	ICBP/2425/086	Remuneration Committee Assurance Report – 8th October 2024	Margaret Gildea	Paper
10:40	**Governance and Risk**			
	ICBP/2425 087	Board Assurance Framework – Quarter 2 2024/25	Helen Dillistone	Paper
	ICBP/2425 088	ICB Risk Register – October 2024	Helen Dillistone	Paper
	ICBP/2425/089	Audit and Governance Committee Assurance Report – 10th October 2024	Sue Sunderland	Paper
	ICBP/2425/090	Finance Estates and Digital Committee Assurance Report – 24th September and 22nd October 2024	Jill Dentith	Paper
	ICBP/2425/091	Population Health Commissioning Committee Assurance Report – 24th October 2024	Margaret Gildea	Paper
	ICBP/2425/092	Public Partnership Committee Assurance Report – 24th September 2024	Sue Sunderland	Paper
	ICBP/2425/093	Quality and Performance Committee Assurance Report – 31st October 2024	Deji Okubadejo	Paper

Time	Reference	Item	Presenter	Delivery
11:00	**Items for information**			
The following items are for information and will not be individually presented				
	ICBP/2425/094	Primary Care Access Improvement Plan	Craig Cook	Paper
	ICBP/2425/095	Delegation of additional specified Specialised Acute Services and Mental Health, Learning Disability and Autism specialised services and associated workforce	Helen Dillistone	Paper
11:10	**Closing Items**			
	ICBP/2425/096	Forward Planner	Dr Kathy McLean	Paper
	ICBP/2425/097	Any Other Business	Dr Kathy McLean	Verbal
	ICBP/2425/098	Questions received from members of the public	Dr Kathy McLean	Verbal
Date and time of next meeting in public: **Date:** Thursday, 16th January 2025 **Time:** 9:15am to 11:15am **Venue:** Joseph Wright Room, Council House, Derby				Verbal

ITEM 075

NHS DERBY AND DERBYSHIRE ICB BOARD REGISTER OF INTERESTS 2023/24

*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	CEO of Derbyshire Community Health Services NHS Foundation Trust	✓				01/07/22	15/09/24	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	15/09/24	
				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	15/09/24	
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	Participant to the Board for Place	Primary & Community Care Delivery Board Chair of Digital and Data Delivery Board Integrated Place Executive	CEO of Derbyshire Community Health Services NHS Foundation Trust	✓				16/09/24	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Employed jointly between NHS Derby and Derbyshire Integrated Care Board and Derbyshire Community Health Services NHS Foundation Trust	✓				01/11/22	01/08/24	
				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	29/10/24	
				Spouse works for Nottingham University Hospitals				✓	01/07/22	Ongoing	
				Work as Training Programme Director and as an Associate Postgraduate Dean for the East Midlands GP Deanery, NHSE		✓			29/10/24	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
Dentith	Jill	Non-Executive Member - Finance, Estates & Digital	Audit & Governance Committee Finance, Estates & Digital Committee People & Culture Committee Quality & Performance Committee	Self-employed through own management consultancy business trading as Jill Dentith Consulting	✓				2012	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Director of Jon Carr Structural Design Ltd	✓				06/04/21	Ongoing	
				Providing part-time management consultancy services to Conexus Healthcare Community Interest Company	✓				01/06/23	30/06/24	
Dillistone	Helen	Chief of Staff	Audit & Governance Committee Public Partnership Committee	Nil							No action required
Garnett*	Linda	Interim Chief People Officer	People & Culture Committee Population Health & Strategic Commissioning Committee Finance, Estates & Digital Committee ICS Executive Team Meeting Clinical & Professional Leadership Group	My husband is an independent consultant and is currently working in the ICS via a commission with Amber valley CVS				✓	01/07/22	31/07/24	None required currently
Gildea	Margaret	Non-Executive Member / Senior Independent Director	Audit & Governance Committee People and Culture Committee Population Health & Strategic Commissioning 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 Midlands 111 Board	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 Women's Health Hub Steering Group	Director of Public Health, Derbyshire County Council	✓				01/09/22	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair. Sheffield based - unlikely to bid in work in Derbyshire
				Director and Trustee of SOAR Community			✓		01/09/22	Ongoing	

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Howells	Dean	Chief Nurse Officer	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee Local Maternity and Neonatal System Board Clinical and Professional Leadership Group Information Governance Assurance Forum ICS Executive Team Meeting Midlands 111 Board	Honorary Professor, University of Wolverhampton	✓				13/09/23	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair.
McLean	Kathy	ICB Chair	Remuneration Committee	Non Executive Director Barking Havering and Redbridge NHS Trust		✓			20/06/23	30/06/2024	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	30/06/2024	
				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	
				Interim Chair The Public Service Consultants	✓				Ongoing	Ongoing	
				Chair of ICS Network, NHS Confederation		✓			01/04/24	Ongoing	
				Chair of East Midlands Specialised & Joint Committees		✓			01/04/24	Ongoing	
				Advisor to Oxehealth		✓			17/02/22	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 End of Life Programme Board Children's Urgent Care Group Community Same Day Urgent Care Delivery Group Amber Valley Place Alliance Group Virtual Wards Delivery Group GP Leadership Group Women's Health Hub Steering 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	CEO of Derbyshire Healthcare NHS Foundation Trust Treasurer of Derby Athletic Club	✓		 ✓		01/04/23 01/03/22	Ongoing Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
Radford	Lee	Chief People Officer	People & Culture Committee Population Health & Strategic Commissioning Committee Finance, Estates & Digital Committee ICS Executive Team Meeting	Nil							No action required
Sadiq*	Perveez	Service Director - Adult Social Care, Derby City Council	N/A	Nil							No action required
Simpson	Paul	Local Authority Partner Member	N/A	TBC							
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 IFR Panel	Nil							No action required

NHS
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Integrated Care Board

SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

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

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

Derby and Derbyshire Integrated Care Board

MINUTES OF NHS DERBY AND DERBYSHIRE ICB BOARD MEETING IN PUBLIC

Held on Thursday, 19th September 2024

The Enterprise Centre, Bridge Street, Derby DE1 3LD

Unconfirmed Minutes

Present:		
Dr Kathy McLean	KM	ICB Chair (Meeting Chair)
Michelle Arrowsmith	MA	ICB Chief Strategy and Delivery Officer / Deputy CEO
Andrew Appleyard	AA	Programme Manager, Adult Social Care Reforms – Derby City Council (Local Authority Partner Member) (on behalf of Perveez Sadiq)
Jim Austin	JA	Chief Executive Officer, DCHSFT (Participant Member to the Board for Place)
Dr Chris Clayton	CC	ICB Chief Executive Officer
Jill Dentith	JED	ICB Non-Executive Member
Helen Dillistone	HD	ICB Chief of Staff
Margaret Gildea	MG	ICB Non-Executive Member / Senior Non-Executive Member
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
Steve Hulme	SH	ICB Chief Pharmacy Officer (on behalf of Chris Weiner)
Dr Andrew Mott	AM	GP Amber Valley (Partner Member for Primary Care Services) / Medical Director of GP Provider Board
Dr Deji Okubadejo	DO	ICB Clinical Lead Member
Stephen Posey	SPo	Chief Executive, UHDBFT / Chair of the Provider Collaborative Leadership Board (NHS Trust and FT Partner Member)
Lee Radford	LR	ICB Chief People Officer
Sue Sunderland	SS	ICB Non-Executive Member
Richard Wright	RW	ICB Non-Executive Member
In Attendance:		
Kay Baggley	KBa	Hartington Community Group Volunteer
Dr Penny Blackwell	PB	Chair of Integrated Place Executive /GP
Dr Ash Dawson	AD	GP, Hartington Surgery
Christina Jones	CJ	ICB Head of Communications
Fran Palmer	FP	ICB Corporate Governance Manager
Suzanne Pickering	SP	ICB Head of Governance
Sarah Smith	SSm	Age UK Falls Prevention Service Advisor for Derbyshire Dales, High Peak and Glossop
Sean Thornton	ST	ICB Director of Communications and Engagement
3 members of the public		
Apologies:		
Dr Avi Bhatia	AB	Participant to the Board for the Clinical & Professional Leadership Group
Mark Powell	MP	Chief Executive DHcFT (NHS Trust and FT Partner Member)
Perveez Sadiq	PS	Service Director, People Services, Adult Social Care Services – Derby City Council (Local Authority Partner Member)
Dr Chris Weiner	CW	ICB Chief Medical Officer

Item No.	Item	Action
ICBP/2425/051	**Welcome, introductions and apologies:** Dr Kathy McLean (KM) welcomed all Board Members and attendees to the Board Meeting in Public. Introductions were made. KM formally acknowledged Richard Wright's (RW) last meeting and welcomed Jim Austin (JA) in his new capacity as Chief Executive Officer, DCHSFT, and Participant to the Board for Place. Apologies for absence were received as noted above.	
ICBP/2425/052	**Confirmation of quoracy** It was confirmed that the meeting was quorate.	
ICBP/2425/053	**Declarations of Interest** The Chair reminded Committee Members of their obligation to declare any interests they may have on issues arising at Committee meetings which might conflict with the business of the ICB. Declarations made by members of the Board are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the ICB Board Secretary or the ICB website, using the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/integrated-care-board-meetings/ No declarations of interest were made with regards to this agenda.	
ICBP/2425/054	**Minutes of the meeting held on 18th July 2024** **The Board APPROVED the minutes of the above meeting as a true and accurate record of the discussions held.**	
ICBP/2425/055	**Action Log – July 2024** Sue Sunderland queried the timeframe of March 2025 of the open action in regards to the NHS Long Term Workforce Plan refresh. Lee Radford stated that this is in progress and is linked to the One Workforce Strategy and 10 Year Plan. **The Board NOTED the action log, which will be updated accordingly.**	
ICBP/2425/056	**Citizen's Story - Hartington Falls** Dr Ash Dawson (AD), Kay Baggley (KBa) and Sarah Smith (SSm) presented a summary of the successes of a community-led programme of falls prevention in the village of Hartington, with community endeavours resulting in the continuation of the programme once funding ends. The presentation outlined the Hartington Alive partnership, the benefits of community insight in shaping the local service offer, and the empowerment of communities to identify local need. Working collaboratively with Hartington Surgery and others across Derbyshire, a	

	need for falls prevention classes within the community was identified, without the need for travel to Buxton for the currently commissioned service. Working with Age UK, falls prevention classes were established, and there is now a view to provide a sustainable, paid-for programme. Following initial assessment of sitting to standing, patients have seen an improvement of 20-25% when re-assessed 12 weeks later. Non-digital solutions have been implemented to reduce inequalities in access to information, and the Hartington Surgery is providing additional sessions to educate users in areas such as diabetes. AD commended the individuals involved with the programme and stated that the participants fund the sessions themselves, as funding for falls currently goes to the commissioned Buxton service. The Board thanked the presenters and made the following comments: • how could the service be replicated across Derbyshire given the diversity of the county and engagement complexities; • a measurement of outcomes would be helpful and the ICB should support this programme of work; • this is a fantastic example of local engagement and collaboration. It was suggested that this approach should be evaluated alongside the Insights Framework and Engagement Model by the ICB's Communications and Engagement team; • this is prevention through activity and positive for mental health. Where do we get the best value from our resources – it was agreed that data would be shared. **The Board NOTED the Citizen's Story.**	
ICBP/2425/057	**Chair's Report** KM highlighted the following: • following the appointment of a new government, Lord Darzi's rapid review has now been received and will be a platform for the development of the 10 year plan, which is expected to be published Spring 2025. There will be an engagement programme from NHS England, which will probably involve ICSs and the general public. The Secretary of State has been clear on 'three shifts' which are increasing focus on prevention; moving services into the community; and utilising digital technology; • a report from Penny Dash in regards to CQC assessment is expected in October; • a visit with the Team Up team highlighted the positive difference that joined up care is making for patients across Derbyshire. **The Board NOTED the Chair's report.**	
ICBP/2425/058	**Chief Executive's Report** Chris Clayton (CC) highlighted the following: • as we approach the mid-point of the financial year, the ICB's operational position will be reviewed over the next few weeks and months to refresh current planning assumptions. Urgent and Emergency Care has been busy over the summer and as we	

	approach winter, the planning for this is showing similarities to last year; • General Practice and Primary Care are fundamental to our care system, and we are currently supporting General Practice through discussions around care models at individual practice-level and Primary Care Network/Place-level; Keith Griffiths (KG) made reference to the ICB Annual Assessment Letter and the deficit of £59.8m. For clarification, due to a national reset for plans in December 2023 and technical accounting issues, we repositioned ourselves at £42m. NHSE's Regional Director of Finance agreed to escalate this to the NHSE national team. Jill Dentith (JD) highlighted the importance of ensuring that any savings we make to reinvest are done on a recurrent basis and not non-recurrent to ensure improvements are made. **The Board NOTED the Chief Executive's report.**	

ICBP/2324/059	**Strategic Update from Place**
	
	Michelle Arrowsmith (MA) introduced the item and welcomed the opportunity to highlight this area given the previous discussions regarding Lord Darzi's report, and the opportunities for the 2025/26 planning process.
	
	Dr Penny Blackwell (PB) provided an update on Place, which included key areas of work, progress and next steps. The following points were made:
	• highlighting the previous citizen story, which focused on place-based working with minimal spend. There are many other projects going ahead across Derbyshire which we are unfortunately not sighted on;
	• we have eight Place alliances, who report into the Derby City Place Partnership and Derbyshire County Place Partnership. The partnerships are led by non-health individuals and work closely with health and wellbeing boards and Derby Health Inequality Partnership. Both report into the Integrated Place Executive, who oversee key place-based service integration/transformation programmes.
	
	The following achievements in Place were covered:
	• Discharge and Flow:
	  ○ private care home contracts are no longer in use, which has reduced a considerable amount of cost pressure in the system;
	  ○ avoided the previous need of winter community beds through Optica, which provides real-time intelligence on delayed transfer of care;
	  ○ healthwatch post – increased the citizens' voice in the co-design of discharge and flow, particularly around the discharge of patients to places they call home;
	• Team Up and Aging Well – different organisations coming together to support falls and frailty, acute home visiting and enhanced care in care homes.	

	The next steps and future focus will be on accelerating the community transformation programme, staying well priorities and implementing the Primary Care Strategy. JA commented on the community transformation programme, which is thought to have a four-fold financial benefit to our system through investment. Derbyshire County Council are currently out to procure support for this and JA will ensure Board see the business case. The following comments were made: • the governance needs to be right to ensure accountability and deliverability are linked into the wider Board arrangements. The ICB's Population Health and Strategic Commissioning Committee currently has the oversight to support and strengthen business cases, planning and development; • more should be devolved to the eight Place Alliances and focus should be on the work being done at this local level; • data on health inequalities is now being received and the health and wellbeing partnerships have responsibilities to look at the greatest impact on inequalities; • we need to ensure the incentives are right for a better connection of General Practices at scale; • integrated care remains a key ambition for the ICB. We are seeing evidence of positive change through discharge performance and reduced admissions for certain cohorts when compared with the previous year, and this is directly linked to the work with Place. **The ICB Board NOTED the update on Place and CONSIDERED the challenges and opportunities set out in the accompanying slides to connect any opportunities in relation to effectively addressing them.**	
ICBP/2425/060	**Opportunities for Delegated Services – Focus on Dental Services** MA presented the paper, which followed on from the development session in June 2024 where the Board discussed delegated services. The paper focused on dental services, and a similar paper on pharmacy and optometry will be brought to future ICB Boards. The paper highlighted the following: • the recently completed Oral Health Needs Assessment has evidenced that over 17% of children in Derby and Derbyshire have evidence of decay. Bolsover has almost a quarter of children with decay compared to 8.8% in Derbyshire Dales. The three year plan aims to address this; • the national dental recovery plan has been enacted locally with dentists. These connections are important to know what is possible from a commissioning point of view and to ensure the plan will work on the ground. The following comments were made: • the driver and measure for this should be for everyone to be able to access an NHS dentist; • it was agreed that the issue is not funding, but is around attracting dentists into the NHS rather than the private sector. Included in the plan is collaborative working with dental schools, who are keen to be involved;	

	• there is currently no output for discussions locally between optometry, dental and general practice. It was suggested that this could be done at Place-level to enable joined up working; • UHDBFT have a pathway to specialised dental services and this is also included within the plan. **The ICB Board** - **AGREED the plan for dental services for 2024/25 and the three year plan (2025/6 to 2028/9) in principle; and** - **NOTED the intention to use all funding and not underspend.**	
ICBP/2425/061	**Infrastructure strategy – High Level Scoping and Delivery Plan** KG presented the paper which set out a high-level 10-year infrastructure delivery plan for estates, including the key deliverables and the proposed groups that will be charged with taking the work forward, building on the structures already in place. This was submitted to NHSE in July 2024 and we are awaiting feedback. Once this has been received the Board will receive an update on how this links with Primary Care, and our clinical strategy. Whilst some deliverables are time limited and will be quicker to implement, there are others which will be ongoing. We need to ensure that Place-level priorities are represented, and this will be facilitated by a dedicated estates lead identified for each Place. The following comments were made: • the Green Agenda is aligned with this strategy; • has all of our mapped estate been fully utilised and are we working together with the public sector to ensure we are utilising their estates also? It was confirmed that the Finance, Estates and Digital Committee is aware of this and work is being done to involve clinicians and how we can utilise community care models; • Board-level visibility and oversight of this need to increase and the work alongside Local Authorities requires equity in this space.. **The ICB Board NOTED and DISCUSSED the slide deck which provides a high-level plan to deliver the objectives and priorities as set out in the system's Infrastructure Strategy.**	
ICBP/2425/062	**Winter Plan** MA updated the Board on the progress being made on the review of the Winter Plan, which is also looking into provider plans. Board will have final sign-off of the Winter Plan in November. The annual winter letter was received from NHSE this week, which detailed the asks from the ICB and its providers and partners. There is a fundamental focus on quality and safety and how risks are managed in these areas. **The ICB Board NOTED the Winter Plan verbal update.**	

ICBP/2425/063	**Performance Report (including relevant Committee Assurance Reports)** <u>Quality, including the Quality and Performance Committee Report</u> Dean Howells (DH) and Deji Okubadejo (DO) gave an overview of the Quality performance report, with the following points noted: 1) CQC have published their review of maternity services today. The journey undertaken recently in the Derbyshire system puts us in a strong position to respond to the core recommendations made within the report; 2) UHDBFT have completed a significant touchpoint meeting with the ICB and NHSE regional and national teams. The meeting demonstrated an improvement in progress around Section 31 requirements and broader cultural elements, especially service user and family engagement. Preparation for the upcoming CQC inspection continues. Stephen Posey (SPo) expressed his gratitude for the support which has been received from the LMNS, regional and national colleagues; 3) deep dive work has commenced on individual cases at CRHFT, which will be reported to the LMNS and Quality and Performance Committee; 4) the national focus on mental health services requires the ICS to produce a report for CQC by the 30th September, and a full governance approach is in place through the Mental Health Delivery Board to sign this off with DHcFT. The focus on provider boards has been significant and they will be required to have an understanding of individual case challenges, which the ICB may have to provide support on; 5) clear action plans for infection prevention and control have been completed with NHSE. The ICB is currently on their third round of visits; 6) Quality and Performance Committee have requested detail on the impact of culture on stressed services. <u>Performance – Including Population Health and Strategic Commissioning Committee Report</u> MA and RW gave an update from a performance perspective with the following points noted: 1) Urgent and Emergency Care has been under pressure throughout Quarters 1 and 2, however there are now fewer long-stay patients due to the ICB's strategic discharge work; 2) work is underway to eliminate all 65-week and 78-week waits by the end of October. Community, and Children and Young People's waits are being focused on weekly by committees; 3) the cancer position is improving in a number of areas; 4) diagnostic waits are a national issue. The community diagnostic hubs will be online during autumn which will hopefully provide improvement for some modalities; 5) mental health, autism and learning disabilities metrics are showing an improvement, as well as a reduction in out-of-area placements; 6) Population Health & Strategic Commissioning Committee have been focusing on the delivery of the strategic plan and seeing the value from projects, alongside ensuring the ICB is commissioning what it wants to deliver in future years from now.	

The Board noted the progress being made in these areas and suggested that it would be useful to understand the impact on different groups and cultures from areas of deprivation.

Finance – Including Finance, Estates and Digital Committee Report

KG and JD gave an update from the Finance, Estates and Digital position with the following points noted:

1) a £50m deficit was agreed with NHSE for 2024/25. The ICB is currently £39m overspent, which is £2.9m worse than expected. The key drivers are the costs implicated from industrial action, and extra bed capacity to deal with demand in acute trusts. It is critical to deliver on the £50m deficit and Month 4 was confirmed as being on plan. £34m has been saved collectively as a system. The Finance, Estates and Digital Committee will look at the risks surrounding this at their meeting next week. This will involve hearing presentations from each provider to understand what savings can be made and what support is needed;
2) NHSE have introduced a financial investigation on ICBs and KG confirmed that Derby and Derbyshire ICB are not included in this;
3) capital is underspent by £2m and this will be utilised by the end of March;
4) £7.5m is still required to complete the dormitory eradication programme. If confirmation is not sought then contractors may be stood down and there will be an impact on mental health patients attending emergency departments;
5) there is currently a technical issue around leases, which could cost £7m. The ICB is working with NHSE on this;
6) Finance, Estates and Digital Committee are monitoring the likely impact of the above points on 2025/26 and beyond, noting that colleagues are working hard to stabilise finances.

Workforce Performance

Lee Radford (LR) and Margaret Gildea (MG) gave an update from the workforce performance perspective, with the following points noted:

1) Month 4 has been challenging for acute colleagues due to a surge in capacity. Performance is broadly on plan but there has been an additional pay cost of around £2m. The ICB is working closely with providers to ensure the right patient safety infrastructure is in place;
2) sickness absence is slightly higher this month and work is underway with provider colleagues on how this is being managed locally;
3) work is progressing with the joined up careers service to close the vacancy gap by recruiting new people in to the NHS;
4) a one workforce approach has been established with anchor institutions to collectively work together to secure our future workforce; and
5) the People and Culture Committee is aiming to strengthen links with the Provider Collaborative Board and the academy.

	The following comments were made: • it would be beneficial to do a review of the original H2 plan against how we are currently performing; • the ICB should not lose sight on the future recruitment process and talent management of NHS staff; • a development session on workforce was requested to consider the public sector workforce model for the future. **The Board NOTED the Performance Report and Committee Assurance Reports.**	
ICBP/2425/064	**ICB Constitution** Helen Dillistone (HD) presented the ICB Constitution, which was amended following NHSE's recommendation. Once approval is received by the ICB Board, the Constitution will be submitted to NHS England for approval. **The ICB Board APPROVED the required amendments as per the NHSE guidance, prior to submission to NHS England for approval.**	
ICBP/2425/065	**Audit and Governance Committee Assurance Report – August 2024** Sue Sunderland (SS) presented the report and highlighted that ahead of the Board development session on risk, only partial assurance is being taken by the Audit and Governance Committee due to a number of static risks. The Committee's recommendation to all ICB committee members is for them to challenge risk scores and encourage the movement of risks. **The Board RECEIVED and NOTED the report for assurance purposes.**	
ICBP/2425/066	**Public Partnership Committee Assurance Report – July 2024** RW presented the report, which was taken as read. No comments or questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes.**	
ICBP/2425/067	**ICB Risk Register Report – August 2024** HD presented the report, which was taken as read. **The Board RECEIVED and NOTED:** • **Appendix 1, the risk register report;** • **Appendix 2, which details the full ICB Corporate Risk Register;** • **Appendix 3, which summarises the movement of all risks in August 2024.**	
ICBP/2425/068	**Forward Planner** The forward planner was taken as read. **The Board NOTED the forward planner for information.**	

ICBP/2425/069	**Glossary** The glossary was taken as read. **The Board NOTED the glossary for information.**	
ICBP/2425/070	**Any Other Business** KM thanked RW for his service to the Board and also the whole Derby and Derbyshire population. RW's time as interim chair and the support provided to KM was recognised.	
ICBP/2425/071	**Risks Identified during the course of the meeting** No risks were identified during the course of the meeting.	
ICBP/2425/072	**Questions received from members of the public** No questions were received from members of the public.	

Date and Time of Next Meetings
Date: Thursday, 21st November 2024 **Time**: 9:15am to 11:00am **Venue:** The Joseph Wright Room, Council House, Derby

Derby and Derbyshire Integrated Care Board

ITEM 077

ICB BOARD MEETING IN PUBLIC

ACTION LOG – SEPTEMBER 2024

Item No.	Item Title	Lead	Action Required	Action Implemented	Due Date
ICBP/2324/050 20.7.2023	NHS Long Term Workforce Plan	Lee Radford	It was agreed that the Plan would return to a future Board for further discussion.	Workforce plan refresh is in progress by the People and Culture Committee.	**March 2025**

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 078

Report Title	Chair's Report – October 2024							
Author	Sean Thornton, Director Communications and Engagement							
Sponsor (Executive Director)	Dr Kathy McLean ICB Chair							
Presenter	Dr Kathy McLean, ICB Chair							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	None							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Not applicable							

Recommendations
The ICB Board are recommended to **NOTE** the ICB Chair's Report.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
We are now half-way through the year and there is clarity emerging about the Government's plans for the longer-term future of the NHS. Following on from the publication of Lord Darzi's Independent Report into the NHS, the Secretary of State has set out the three 'shifts' he expects to see: from hospital to community, from analogue to digital and from treatment to prevention. Following this, in recent weeks the Government has launched what it calls, "the biggest national conversation about the future of the NHS since its birth". Members of the public, as well as NHS staff and experts, are invited to share their experiences, views and ideas for fixing the NHS via the Change NHS online platform, which will be live until the start of next year, and available via the NHS App. The ICB, and all NHS partners, will contribute to this in a variety of ways, in line with the national engagement programme. A delegation of Derby and Derbyshire system leaders will attend the regional event on 28th November to feed in our views, and we will be developing a programme of staff and public engagement to ensure there is a broad discussion to inform the plan.

Last week, NHS England wrote to ICB and Trust Chief Executives and Chairs about the evolution of the future operating model for the NHS. The aim of this work is to ensure that the way the NHS works supports delivery of today's priorities and sets us up to deliver the neighbourhood health model that will underpin a health and care system that is fit for the future. It is clear in the letter that this does not mean more reorganisation, but optimisation and clarity for every part of the existing system. The letter outlines four aims:

1) Simplify and reduce duplication, clarifying roles and responsibilities and being clear on the place of performance management;
2) Shift resources, time and energy to neighbourhood health;
3) Devolve decision-making to those best placed to make changes, clarifying the role of integrated care partnerships (ICPs) and health and wellbeing boards.
4) Enable leaders to manage complexity at a local level, supporting leaders with new strategic commissioning frameworks to include national best practice.

This is set out as a direction of travel, with no immediate changes for 2024/25. The Board will of course discuss this in greater detail in due course.

A further element of the future landscape was the Chancellor's Autumn Budget and Spending Review for the rest of this financial year and next, which was announced at the end of October. In such a tough financial climate, additional capital investment is welcome, which will help us repair and modernise hospitals, GP practices and other facilities, as well as continuing to update technology like diagnostic scanners and develop key platforms like the NHS App and Federated Data Platform (FDP), which will boost productivity for the benefit of patients and the taxpayer in the long term. Both the Chancellor and Secretary of State were clear that we cannot fix everything in a single budget. Hard work by Trust and ICB teams nationally has already delivered £2bn of efficiency savings in the first five months of this financial year. We will receive further information in due course.

Our review of the first half of the financial year (H1) has been helpful in confirming our position against the aims we stated in our 2024/25 operational plan and our broader Joint Forward Plan. We continue to have significant focus on the challenges posed by today, and I have said before both locally and nationally that it's important that we continue to keep a focus on the future goals around prevention and the reduction of health inequalities. It is clearly challenging to move into this space given the existing operational pressures, but it is encouraging to see through our H1 review that our performance is largely on track. There remain clear risks, which we will continue to manage across our system partnership, but we enter the second half of the year with clarity where we need to further prioritise our attention.

Local Landscape

We know that the 'flu season in the southern hemisphere means that this year's respiratory illness incident will be high and so the importance of vaccination by staff and residents against 'flu, Covid-19 and Respiratory Syncytial Virus (RSV) cannot be overstated. The vaccinations represent the key prevention arm of our winter plans, and while the these seek to ensure that we have the best possible arrangements to keep patients cared for and staff supported throughout the busy period, there are risks. There is no additional winter funding to establish additional schemes over the periods of peak demand in the way that we had in previous years; all system partners are aware of this position and have developed their plans in this context.

I would like to thank all staff across the health and care system ahead of winter – from the work of managers and leaders in steering the approach and the efforts of frontline colleagues, we all have a part to play over the next few months.

In Place, there is ongoing engagement around the emerging Primary Care Model and its alignment to Place. The model would see patients cared for in a stratified way depending on the complexity of their needs and conditions. Discussions are continuing across PCNs and Local Place Alliances to share, listen and talk about the model and understand potential barriers, such as data sharing. Our leaders in Place have also been considering the future focus of the Integrated Place Executive, and how to best collect, measure and report outcomes that are resulting from Place work. Our excellent work on discharge and Team Up are already showing clear outputs and improved outcomes.

I have been pleased to develop a programme of visits to a range of groups and services across the city and county. I will update the Board on my findings from those. One of the first was visiting volunteers and staff at not-for-profit organisation Connected Perinatal, who support new mums. Mums and their new babies are some of the most vulnerable members of our society and need as much support as we can offer. I spent an afternoon with the staff team and volunteers and explored the positive impact their work has on families plus the opportunities and challenges of working in the integrated care system. It was insightful and hugely helpful to get closer to this work and understand more about the offer that's available for families. I am also delighted to welcome representatives from the service to the Board session for our Citizen's Story agenda item.

ICB Board Matters
Paul Simpson, Chief Executive of Derby City Council, has been approved as the Local Authority Partner Member on the ICB Board. Paul will replace Andy Smith, Strategic Director or People Services at the City Council, who has stood down due to other external commitments. We are grateful to Andy for his input to the ICB since its inception in July 2022.

Richard Wright has now retired from the ICB and we are currently in the process of appointing a new Non-Executive Member to the Board. Colleagues will be supporting me in the recruitment process and I will make an announcement of the appointment in due course.

Keith Griffiths retires from the ICB and NHS at the end of November and we are thankful for Keith's strong financial leadership in the last 30 months. The Chief Executive has highlighted the interim arrangements for our financial leadership while we seek to appoint to a joint Chief Finance Officer post with colleagues in Nottingham and Nottinghamshire ICB. Claire Finn, currently Interim Executive Chief Finance Officer at University Hospitals of Derby and Burton will join the ICB Board at the end of November for a period of six months.

Meeting the East Midlands Mayor
I was delighted to meet with Claire Ward, Mayor of the East Midlands, in October to discuss her thoughts on how we can work together to improve our population's health across Nottingham, Nottinghamshire, Derby and Derbyshire. Claire was elected in May and heads up the East Midlands Combined County Authority (EMCCA), which brings together the City and County Councils across Nottingham, Nottinghamshire, Derby and Derbyshire, as well as working closely with the District and Borough Councils. EMCCA has a remit to work, in partnership with other bodies, to harness the potential of the East Midlands, making it the best place to live, to work and to learn. Further information on the meeting, which Chris and I held jointly with colleagues from Nottingham and Nottinghamshire ICB, is available in a blog we published.

National Landscape

Change NHS: a health service fit for the future
The listening exercise that will shape the 10-Year Health Plan is now live, with a dedicated section for those who work in and around health and care to share their experiences of health services and put forward ideas for improvement. NHS England and the Department of Health and Social Care (DHSC) will be working closely to deliver engagement for this work, and there

will be a local approach to engaging with staff and the public, and further details on the approach will be confirmed in early December.

The State of Health Care and Adult Social Care in England 2023/24
This annual assessment of health and social care in England, published by the Care Quality Commission, suggests finance, joint forward planning and workforce depletion are among the main challenges for integrated care boards (ICBs) as people struggle to access the care they need. These are of course all firmly on the agenda for this Board and the wider health and care system. I recorded a podcast interview with Matthew Taylor, NHS Confederation's Chief Executive, talking through the key findings and issues that came out of that report. The reports poses some key questions, with integrated care systems now just over two years old, including how effective are we in succeeding at our goals, and what needs to change for us to be more effective in the coming years?

Review into the operational effectiveness of the Care Quality Commission
This report, led by Dr Penny Dash and published by DHSC, reviews the operational effectiveness of the Care Quality Commission. It highlights areas for improvement, including the need for better operational performance, challenges with IT systems and concerns about the credibility of inspections and ratings.

Unlocking prevention in integrated care systems.
This report explores how integrated care systems can unlock the prevention agenda by overcoming the persistent barriers to prevention. It shares examples of best practice across the country and makes several recommendations to government and national bodies, including financial and regulatory incentives for work on prevention and ICSs being given autonomy to spend time and money where it will have greatest impact. Of course, we are well aware of the drive to move more firmly into the prevention space, and the challenges in doing so given existing pressures within the NHS system. However, it is evident that these challenges, particularly those in the urgent and emergency care system, can be mitigated by a greater focus on prevention. It is one of the key challenges for the Board in the coming months and years to determine how we can make this transition.

NHS England Chair To Stand Down
It has been announced that NHS England's Chair, Richard Meddings intends to stand down at the end of the financial year. Richard has been vocal about the challenges facing the NHS, while also being a champion of frontline staff and everything they are able to achieve in the face of those challenges. NHS England will be announcing Richard's replacement in due course.

NHS Confederation Activities
The ICS Network conference takes place on 27 November. The conference provides an important opportunity to connect with colleagues from across the country, and also provides a chance to provide some feedback about the work of the Network and how it best supports ICBs. This year's theme will be 'Tackling today while building for tomorrow', which is something we have spoken about frequently in Derby and Derbyshire. The day will focus on how we can support systems on their delivery of the four core purposes of ICSs and will involve engaging keynote speakers, breakout sessions, and lots of networking opportunities.

The Network has played a key role in recent weeks, influencing on behalf of our members, including engagement with NHSE colleagues on the future system oversight arrangements, and working with the DHSC team leading on the 10 Year Health Plan. The Network's Improvement Team have already contributed to the 10 Year Plan team's thinking on the role improvement will play in transforming health services, and is contributing to a number of the working groups that are being established to support the development of the plan.

Identification of Key Risks					
SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Not applicable to this report.

Financial impact on the ICB or wider Integrated Care System		
Yes ☐	No☐	N/A☒
Details/Findings Not applicable to this report.		**Has this been signed off by a finance team member?** Not applicable 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.					
Identification of Key Risks					
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	☐
Not applicable to this report.					

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 079

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

Recommendations
The ICB Board are recommended to **NOTE** the ICB Chief Executive Officer's Report.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
Our Board agenda today outlines the outputs from our review of our position with regards to the 2024/25 operational plan, as we reached the half-way point of the year. I will not repeat the detailed contained elsewhere on the agenda but wish to outline some headlines that have emerged from the review. Firstly, I wish to record the significant effort that been put into the review during September and October. Teams across the NHS system have worked hard to collate the stocktake, alongside other existing work pressures, and the result has been critical in enabling us to understand our current position, to identify where we have additional risks to manage, and to also provide assurance to this Board, our partner Boards and to regulators that we have clear grip on managing delivery. This has been a review that has included our Chief Operating Officers, Chief Finance Officers and Chief People Officers, alongside our clinical leadership across nursing and medical disciplines, and we set out our intent for this quadrumvirate approach to continue going forward. It has also been important to reflect and promote the successes across the system this year, to identify that in challenging circumstances we continue to make positive progress. These are borne out of detailed planning, and delivered through constant attention to our agreed priorities and programmes by teams across the NHS family. The headlines of this identify that our GPs

have seen an above-plan increase in appointments, we have been managing an increase in demand within our A&E departments, achievement of much of our activity plan for electives, strong performance against plan for 62-day cancer treatments and achievement of nearly all targets for mental health, learning disability and autism.

For the second half of the year (H2), three collective priorities have been identified, which will be owned by our three delivery boards and overseen by the NHS Executive Team:

1. To continue to provide safe and effective emergency care over the course of the H2 period recognising the need for us to balance and prioritise operational and clinical risk to achieve this.
2. To deliver continued improvements in our cancer, mental health and elective care position to ensure we continue to attend to the needs of those patients awaiting important non-emergency care.
3. To do the above operational priorities whilst living within the limits of our resource position principally focused for H2 on our people and our available finances.

Finally on performance, as we head into winter, the Urgent and Emergency Care System remains under significant pressure and associated costs are driving both our financial position and impacts in other areas, including planned care and community activity. The NHS Chief Executives have agreed a programme of actions to ensure we continue to give attention to this area of care as one of the system's identified priorities. These actions include:

- Continuing our communications to assist patients in navigation to the right place of care.
- Decompressing our system, ensuring that our system is working hardest to support the avoidance of harm to our most vulnerable patients.
- Immediate actions agreed include reviewing our triaging of patients into co-located UTCs and reviewing the medically fit for discharge thresholds.
- Vaccination teams to link with trusts to check we are on plan with delivery to mobilise the campaigns and encourage all staff to have their vaccinations.
- Review options to improve UTC activity and accessibility, in particular at Ilkeston.
- Review infection prevention and control issues.

Within the ICB, we have been encouraging our staff to complete their Staff Surveys, as a key tool in helping us understand the steps we can continue to take to be an inclusive and compassionate employer. The latest figures show a strong completion rate across our teams, with more than 75% of colleagues having given there views at the time of writing. We have also been encouraging our staff to take up the offer of free influenza and Covid-19 vaccinations, and more than 200 staff had done so by the end of October. This is important to help our staff stay healthy this winter, to ensure that we can maintain ICB business, as well as to play our part in the protection of our patients. Our all-staff event on 20th November will have occurred prior to the meeting of the ICB Board, but our two areas of focus in that session were confirming our clear priorities for the next period for the ICB and system, and working on the continued improvement of our culture within the ICB. We are keen to ensure that we work with our staff on both of these areas in detail following the event.

We have now seen the headline figures announced for the NHS from the Chancellor of the Exchequer, Rt Hon Rachel Reeves, in her first budget. These include providing a £22bn increase in the day-to-day health budget, and a £3.1bn increase in the capital budget, by the end of 2025. This level of additional funding is to be welcomed, and at the time of writing we await further messaging from Government and NHS England around the mechanism for calculating and distributing the money, along with the deliverables attached to it.

I have notified the Board previously of the recruitment of a Joint Chief Finance Officer with NHS Nottingham and Nottinghamshire ICB. That post has been advertised and interviews will take place on 4th December. The postholders time will be split 50:50 across each ICB. This joint role does not signal any plans to merge the Finance functions of the ICBs, and the successful candidate will be jointly accountable to Amanda Sullivan, CEO of Nottingham and Nottinghamshire ICB and myself. As an interim step, I am pleased to announce the appointment of Claire Finn as the ICB's Interim Chief Finance Officer, to provide cover the role vacated by Keith Griffiths when he retires at the end of November. Claire will be joining us from University Hospitals of Derby and Burton, where she is currently the Interim Executive Chief Finance Officer. Claire joined the ICB on 18th November for a period of 6 months, or until the new Joint Chief Finance Officer is appointed. Claire is having a two-week handover period with Keith prior to his departure and will assume all of Keith's ICB and system financial responsibilities.

Of course, this will be Keith's final ICB Board meeting prior to his retirement, and I wish to place on record my sincere thanks for his expert stewardship of the ICB and wider NHS system's financial performance in the last two and a half years. Keith has played a crucial role in the sophistication of our financial planning and monitoring, our collaboration across the system's finance community, as well as ensuring we have been able to give the assurance required by our regulators on the credibility of our financial plans. The Board will join me in wishing Keith well for a long and happy retirement.

I continue to attend a range of local, regional and national meetings on behalf of the ICB Board and the wider Joined Up Care Derbyshire system. Our local performance conversations, along with regional and national assurance meetings have continued to be prominent since the last ICB Board meeting.

Dr Chris Clayton
Chief Executive Officer

National developments

Independent investigation of the NHS in England
Lord Darzi's report, published on September 12, provides an understanding of the current performance of the NHS across England and the challenges facing the healthcare system.

Government issues rallying cry to the nation to help fix NHS
Members of the public, NHS staff, and experts, are invited to share their experiences, views and ideas for fixing the NHS via the Change NHS online platform, which launched on October 21 and will be live until the start of next year. The public engagement exercise will help shape the government's 10 Year Health Plan which will be published in spring 2025 and will be underlined by 3 big shifts in healthcare.

Trial to let women use breast diagnostic clinics through NHS App
Women with worrying lumps are to be directly referred to a breast diagnostic clinic using the NHS App as part of a new trial, the Health and Social Care Secretary announced. This will lead to faster diagnosis for cancer patients and free up more GP appointments.

Major crackdown on NHS waste
A new strategy is being published to radically cut the number of single-use medical devices in the health service.

[One in eight toddlers and primary school aged children obese]
New statistics show around 15% of children aged between two and 15 were obese in 2022 – similar to 2019 (16%). The latest Health Survey for England shows 64% of adults were overweight or obese in 202, highlighting the importance of supporting people who are overweight to reach a healthier weight.

[Thousands more people with type 1 diabetes to get artificial pancreas in NHS roll out]
Tens of thousands of children and eligible adults living with type 1 diabetes across England are set to receive an 'artificial pancreas' thanks to cost-effective deals secured by the NHS with suppliers of the technology.

[NHS rolls out free eyesight, hearing and dental checks for children at residential special schools]
Children and young people with special educational needs and disabilities in residential special schools and colleges across England are to be offered free NHS eyesight, hearing and dental checks from next year.

[Pressure on A&E continues with 1.2 million extra attendances so far this year]
New NHS data shows there have been 1.2 million more accident and emergency (A&E) attendances so far this year compared to the same period before the pandemic, as the NHS ramps up its preparations for winter.

[England's NHS mental health services treat record 3.8 million people last year]
Around 3.8 million people were in contact with NHS mental health, learning disability and autism services over the last year, up almost two fifths compared to before the pandemic.

[Anonymous reporting for NHS staff to report sexual misconduct at work]
NHS staff will now be able to anonymously report incidents of sexual misconduct, as part of major plans to improve safety for staff across the health service.

[Over 10 million Covid and flu jabs delivered as NHS ramps up protection ahead of winter]
As of 17 October, NHS staff delivered more than 10 million Covid and flu vaccinations (10,709,958).

[Almost 1 in 10 secondary school pupils currently vape, new NHS survey shows]
A quarter of 11 to 15-year-olds have tried vaping and nearly 1 in 10 (9%) do it frequently, according to new statistics published in October. The Smoking, drinking and drug use among young people in England report for 2023 showed regular or occasional vaping in high school children had increased from 6% in 2018.

[NHS diagnoses thousands more cancers as cases rise by 5%]
New figures published in October show the NHS diagnosed over 11,000 more cancers in 2022, reaching a new record high level – with almost 950 people a day getting a diagnosis in England.

[NHS England Chair to stand down at the end of March]
The chair of NHS England Richard Meddings has this week notified the Secretary of State that he will stand down from his role at the end of March.

1,400 libraries now offering people support to use NHS App

The NHS is now offering the public support in how to access online health services including the NHS App at 1,400 libraries across England. The NHS has been working with the National Health Literacy Partnership over recent weeks to provide public and NHS libraries with toolkits and information resources to enable them to support their service users.

NHS launches major new stroke campaign as thousands delay calling 999 by nearly 90 minutes

Tens of thousands of people who have a stroke could be diagnosed and treated sooner as new data found that the average time between onset of first symptoms and a 999 call being made was nearly an hour and a half.

Local developments

Deputy Chief Executive confirmed at University Hospitals of Derby and Burton

Garry Marsh has been appointed as Deputy Chief Executive, alongside his existing Executive Chief Nurse role.

Deputy Chief Executive visits dentists to explore NHS dental provision expansion

The ICB's deputy chief executive Michelle Arrowsmith visited a Chesterfield dental practice to discuss the challenges and opportunities of expanding dental provision in Derbyshire.

"Think which service", urge health leaders

Health leaders in Derby and Derbyshire are urging people to "think which service" is right for their needs, as we head into the colder months.

New GP practice branch for housing site

A new GP surgery branch is to be built in South Derbyshire to provide for the healthcare needs of the growing local population. Newhall Surgery, in Swadlincote, has been awarded the right to build the facility on the Drakelow housing development site, near Burton-on-Trent.

New Director of Public Health Annual Report is a call to action to reduce smoking harms

Derbyshire County Council published the latest Director of Public Health Annual Report which focuses on the work being carried out across the county to go further and faster in reducing the harms caused by smoking, to save lives and create a smoke free future for the next generation.

Cabinet to decide on changes to learning disability support

Members of Cabinet, who meet on Thursday 14 November 2024, will hear that 324 people took part in a consultation on options to re-design day opportunities and short breaks that we provide. The report to be discussed says our emphasis on future planning for people with learning disabilities and/or who are autistic is being transformed to increase their independence to help them lead safe, fulfilled lives.

Updates from the Mental Health, Learning Disabilities and Autism Delivery Board
The Mental Health, Learning Disabilities and Autism Delivery Board brings together partner organisations working across health and social care in Derby and Derbyshire. The Delivery Board met on Thursday September 5 2024. This update shares key points of discussion from the meeting.

Upcoming changes to parking at Royal Derby Hospital
Construction will begin on a new multi-storey car park at University Hospitals of Derby and Burton from Monday October 14. The multi-storey will create more than 500 additional spaces when construction is complete in late summer 2025.

CT scanner delivery at Ilkeston Community Hospital
Ilkeston Community Hospital has taken delivery of its new CT scanner as the next step in the development of a Community Diagnostic Centre (CDC) onsite.

Have your say on stroke rehabilitation services
People across Derby and Derbyshire are being invited to have their say over services that help with recovery from a stroke.

Deputy Chief Executive goes 'back to the floor' with Ashbourne Ambulance Crew
The ICB's Deputy Chief Executive Michelle Arrowsmith went 'back to the floor' joining the Ashbourne ambulance crew for an eight-hour shift, experiencing life on the frontline.

Identification of Key Risks					
SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐
Not applicable to this report.					

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

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

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

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

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

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

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

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

Details/Findings
Not applicable to this report.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 080

Report Title	Joint Forward Plan Update							
Author	Craig Cook, Director of Strategy and Planning							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Presenter	Dr Chris Clayton, ICB Chief Executive Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Progress Report							
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 Joint Forward Plan Update for assurance purposes.
Purpose
In line with NHS England Guidance, the Derby and Derbyshire Integrated Care Board (the ICB) has reviewed progress of delivery against the first year of the Derby and Derbyshire NHS' Joint Forward Plan.
Background
In July 2023, the ICB published its *Joint Forward Plan* for the period 2023/24 to 2027/28, which set out the NHS' contribution to achieve the aims of the wider Integrated Care Partnership Strategy. In doing so, the plan set out key *guiding policies of action* for the Derby and Derbyshire NHS to change its operating model over the next five years, becoming more (i) preventative in nature; (ii) personalised for the citizen; (iii) intelligence led and (iv) with services integrated by design.
Report Summary
Against the backdrop of a very difficult operating environment, the report details some areas we were able to advance elements of our JFP aim to **enhance NHS "prevention focused" activity**, as follows:

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

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

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

However, we acknowledge that our improvement effort needs to focus on achieving more *fundamental* change at a greater scale and pace over the remaining period of the JFP period, which will be shaped significantly by the priorities of the new Government and its 10-year plan for health and care, which will be published in the spring 2025.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☒
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☒	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒
Details/Findings Not applicable		**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?					
Not applicable					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Not applicable					

Derby and Derbyshire
Integrated Care Board

Joint Forward Plan

Update

Our local health and care system

Our Integrated Care System (ICS) covers Derby and Derbyshire. It is made up of:

- NHS Derby and Derbyshire Integrated Care Board, working together with NHS provider organisations (independent organisations delivering health and care services)
- Integrated Care Partnership – this is a partnership committee between the NHS and the two upper tier local authorities. Its broader membership includes the Voluntary, Community and Social Enterprise sector and district authorities. Its principal purpose is to create an Integrated Care Strategy.
- Two Health and Wellbeing Boards from Derby and Derbyshire respectively. They oversee the Joint Strategic Needs Assessments. From these documents the Health and Wellbeing Boards create a joint Health and Well Being Strategy for each area.

The Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board is the organisation responsible for:

- Planning to meet local health needs
- Managing the NHS budget and allocating resources
- Ensuring services are in place to deliver against ambitions
- Overseeing delivery of improved outcomes for their population
- Working as an anchor institution to help the NHS support broader social and economic development.

Three areas of work

- Strategic commissioning (understanding need, putting in place services to meet that need, managing contracts for delivery of those services)
- Integrated care (convenor of the NHS family and wider system, joining services up at system and local level)
- Assurance (managing performance, quality and outcomes at a strategic, system, level)

Framing the Joint Forward Plan – the NHS' contribution to meeting the ambition of the Integrated Care Strategy

The Derby and Derbyshire Integrated Care Strategy has established an ambition for improving health and wellbeing across the life course of people living in Derby and Derbyshire – framed from the perspective of Starting Well, Staying Well and Ageing Well.

1. **Start Well** – People have a healthy pregnancy, children are born safe and well into a nurturing and secure relationship with care givers, with good nutrition, access to health care, social care, and education. Children thrive and develop positive and healthy relationships.

2. **Stay Well** - All citizens live a healthy life, can make healthy choices, and are protected from harm. They maintain quality of life and recover well from ill health or injury.

3. **Age Well** - Citizens thrive and stay fit, safe, and secure into older age. They maintain independence and actively participate in society. They have a personalised, comfortable, and supported end of life.

To deliver this ambition, the Strategy sets our four key areas of 'actions' for creating integrated care - thus affecting how the NHS will operate going forward.

The IC Strategy therefore forms one core input into the shaping of this Joint Forward Plan.

Prioritise prevention and early intervention to avoid ill-health	Reduce inequalities in outcomes, experience and access
Develop care that is strengths based and personalised	Improve connectivity and alignment to join up care

Our Joint Forward Plan – in a nutshell…

The intent of the JFP…

"The purpose of the Derby and Derbyshire NHS' Plan, is to set the NHS on a different course over the next five years and change the way it operates"…

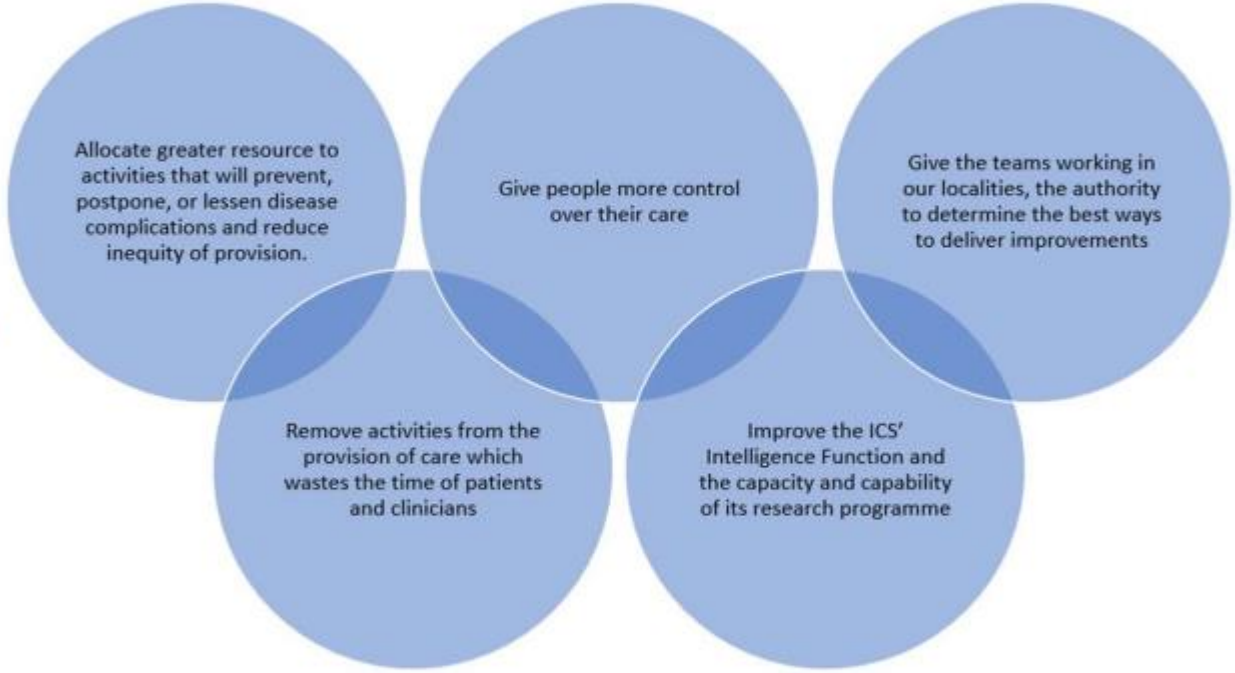
"The course will see the NHS change its operating model - so that it becomes more preventative in nature; more personalised for the citizen; intelligence led; with services integrated by design".

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

…"there are some fundamental aspects… which if properly addressed, would allow the NHS to meet these challenges in a more effective way:

- *The type of workforce that we invest in*
- *How we invest financial resource*
- *The nature of the care that we deliver"…*

Guiding policies for action…



Progress

Team Up model reducing A+E admissions

The 12 locally led neighbourhood teams in the Team Up model are seeing more than 5,000 people with frailty and complexity at home every month. This has contributed directly to slower growth in A&E attendance and non-elective admissions for over 65 with frailty. Over 86% of GP practices reported freed-up GP appointments.

Increased hypertension detection

We increased the number of blood pressure checks, identifying a cohort of people identified as having high to very high blood pressure and directing them to an appropriate intervention.

Increased access to care services for Children and Young People (CYP)

We have increased the number of children and young people accessing services by a third over.

Tobacco Dependency Treatment Services

We have enhanced access to NHS funded tobacco treatment services, with 3,400 people in a general acute and mental health facility accessing care.

Improved Dementia Diagnosis

We exceeded our target dementia diagnosis rate, achieving 68.2%, representing a 2% improvement on the March 2023 position.

Increased access to specialist perinatal and maternal mental health services

We increased the number of women accessing specialist perinatal and maternal mental health services by 80% and ended the year in the top 10 of ICBs nationally for best access levels.

New Leadership Development & Talent Management offer

A new consistent core offer is now available for leadership development and induction for all new leaders anywhere in the system supporting a culture of improvement, encouraging learning and promoting system working.

Further rollout of the Derbyshire Shared Care Record (DSCR)

The DSCR already helps to join up a patient's record from different health and social care organisations creating a comprehensive and up-to-date record and improving the care people receive. It is already used by a range of partners, but we will expand this further to partners such as EMAS, to support improved support to emergency crews and expand the local authority data set to include children's services.

Electronic Patient Record

The rollout of NerveCentre across our acute two hospitals will mean staff can have easy access to patient records at the bedside, at the click of a button. It is estimated to deliver 4.9 million hours back to patient care over seven years.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 081

Report Title	Seasonal Plan							
Author	Emma Ince, Director of Delivery							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Presenter	Dr Chris Weiner, ICB Chief Medical Officer							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 – Seasonal Plan Summary							
Assurance Report Signed off by Chair	Not applicable.							
Which committee has the subject matter been through?	Population Health and Strategic Commissioning Committee, 24th October 2024							

Recommendations
The ICB Board are recommended to **APPROVE** the Derby and Derbyshire 2024/25 Seasonal Plan.
Purpose
This paper provides a summary of the Seasonal Plan for 2024/25, including the approach taken, an assessment of capacity and demand over winter, and escalation and monitoring arrangements.
Background
The ICB has a key role in understanding the pressure across the system and ensuring that plans are in place to maintain safe and effective services. Every year health and care partners across the ICS bring organisational plans together, collaboratively contributing to an overarching system plan to ensure resilience over winter. The local seasonal planning process commenced earlier this year; an event was held in May 2024 to review the effectiveness of winter planning in 2023/24. All health and social care providers, including VCSE partners, were represented. Collectively representatives identified what worked well during last winter and what could be improved ahead of this coming winter. The outcomes and learning from this session informed seasonal planning for 2024/25. Following the review, a fortnightly seasonal planning forum was established to collaboratively develop the seasonal plan with good engagement from all system partners throughout the planning process. The seasonal plan builds on the work completed for the 2024/25 Operational Plan, encompassing the High Impact Priority Interventions included within the Urgent and Emergency Care Recovery Plan to ensure safe and effective care this winter.

NHS England publish guidance and areas of focus that reflect expected pressures over winter. The publication for 2024/25 arrived during September 2024 and the seasonal plan considers what is in place in Derby and Derbyshire against the requirements in the letter. A regional Winter Summit took place for the Midlands region on 10th September 2024. To date there has been no confirmation of additional funding for seasonal pressures, and the development of the system seasonal plan assumed no additional system income.

It is important that the system plan accurately reflects the plans in place across all local health and social care organisations. Health and social care providers across the Derby and Derbyshire Integrated Care System (DD ICS) have completed individual organisational plans to ensure safe and effective care is maintained during expected peaks in activity during the winter period.

Ahead of completion of the seasonal plan for 2024/25, NHS England requested a system submission relating to winter pressures and preparedness. Each system was asked to provide a comprehensive response to Key Lines of Enquiry (KLOE) that were shared in August 2024. The responses to the individual KLOEs were reviewed by a subject matter expert, providing their professional view and assurance rating for the system. Feedback was positive with a high level of assurance for responses to seven of the ten KLOEs and a further two rated as a mid to high level of assurance. Further detail was requested against three of the responses, and this has been resubmitted, awaiting final feedback.

Seasonal plan development reports through to the Urgent, Emergency and Critical Care (UECC) Delivery Board. The UECC Delivery Board reviewed the seasonal plan for 2024/25 on 7th November 2024 and reported a high degree of assurance on both the level of planning, and the plan. The Board recognised the urgent and emergency care demand across the region and noted that there are significant risks to delivery because of the climate in which services are operating. The plan includes the following sections, summarised:

- **NHS England Winter Letter for 2024/25**
  Including expectations set out in the winter letter received this year, with consideration of where these are reflected in the current High Impact Priority Interventions and the UEC recovery plan.
- **Demand and capacity position statement.**
  There is sufficient capacity to meet expected demand across services in Derby and Derbyshire with no organisations RAG rated as red. Amber assessments reflect a level of uncertainty with demand or a requirement for plans to be delivered to support capacity assumptions.
- **Overview of core services available over winter.**
  Including a range of services available to support urgent and emergency pathways across inflow, flow and outflow.
- **System risks, potential impact, and mitigation.**
  Across four thematic areas: workforce; capacity; demand and IPC
- **Prevention**
  Including an overview of the vaccination programme, and arrangements relating to infection prevention control (IPC)
- **System escalation, system monitoring and oversight.**
  Including the system co-ordination centre and arrangements for the winter room; detail regarding the weekly winter monitoring group set up to track changes to expected levels of demand and any risk to the delivery of plans to create additional capacity.
- **Communications**
  Summary of the communication plan including campaigns scheduled over winter.

Scenario stress testing of the seasonal plan is scheduled for the end of November and will inform the review of escalation triggers and processes that is currently underway.

Report Summary

Engagement in seasonal planning has been positive, with all partners actively contributing to the process. The seasonal plan has been considered by the Population Health and Strategic Commissioning Committee and the Urgent, Emergency and Critical Care Delivery Board. The plan has been submitted to NHS England and feedback is expected.

Delivery and performance of the seasonal plan is monitored by the Urgent, Emergency and Critical Care Delivery Board with specific additional monitoring arrangements in place over winter to manage emerging risk.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☒	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Included within report.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

Joined Up Care Derbyshire

Seasonal Plan Summary

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council

EXECUTIVE SUMMARY

- Capacity and demand profiling has been undertaken by all organisations; mitigation plans are in place to address any shortfall over winter.
- This plan details oversight and escalation processes to ensure a collective and dynamic management of risk is in place throughout the winter period.
- High demand is expected; system escalation processes must be effective to support the operating environment this winter:
    - Individual organisations have reviewed internal triggers and actions.
    - The ICB UEC Team are working with partner organisations to refresh the system escalation plan, agreeing thresholds and the arrangements for command and control during heightened pressure.
    - Demand, and the delivery of plans to create additional capacity will be tracked and monitored weekly throughout the winter period to ensure system partners have a shared understanding and awareness; and enabling the system to respond dynamically to emerging risk.
    - Delivery of the system UEC Rapid Action Plan will support with preparedness ahead of winter.
- The system seasonal plan is under continual review and will change to reflect system plans as they continue to develop

APPROACH & PURPOSE

- An effective system seasonal plan will ensure the system is safe over winter and that there is a shared understanding of demand and arrangements relating to capacity, surge and escalation.
- Partners and providers from across Derby and Derbyshire ICS have worked collaboratively to coproduce a system seasonal plan to ensure the system is prepared for the heightened demands of the winter season.
- Local approach:
    - Winter wash up - review of effectiveness of plans for 23/24 to inform arrangement for 24/25
    - Fortnightly planning group - full system representation to work through requirements
    - Regional Winter Summit – hosted by NHSE
    - Winter key lines of enquiry (KLOE) completed
    - Wider engagement – targeted engagement in addition to weekly planning group
    - Weekly Winter Monitoring Group – will be established from November – March
    - Effective System Control Centre and Clinical Navigation Hub, enhanced by adding a Winter Room facility
- Initial winter plan submission to NHSE on 23rd October

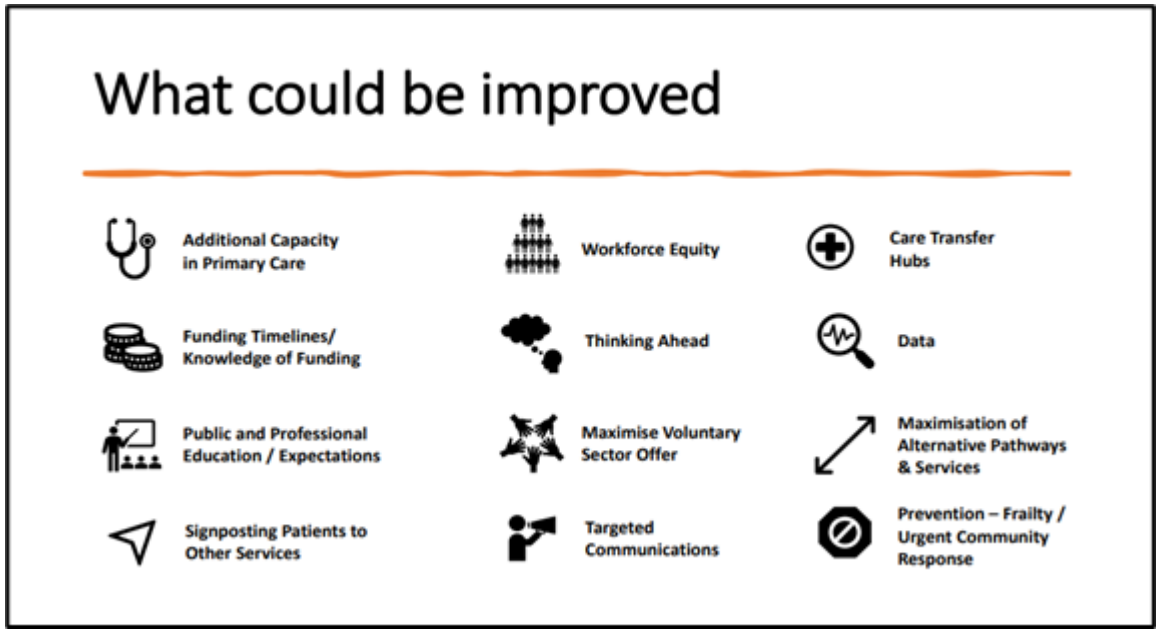
ROLES AND RESPONSIBILITIES

Integrated Care Board (ICB)	• The ICB coordinate efforts across healthcare providers to manage winter pressures, maintain oversight through the System Co-ordination Centre (SCC), implement the revised OPEL framework, develop a comprehensive winter plan, and report to NHS England (NHSE).
Hospital	• Hospitals need to ensure adequate staffing, maximize bed capacity, and implement strict infection control measures.
Primary Care and Community Health	• Primary care should manage non-urgent cases, promote vaccinations, and educate the public on health during winter. • Community health services must support patients at home, ensure timely discharges, and provide rehabilitation services.
Ambulance Services	• Ensure rapid response times and effective triage to manage emergency cases efficiently.
Local Authority	• Local authorities are responsible for coordinating with Integrated Care Systems (ICSs) to manage winter pressures, providing social care support to facilitate hospital discharges, and ensuring community services are available for vulnerable populations.
Public Health	• Public health focuses on leading vaccination campaigns for flu and COVID-19, conducting health education campaigns to inform the public on staying healthy during winter, and implementing infection control measures in community settings.

2023/2024 – LESSONS LEARNED

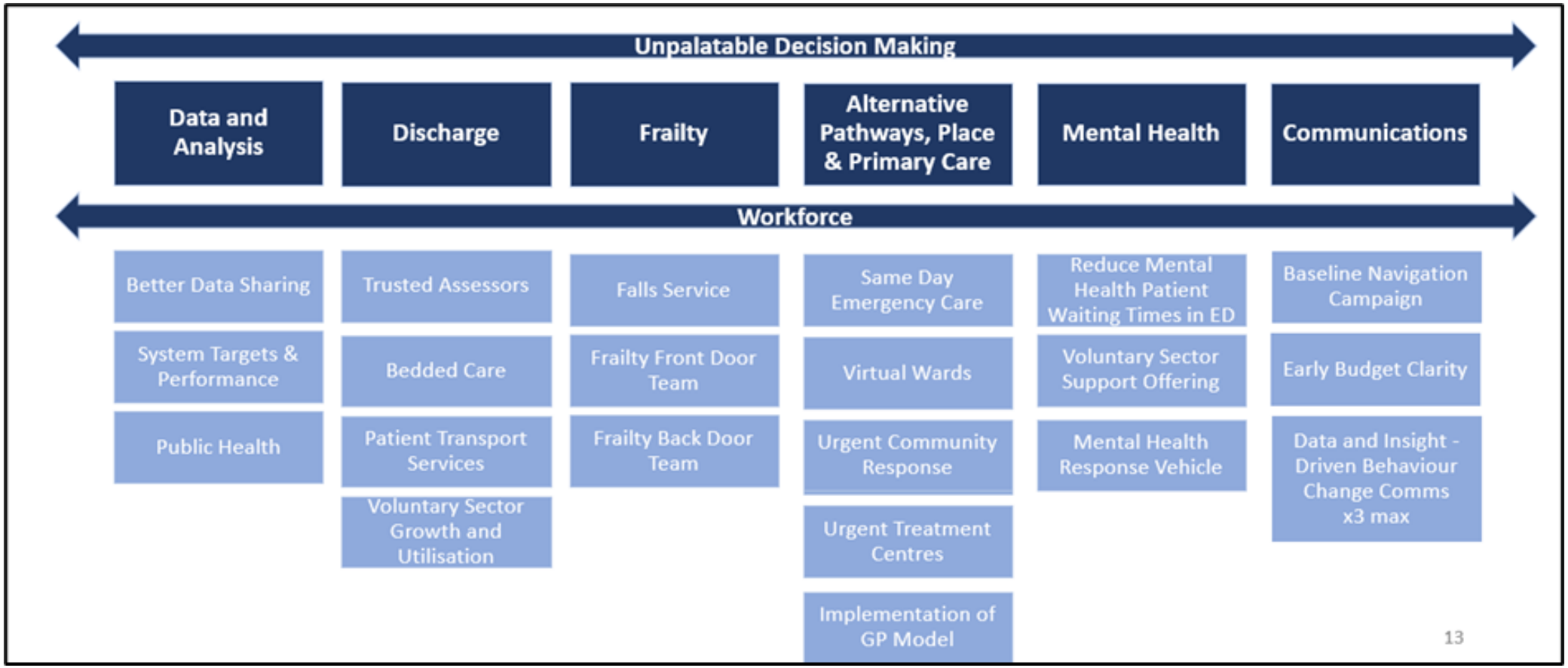
On the 1st of May 2024 Joined Up Care Derbyshire held a Winter Wash Up event with representation from all partners and providers across the system to reflect, review and start preparing for winter 2024/25.

The session was interactive, attendees were involved and engaged in collaboratively working to understand how effective plans for winter 2023/24 had been, what worked well, and where there were opportunities for improvement in winter 2024/25.



2024/2025 – AGREED PRIORITIES

A collective set of priorities were agreed at the end of the session and all providers were asked to ensure their internal winter plans aligned to the priorities agreed.



WINTER LETTER SUMMARY

- The NHS England winter letter for 2024/25 emphasises the need for:
  - Coordinated efforts across healthcare providers to manage winter pressures.
  - Adequate staffing
  - Maximising bed capacity and utilisation
  - implementing stringent infection control measures to protect service capacity

- The letter also highlights:
  - The importance of flu and COVID-19 vaccination uptake and associated campaigns and access
  - Public health education to inform the public on staying healthy

- Integrated Care Systems (ICSs) are tasked with leading these objectives, maintaining oversight through the System Co-ordination Centre (SCC), and ensuring a comprehensive winter plan is in place to support the entire healthcare system.

- The following three slides detail the priorities set out, the interdependencies between the UEC recovery plan, the NHSE winter letter and the UEC High Impact Interventions.

	UEC Recovery Plan	NHSE Winter Letter	UEC 10 High Impact Interventions
INFLOW	Reducing ambulance handover delays	**NHS Trusts are asked to;** **Ensure appropriate senior clinical decision-makers can make decisions in live time to manage flow:** • including taking risk-based decisions to ensure ED crowding is minimised and ambulances are released in a timely way	• **Single point of access**: Driving standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.
		• The system provider plans aim to manage flow to minimise ED crowding and support timely ambulance releases. This includes specialist in reach, additional senior decision-makers in ED and assessment areas, and support from DHU clinicians for appropriate triage and care settings. • Derbyshire plans to implement the regional 45-minute handover initiative with dynamic risk assessment to ensure timely ambulance releases and shared system risk. • The Clinical Navigation Hub will support demand management across the system, ensuring patients receive the right care in the right setting at the right time.	
	Reducing admitted and non-admitted time in EDs, with an intention of reducing long waits, particularly for mental health patients	**ICBs are asked to;** **Provide alternatives to hospital attendance and admission:** • especially for people with complex needs, frail older people, children and young people and patients with mental health issues, who are better served with a community response outside of a hospital setting • this should include ensuring all mental health response vehicles available for use are staffed and, on the road, ahead of winter • primary care and community services should be working with these patients to actively avoid hospital admissions **Ensure the proactive identification and management of people with complex needs and long-term conditions so care is optimised ahead of winter:** • primary care and community services should be working with these patients to actively avoid hospital admissions	**Same Day Emergency Care**: Reduce variation and provide guidance to operate SDEC services for at least 12 hours daily, 7 days a week. **Frailty**: Improve recognition and referral to acute frailty services to avoid admissions. **Urgent Community Response**: Increase and standardise referrals to improve care and reduce ambulance pressure and unnecessary admission. **Virtual Wards**: Standardise and enhance care to prevent hospital admissions and improve discharge. **Acute Respiratory Infection Hubs**: Roll out services for same-day urgent assessment to relieve ED and general practice pressures.
		• Derby and Derbyshire have several admission avoidance pathways to manage patients with complex needs and long-term conditions, providing alternatives to hospital attendance. High Intensity Users are supported within the community to avoid ED and the joint EMAS Paramedic and Mental Health Nurse See and Treat Model will operate daily from 4pm-1am starting in September. • Opportunities to increase Virtual Ward and CNH utilisation, review SDEC models for consistency, expand the HIU project beyond the City.	

	UEC Recovery Plan	NHSE Winter Letter	UEC 10 High Impact Interventions
FLOW	Maintaining average G&A core capacity across the year at the level achieved in the last quarter of 2023/24, equivalent to at least 99,500 beds nationally, allowing for seasonality	**NHS Trusts are asked to;** • review general and acute core and escalation bed capacity plans with board assurance on delivery by the peak winter period **Ensure the fundamental standards of care are in place in all settings at all times;** • particularly in periods of full capacity when patients might be in the wrong place for their care • if caring for patients in temporary escalation spaces, do so in accordance with the principles for providing safe and good quality care in temporary escalation spaces **NHSE will continue to support operational excellence by**; • co-ordinating an exercise to re-confirm capacity plans for this winter, which will be regularly monitored	• Medical bed provision and productivity
		• Trusts have reviewed their general and acute core and escalation beds and this is included as part of the system seasonal plan as well as internal mitigation plans for any areas of pressure. A commitment to maintain fundamental care standards throughout winter has been made and the principles for providing safe and good quality care in temporary escalation spaces will be adhered to. • Organisations have confirmed there will not be a reduction in the number of G&A beds throughout this winter and will maintain the Q4 position of last winter.	
	Improving length of stay for all admitted patients (specifically emergency admissions with a length of stay of 1+ day)	**NHS trusts are asked to;** • review and test full capacity plans. This should be in advance of winter in line with our letter of 24 June 2024, this should include ensuring care outside of a normal cubical or ward environment is not normalised; it is only used in periods of elevated pressure; it is always escalated to an appropriate member of the executive and at system level; and it is used for the minimum amount of time possible	**Intermediate care demand and capacity:** Supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
		• Acute Trusts regularly review and test their full capacity plans (FCP). The implementation of the FCP is considered and discussed via their x3 daily operational meetings, and this will continue throughout the winter period. Within these escalation areas, alternative pathways, ways to de-escalate are all considered. As part of BAU, our System Coordination Centre commander's seek assurance from Acute colleagues regarding de-escalation plans for any patients in un-conventional spaces ensuring this is not normalised. • Following completion of the winter plan, the system will conduct scenario stress testing.	

	UEC Recovery Plan	NHSE Winter Letter	UEC 10 High Impact Interventions
OUTFLOW	Reducing average delays post discharge ready date (combining the two published metrics (a) the percentage of patients discharged on their discharge-ready date and (b) the average delays for patients not discharged on their DRD)	**ICBs are asked to ;** • work with community partners, local government colleagues and social care services to ensure patients can be discharged in a timely manner to support UEC flow • ensure long patient delays and patient safety issues are reported, including to board level, and actions are taken appropriately, including involving senior clinical decision makers **NHS Trusts are asked to**; • ensure plans are in place to maximise patient flow throughout the hospital, 7 days per week: with appropriate front door streaming, senior decision-making, regular board and ward rounds throughout the day, and timely discharge, regardless of the pathway through which a patient is leaving hospital or a community bedded facility	• **Care Transfer Hubs:** Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
		• There is a Care Transfer Hub working group established to lead the development of one system Care Transfer Hub. The development of this will be an incremental process – with the current hubs operating out of CRH and UHDB continuing to do so until confidence in a new way of working is established. The hub aims to improve equity of access to intermediate care pathways for Derbyshire citizens with one MDT having oversight of all referrals. System partners are represented within the working group. Monthly highlight reports are shared with the Discharge Planning and Improvement Group (DPIG) for monitoring of progress. • OPTICA system rolled out in both acute hospitals providing real time information on discharge delays. The care transfer hub will work to collate a view of delays for citizens in OOA hospitals. • Providers have internal improvement plans to ensure that discharge processes are as effective as possible.	
	Improving length of stay in NHS commissioned community beds	**ICBs are asked to**; work with community partners, local government colleagues and social care services to ensure patients can be discharged in a timely manner to support UEC flow	**Community bed productivity and flow**: Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.
		• The community provider and both Acute trusts undertake weekly 'Long Length of Stay' Meetings to identify and address opportunities to improve LoS. • DCHS have regular meetings with Local Authority colleagues to support with onward care. • The ICB also has a Pathways Operations Group (stood up as required) and a Discharge Pathways Improvement group (weekly) that meet regularly. Members include all NHS partners including local authority to streamline the discharge processes and support UEC flow. • Opportunities to undertake MADE events in both community, mental health, and Acute settings.	

CAPACITY AND DEMAND

POSITION STATEMENT – FULL SYSTEM

Provision		RAG (Capacity)
Chesterfield Royal Hospital	• Chesterfield Royal Hospital has a core bed base of 527 beds, with an average occupancy of 95% from October 2024 to March 2025 (between 92%- 98%). Internal improvements aim to reduce Length of Stay, improving the bed base by approximately 45 beds • **Peak bed demand in February 2025 is predicted to be 541,** which balances out after improvements and escalation beds • Focused improvement work required in the community to support patients getting home, particularly for P1. Consider the utilisation of voluntary sector services. • An additional 15 escalation beds will be available for use during winter (Oct 24 – Mar 25).	Dependant on D2A capacity
University Hospitals Derby and Burton	• RDH is currently operating with a medical bed gap, using 42-50 outlying beds and two A&E escalation areas (C-side and The Quad) for an additional 16 spaces. The Acute Front Door Project starting in October 2024 will temporarily remove this capacity, the Discharge Assessment Unit (DAU) will provide overnight care for 18 patients as a temporary escalation space. • **UHDB predicts a winter bed deficit of 191 beds, with 29 at QHB and 162 at RDH, based on 98% occupancy at its peak in January**. Planned mitigations/ actions are in place to address this deficit and have accounted for lost capacity, with a broader focus on ensuring there is the right capacity across the internal bed base for 2025/26.	The modelling is based on a 98% bed occupancy
Community Urgent Treatment Centres	• Plans indicate sufficient capacity to meet the demand, 13% planned daily increase in appointments for Winter 24/25 vs 23/24, • The Ilkeston plan involves a phased increase in appointments from October to March, aligned with recruitment and retention plans. (appointments increase from 40 to 90). • DUTC is already operating above expected volume. No workforce/capacity concerns have been flagged; therefore, the assessment is that there is sufficient capacity within the DUTC to meet the level of demand.	Whilst sufficient capacity outlined, it is dependent on recruitment/ workforce plans
Co-Located UTCs	• Plans indicate sufficient capacity to meet the demand this winter • Opportunity to increase activity and throughput into the co-located UTC. Work taking place with Acutes and DHU to support this.	Increase in utilisation required to support wider system pressures.
Same Day Emergency Care (SDEC)	• Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day , 7 days a week. • Workforce review. Demand and capacity modelling (in progress). Rapid access to diagnostics 7 days a week. • Maximising opportunities including direct referrals from alternative pathways.	Improvement plans in place, demand and capacity modelling in progress
Virtual Ward Capacity	• An audit has been completed; positive findings indicate 100% of Derby and Derbyshire patients on the Virtual Ward were the right patients. • Sufficient capacity to meet the current demand, however, there is an opportunity to increase the utilisation within Derbyshire to support with reducing ED attendance and admissions through a step-up model. This is being explored through the development of a generalist and step up model to support community teams.	Increase in utilisation required to support wider system pressures.

POSITION STATEMENT – FULL SYSTEM

Provision		RAG (Capacity)
D2A Modelling	• Overall, the winter period shows there to be a gap in Pathway 2b beds in January 2025 (-10) and March 2025 (-1). • The modelling indicates there is sufficient capacity within the D2A pathways (excluding the above P2b gap). However, the data is not reliable as it also factors the Private, Voluntary, Independent (PVI) provision into the modelling. The delays to discharge have not been quantified including the time it can take to secure packages, therefore there is a potential for delays in access for patients requiring D2A packages within the County which will impact CRH. • This has highlighted the need for targeted interventions to manage deficits in the North of the County, please refer to the Full Seasonal Plan for more information regarding mitigations. • Winter Escalation post being established to co-ordinate system capacity and demand and oversee Pathways Operations Group (POG) meetings	While the collective position shows balance, there are different pressures in city/county which offset each other as part of the total position.
Mental Health	• Plans indicate sufficient capacity to meet the demand this winter • Projected position based on demand increase of 4% this winter is forecast to be managed through internal Acute beds and out of area placements.	MH bed challenges nationally. Requires system support with NCTR
Primary Care	• Whilst the capacity has been modelled on 23/24 actuals, the impact of collective action and any gap in provision is unknown. • There has been no additional funding provided for the delivery of ARI hubs therefore, there is a decrease in capacity compared to last year.	Unknown impact of collective action
111 Capacity	• Plans indicate sufficient capacity to meet the demand this winter • There is a plan in year to reinstate urgent dental capacity. The ICB is awaiting final sign-off of plans which aim to increase patient access and to assist those with urgent treatment need	
999 Capacity	• Plans indicate sufficient capacity to meet the demand this winter • Work is ongoing with system partners to implement the 45-minute handover initiative	
Patient Transport Services (PTS)	• The additional 5 vehicles which have been ringfenced for discharge will support the system this winter. These have been funded through the BCF until the end of March 2025 and are a repeat of last year's initiative.	Increasing the number of pre-booked journeys will support .
Community services, such as Urgent Community Response, Team up, Community Nursing	• Predominantly sufficient capacity to meet current demand, there are opportunity to increase referrals into Team up including into the Falls recovery service. • There are some challenges within the community nursing services which have mitigating plans in place • Current Team Up challenges in Derby City, including planned withdrawal from the service by a number of PCNs/Practices, and their objection to signing the Data Sharing agreement will have a negative impact on the capacity of the HIU service.	Clinical prioritisation in place to ensure urgent referrals seen.
Clinical Navigation Hub	• Maximising opportunities to increase flow into the CNH – 111 online platform dispositions are being explored. • Continued collaboration with EMAS to increase appropriate referrals.	

MITIGATION

N.B. The table below is a summary and does not detail all mitigation planned.

Chesterfield Royal Hospital	University Hospitals Derby and Burton	Mental Health	Alternative Pathways, Place and Primary Care
• Flexible use of additional medical capacity • Critical Care surge capacity • Elective surge capacity over winter • Increased bed base in Paediatrics • Improving onboarding rates on virtual wards • Reprovision of some P2 capacity on site at CRHFT to meet unmet demand • LLOS work Deep dives into top 5 Patients each week • Home from Hospital Coordinator increase hours/wte • Weekend Cover for Discharge Coordinators • An additional Senior Matron for 6 months to support M&EC leadership team. • Medical and Nursing staffing establishment in ED • Band 7 in ED to have a helicopter role to facilitate improved operation management on shop floor • Additional operational admin support (chaser) in ED Ambulatory Care to improve patient flow and reduce wait times • Additional Airvo machine • Additional Paediatric doctor overnight during the winter period to support Nightingale, Neonates and in reach into ED • Increased Rapid Access Clinics which will provide additional urgent clinic slots • Paediatrics outreach nurse to be implemented to do 'fresh eyes' assessment of all Paediatrics areas including ED – 24/7	• Additional medical capacity • Consolidation of all Gynaecology activity on Ward and release of Gynaecology Day case • Additional scanning capacity • Right sizing SDEC • Additional ICU nurse and consultant staffing • Additional Caesarean Section lists for Maternity Surge (usually seen in September) • Right sizing SDEC • UTC at QHB • Expansion of Orthopaedic Assessment Unit (OAU) offer • Enhanced Pharmacy Support • CTAU- Proposal to open until 9pm • Discharge Support Officer (DSO) on NMU to support with discharges • Proposal to staff 2x super surge beds on 303 to support bed base • Ward 2 beds – additional capacity for 5 beds • Additional Portering • Additional Physiotherapy and OT (DME & Stroke • Additional Community Capacity - Phillip Ward staffing • Mortuary Body store Cross Site Contingency – increased capacity for increased demand • Increased Phlebotomy	• Mental Health Response Vehicle • Community LD / Crisis Services • DCHS OPMH bed capacity will be set at 18 with ability to flex to 19 as required and where staffing allows • LD Intensive Support Team • Emotion Regulation Pathway (ERP) • Increase in Inpatient Resource • Increased resource in Health Based Place of Safety Suites - Currently 2 HBPOS Suites – 1 at each unit. • Deaf and Hard of Hearing Line – implemented from December 2023 following NHSE mandate.	• DCC/ DCHS Sprint work to continue to increase flow through P2 bedded settings . • Additional PTS discharge vehicles • Perth House – trialing reduced beds flexibility : 15 beds at ability to manage increased needs based on acute demand • Winter Escalation post being established to co-ordinate system capacity and demand and oversee POG meetings • Vaccination Programme Delivery • MADE Events – proactive plans around peak periods (e.g. Christmas/ Half Term / Easter. • Voluntary Sector Access • OPTICA • SHREWD • Community Diagnostic Centres

SERVICES IN PLACE TO SUPPORT THE URGENT AND EMERGENCY CARE PATHWAY

SERVICES IN PLACE TO SUPPORT THE UEC PATHWAY

N.B. The table below is a summary and does not detail all mitigation planned.

See Key	Service	Description
I	Urgent Treatment Centres (UTC)	Urgent Treatment Centres deal with many of the most common ailments people sometimes attend A&E for. There are 4 community base UTCs, and 2 co-located UTCs at both sites.
I	NHS 111	NHS 111 services aim to ensure that patients get the right advice and treatment they need in the most appropriate care setting.
I	GP In hours	On the day appointment capacity will support the management of urgent primary care needs of patients this winter.
I	GP OOH	Delivers a versatile and responsive service to meet the urgent primary care needs of patients.
I	EMAS 999	Provide emergency ambulance response services, patients are referred to the most appropriate services.
I F	Mental Health Liaison	Liaison mental health services support people in crisis in all areas of the hospital including the Emergency Department.
I	MH CRISIS Support	Home based intensive support will help reduce both the number and length of hospital admissions and ease the pressure on inpatient units.
I	Mental Health Response Vehicle	A joint EMAS Paramedic and Mental Health Nurse See and Treat Model is in operation daily from 4pm-1am. It aims to reduce the dispatch of an ambulance for mental health related calls, reducing mental health attendance at ED and supporting purposeful admissions.
I	Mental Health NHS111 option	NHS 111 mental health option provides immediate access to mental health support, helping to prevent crises and reduce the need for emergency services.
I O	Team up	The Team Up Urgent Community Response service offers crisis care within two hours and reablement care within two days of referral. It includes home visiting services by health and care professionals, rapid response nursing and therapy services and expanded falls prevention and recovery services across the city and county.
I O	Pharmacy first	Pharmacy First enables patients to be referred into community pharmacy for a minor illness or an urgent repeat medicine supply.
I O	Urgent Community Response (UCR)	Providing urgent responsive community nursing care to the housebound in and out of hours, so patients are being managed effectively in the community in a timely manner, supporting end of life patients, recent discharge patients and to prevent admission.
I	Clinical Navigation Hub (CNH)	Clinical Navigation Hub navigates patients, directing them to the right services in a timely way.
I	Vaccination Programme	This programme encourages the uptake of vaccinations including those for COVID, Flu and RSV.
I O	Time limited bed based & homecare support	A range of Health and Social Care services including 24hr community bedded care and homebased reablement support.
I O	Virtual Wards	Provision of hospital-level care at home, reducing the demand for acute bedded services.
I O	End of Life Care	Provision of specialist, palliative and end of life care and support for adults and children with life limiting illness.
I F	Acute Trusts	Including (but not limited to) Emergency Department, Assessment Units, Inpatient and Critical Care provision.
I F	Same Day Emergency Care	Same Day Emergency Care and enhanced front door frailty services provide consultant led assessment and care plan. Patients are referred to the most appropriate place of care, hospital admissions are avoided where possible.

Key and Descriptions:	
I	Inflow
F	Flow
O	Outflow

RISKS AND MITIGATIONS

Please note: This slide is a high-level summary of the risks/mitigations highlighted within individual plans.

KEY SYSTEM RISKS & MITIGATIONS

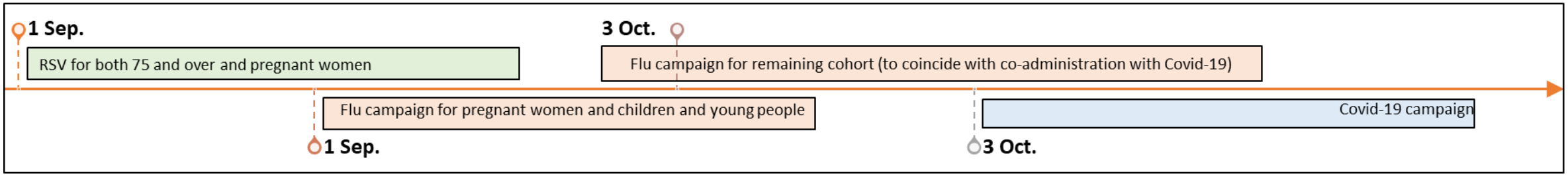
Risk	Description	Impact	Mitigations
Workforce	• Insufficient staffing levels • Potential industrial action	• Increased sickness and burnout • Reduced capacity of services due to insufficient staffing • Reduced staff resilience • Financial cost of additional temporary staffing	• Increase recruitment, use temporary staff, provide staff wellbeing support including mental health support, offer flexible shifts where possible. Effective management of annual leave. • Strong planning with system partners, developing contingency plans to manage risk and ensure essential services continue • Encouraging vaccination uptake
Capacity	• Limited bed availability and resources to handle increased demand across all services • Ambulance handover delays and delayed ambulance response times • GP collective action • No additional funding for ARI hubs this winter, reduction in capacity/ offer from last year	• Increased use of unconventional care settings and the associated risk. • Delayed ambulance response to patients in the community. • Patients not receiving the most appropriate support in a timely way. • The financial cost of escalation • Reduction in General Practice capacity due to implementing safer limits to the working day (Contractual Action) • Risk of general practice signposting/referring to other sites	• Supporting patients to stay well at home • Planned additionality within a range of services • Effective utilisation, optimal length of stay and throughput from existing services to maximise capacity. • Optimal patient flow and discharge processes to minimise delays with effective coordination with community services. • Streamlined handover processes, improved communication between ambulance services and hospitals, and implementation of rapid triage and handover protocols to maintain capacity within ambulance resources

Demand	• Increased demand across the UEC pathway
	• Increased acuity
	• Increased demand for primary care services
	• Overcrowding in emergency departments
		• Longer waiting times
		• Potential delays in care
		• Harm related to delay
			• Demand management and resource planning
			  • Targeted Communication campaigns, informing patients of use of appropriate services.
			  • Improved utilisation of alternative pathways such as CNH, SDEC, UCR, UTCs, VW including
			  • Increased see & treat, hear & treat and direct pathway conveyance other than to ED.
			  • Patients redirected to pharmacies, increased referrals into the Pharmacy First Service
			  • Service level capacity and demand plans in place to manage expected activity

Infection, Prevention Control (IPC)	• COVID, Influenza, Respiratory Syncytial Virus (RSV), Norovirus, and MPOX within care settings. • There is an increased risk of whooping cough (pertussis) due to a rise in cases observed earlier this year	• Increase in hospital / other care setting acquired infection • Increased resources required for cleaning and decontamination • Potential delays in next step of care • Increase demand for side rooms • Increase in staff sickness • Increased demand for speciality services	• Encourage uptake of vaccinations for the public and the workforce • Regular hygiene practice reminders • Monitoring of IPC risks • Provide regular staff training • Fast implementation of strict isolation processes • Ensure adequate PPE is available and used with regular deep cleans • Education, support and adherence to policy in all health and care settings • Easy access to expert IPC advice • Pro-active vaccination projects PCNs/Practices are undertaking will support with vaccine hesitancy and target patients not vaccinated to-date despite repeated invitations

PREVENTION

VACCINATION PROGRAMME



NEW PROGRAMME Respiratory Syncytial Virus (RSV) commences 1/9/24

- Programme for older adults: Everyone turning 75 years old on or after the 1 September 2024 will be offered a single dose of RSV vaccine. The vaccine will also be offered to those who are already aged 75 to 79 years on 1 September 2024 as part of a catch-up programme. This will be delivered via GP practices
- Programme for pregnant people to protect infants: All those that are at least 28 week pregnant will be eligible for the vaccine. This will be delivered via maternity services at CRH and sites and UHDB (London Road and Queen's Hospital Burton). Opportunistic vaccination will be undertaken at GP practices also

Flu season 2024/25 will be a phased delivery:

1st September

- pregnant women – delivery model is via maternity providers and opportunistically through GPs
- children and young people – delivery model is via GPs and through School Aged Immunisation Service

3rd October 2024

- those aged 65 years and over
- those aged 18 years to under 65 years in clinical risk groups (as defined by the Green Book, Influenza Chapter 19)
- those in long-stay residential care homes
- carers in receipt of carer's allowance, or those who are the main carer of an elderly or disabled person
- close contacts of immunocompromised individuals
- frontline workers in a social care setting without an employer led occupational health scheme including those working for a registered residential care or nursing home, registered domiciliary care providers, voluntary managed hospice providers and those that are employed by those who receive direct payments (personal budgets) or Personal Health budgets, such as Personal Assistants
- All frontline health care workers, including both clinical and non-clinical staff who have contact with patients, should be offered flu vaccine from October as a vital part of the organisations' policy for the prevention of the transmission of flu

COVID-19 – commences 3/10/24

- 124 sites delivering COVID-19 vaccination across JUCD
- Can be co-administered with flu
- The eligible cohorts have been identified by JCVI as
  - all Adults over 65
  - residents in older adult care homes
  - persons aged 6 months to 64 years in a clinical risk group
  - Frontline health and social care workers (government decision)

INFECTION PREVENTION CONTROL

- Regular meetings taking place to review IPC processes in organisations
  - IPC teams proactively supporting de-isolation of patients and monitor for escalation for cohort bays
- Regional IPC input and support available as and when required.
- Organisations have reviewed their internal IPC plans and are aligned with the National IPC manual.
- All organisations are committed to enhancing their Vaccination Programmes to ensure staff are well-protected and prepared for the winter season
- Individual providers have confirmed they have plans in place for managing Measles, Mpox, Covid, Norovirus, Flu and other infectious diseases.
  - Emergent disease and IPC working groups stood up, dynamically reviewing information, risks and plans accordingly.
- IPC updates will be shared at the weekly Winter Monitoring group.

SYSTEM ESCALATION & MONITORING

SYSTEM COORDINATION CENTRE (SCC)

- Daily management of operational pressures as part of established BAU.
- A physical 'Winter Room' in operation from the 1st of November at the Scarsdale site.
  - Support focused resilience and risk understanding and mitigation response
  - Plan transition to Operations Room with year-round availability in response to escalation
- Senior Operational Cover to be provided 08:00 – 18:00, 7/7, supported out of hours by the on-call teams.
  - Potential to extend SCC until 8pm each day
  - Clear access to Senior Clinical Leadership to support with risk management and escalations
- Operational oversight and understanding of the system position through the daily system call and Provider bed/capacity meetings.
- Live position visible via SHREWD, EMAS Screens, NACC
- Winter room shared space with EPRR, enhancing response to EPRR/business continuity incidents and closer working between EPRR and UEC Teams.
- Clear escalation process into the SCC across the system
- SCC management of single point of contact (SPC) inbox into the ICB
- Recent peer reviews set against NHSE Maturity index – positive feedback.
- Coordination of mutual aid beyond DDICB as part of escalation

SYSTEM ESCALATION, MONITORING AND OVERSIGHT

BUSINESS AS USUAL

- Senior Operational Management Cover from 8am – 6pm 7/7
- Team supporting with operational oversight and management, providing updates to regional colleagues, as necessary.
  - Monitoring of ambulance handovers
  - Mutual aid requests within ICS
  - Repatriations
  - Mental Health Escalations
  - Ensuring Alternative Pathways are pursued
- Daily System Calls and routine updates
- Automated data flow

WINTER (November – March)

- Extend operating hours to 8pm
- 'Winter Room' – local ops centre being established at Scarsdale
- Winter Director identified
- Escalation Process and Trigger review
- OPEL framework and guidance expected for: Acutes, MH, 111, Community and Primary Care.
- Automated data flow – incorporating changes from OPEL refresh
- Weekly Winter Monitoring Group
- 45minute Ambulance Handover initiative
- Quality led NHS visits to sites, supportive peer and not assurance
- Daily system calls extended to include weekends

HEIGHTENED PRESSURE AND ESCALATION MANAGEMENT

- Clear escalation triggers and scores determining which process to follow
- Agreed meeting cadence initiated
- Senior Leadership involvement
- Dynamic risk assessments
- Mutual aid beyond DDICB
- Regional Support
- Unlocking blockers to provide additional resource

COMMUNICATIONS PLAN

As part of the winter planning, the Communications Team has developed a communications plan that reflects early discussions and prioritises campaigns aligned with capacity and feasibility. The chosen campaigns also reflect the priorities identified during the winter wash-up event, supporting key objectives such as discharge, navigation, and urgent treatment centres, all focused on enhancing public education.

September	October	November	December	January	February	March
	Covid and Flu					
	Navigation campaign – Think Which Service					
		Self-referral library				
	Derbyshire County Council – Stay Well This Winter					
	Urgent Treatment Centres					
	Discharge					
	Save Havens/Crisis Hubs					

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 082

Report Title	Strategic Update from the Provider Collaborative							
Author	Tamsin Hooton, Programme Director, Provider Collaborative							
Sponsor (Executive Director)	Chris Clayton, Chief Executive Officer							
Presenters	Stephen Posey, Chief Executive Officer, UHDBFT Tamsin Hooton, Programme Director, Provider Collaborative							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Provider Collaborative Update Report Appendix 2 – JUCD Provider Collaborative Priorities and Work Programme 2024/25							
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 update on the Strategic Update from the Provider Collaborative for assurance.

Purpose

To provide an update on the priorities and work programme of the JUCD Provider Collaborative.

Background

The JUCD Provider Collaborative is a key part of the ICS system, bringing together NHS providers to work together on improvement priorities. The Collaborative was formed in 2022 with the creation of the Provider Collaborative Leadership Board, which has been leading the development of the collaborative, including developing its work programme and contribution to the ICS Joint Forward Plan. The attached paper provides an update on the work of the collaborative.

Report Summary

See attached report at Appendix 1.

Identification of Key Risks

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

SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☒
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☒	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

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

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

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.					

Provider Collaborative Update

JUCD ICB Board November 2024

1. Introduction and Background

The JUCD Provider Collaborative has been meeting since 2022, first in 'shadow' form and then more formally after the Health and Care Act changes as a part of the JUCD Integrated Care System (ICS) architecture.

The Collaborative is what is known as an 'all in' collaborative, that is it includes providers of all sectors representing the totality of NHS provision in the ICS. The members of the JUCD Collaborative are:

- Chesterfield Royal Hospital NHS FT
- Derbyshire Community Health Services NHS FT
- Derbyshire Healthcare NHS FT
- DHU Health Care C.I.C
- East Midlands Ambulance Service NHS Trust
- GP practices are represented by the GP Provider Board
- University Hospitals of Derby and Burton NHS FT

This paper provides an overview of the collaborative's priorities, progress on our work plan, governance and resourcing of the collaborative and considers the future contribution of the collaborative to the ICS.

2. Role of the collaborative - vision, purpose and priorities

The collaborative has agreed a clear vision and purpose [see slide 2 in appendix 1]. Our core purpose is to work together to do things that cannot be achieved through individual providers working alone. Our vision is *'**to work together as providers to achieve tangible improvements to the way care is delivered,** supporting the Joined Up Care Derbyshire quadruple aim'* and also helping to deliver the JUCD Joint Forward Plan (JFP).

The collaborative's three priorities are:

- Working together to **improve productivity and efficiency**, supported by a strong system continuous improvement approach
- Developing **at scale integrated care models** and pathways that improve sustainability and outcomes, including addressing fragile services
- Standardisation, harmonisation and consolidation of **corporate and back-office functions**

As an 'all in' collaborative we have recognised that there are many different scales and variations of collaboration and partnership working to address different problems, and not all providers need to be involved in every collaborative scheme. The collaborative acts as an umbrella for multiple different partnerships and alliances to solve different problems, supporting collaborations rather than being a homogenous entity. Examples of bi-lateral collaboration that are supported by the collaborative and respond to our shared priorities include the neurodivergence alliance between DHCS and DHCFT, CAMHs partnership work between DHCFT and CRH, CRH and UHDB working towards a partnership model of

ophthalmology and the integration of urgent and emergency care provision between EMAS and DHU.

The past twelve months have seen the collaborative reappraise its focus and hone down our priorities, concluding that we must focus on doing a small number of things well at this stage of our maturity. We have undertaken a self-assessment using the national maturity matrix for collaboratives and are using this to help guide our development plan. We are 'developing' in relation to the national expectations of collaboratives, and have some areas of development, including programme delivery and impact on health inequalities among other things. Our focus is on the 'value added' through partnership working or integrated care, rather than having oversight of the combined responsibilities of existing statutory organisations.

3. Work programme and benefits plan

The collaborative has agreed a programme of work that responds to our three priorities, which was approved by the Collaborative Leadership Board in July of this year. There are a number of initiatives with this work programme, and details of each initiative including key deliverables are included in the slide pack attached as Appendix 1. The current work programme includes the following projects:

3.1 Productivity and efficiency supported by continuous improvement approach

- NHS Impact - Joined Up Improvement, shared training and skills development programme
- System ePMO and programme management approach
- Primary secondary care interface - single points of contact

3.2 Sustainable, integrated care including fragile services

- Ophthalmology - single partnership model of delivery
- Haematology (mutual aid and left shift)
- Neurodivergence (ALD) Alliance
- CAMHS partnership, workforce sustainability and efficiencies
- Speech and Language Therapy - single children's service model
- Musculo-Skeletal improvement programme

3.3 At scale corporate and enabling functions

- Shared procurement workstream
- People services collaborative (recruitment and supply, Derbyshire Academy, digital people services)
- Estates strategy, utilisation and efficiencies workstream
- Shared enabling functions ‘at scale’ model, in development
- Digital and data including contract harmonisation, service consolidation and automation projects

Each workstream has an SRO and in most cases we have identified a named programme lead for each scheme. Detailed project plans have been developed although in some cases projects are at an early stage of development or existing workplans are being revised. Programme reporting is fed through the system ePMO into PCLB and the collaborative also provides updates on progress to a number of ICB committees and programme boards.

Our current focus is creating a comprehensive benefits plan for the collaborative, which clearly articulates the impact that each project will have, whether benefits are financial or deliver improvements to quality, patient or staff experience. In this respect, the provider collaborative is in a similar position to the place work programme and the system transformation and

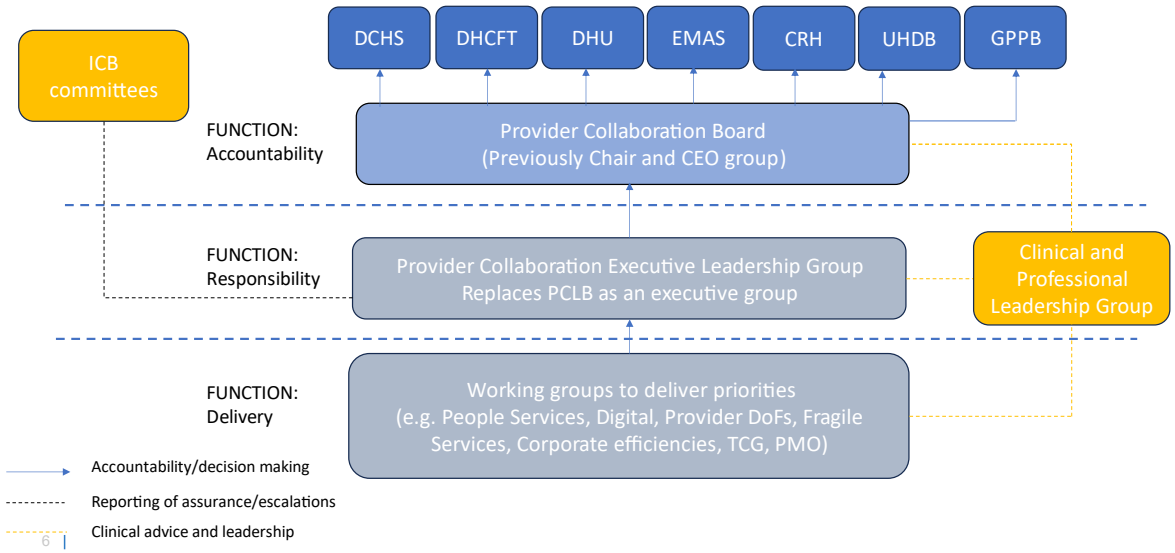
Delivery Boards. The system PMO team is providing central support to develop a consistent approach to benefits realisation, recognising that there is a need for skills development and analytical support to do this consistently well across multiple system programmes.

The PCLB will be responsible for benefits realisation and tracking and reporting benefits to other system groups. Although our benefits plan is still in development, there are tangible contributions both financial and non-financial emerging from the work, including financial benefits from shared procurement, and support for waiting times and equality of patient access in some clinical pathways e.g. SLT and haematology.

4. Governance and relationship to the ICB

The provider collaborative is led by the Provider Collaborative Leadership Board (PCLB), which is a Chief Executive level group, accountable to provider Boards. We are in the process of refining the governance for the collaborative in response to a review of our effectiveness and learning from other collaboratives. This will involve making the current informal Chairs and CEO group into a formal Provider Collaboration Board, which will provide the strategic leadership for the collaborative, and reframing the current PCLB into a Provider Executive Leadership Group, which will be responsible for our workplan delivery and will include a wider cross-section of Executives and programme SROs. The diagram below shows the future structure, which is operative from October 2024 but subject to formal sign-off by provider Boards.

Governance structure for JUCD provider collaborative(October 2024)



5. Resources to support the collaborative and system improvement work

One of the greatest challenges for the collaborative, which affects progress and impact, is identifying sufficient resources to deliver our work programme and progress the opportunities that we have identified.

The Collaborative is supported by a very small team consisting of two dedicated roles, a Programme Director and a Strategic Finance lead. The SRO for the collaborative, CEO of

UHDB, as well as the SROs for the individual collaborative programmes of work, are all substantive provider executives from across the partner organisations. This time is given voluntarily, but releasing sufficient time to progress delivery of our objectives at pace in addition to existing responsibilities and operational pressures within statutory organisations remains an ongoing challenge. There are similar constraints in releasing project management time. In some cases we have created new dedicated roles e.g. the ophthalmology integration role, but workforce and financial constraints mean that doing this across all our programmes is unrealistic at this time.

In addition to roles which are dedicated to supporting the collaborative, the collaborative hosts the system PMO function, which is a small team of 2.6 wte. This team leads the system ePMO development and reporting, supports the Joined Up Improvement work on continuous improvement and provides support for programme management across all ICB led programmes and place programmes as well as the collaborative's workplan. Some of the collaborative's senior management time is also therefore spent supporting wider system working in relation to improvement, transformation and programme management, as well as the collaborative's specific priorities.

The Collaborative leadership would welcome a discussion regarding how we align more of the ICB resources around transformation, delivery and quality improvement to support the collaborative priorities, where this supports delivery of the Joint Forward Plan. Currently we risk duplicating resources and efforts in different parts of the system.

6. Learning and reflections, looking to the future

The provider collaborative has taken time to mature and develop, including developing clarity and consensus about what the collaborative is for and what it is not. As with any strategic change of this scale, it has taken time to establish the fundamentals of delivery including clarity about priorities, ways of working and delivery structures. The collaborative now has a clear and well-structured work programme and a strong foundation from which to move forward to delivery.

Distributed leadership is a defining characteristic of the JUCD system and sometimes works well but at times accountability and roles can be unclear. As a system we should consider how to strengthen accountability and support for leadership within the collaborative within the ICS architecture to be more effective in delivering the aims of the ICS strategy and JFP.

Our focus on delivery of benefits is very much aligned with work across the wider system approach to benefits realisation and delivery of the JFP, the collaborative has a significant contribution to made to addressing some of the key priorities in the system. However, it is only one element of wider system working and the collaborative is not a shorthand for the combined responsibilities of the NHS providers.

There has been some successful progress in developing partnership working in a number of service areas including speech and language, neurodivergence as well as enabling functions which can be built on to deliver benefits at greater scale.

Joined Up Care Derbyshire

JUCD Provider Collaborative

PRIORITIES AND WORK PROGRAMME 2024/25

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council

Provider Collaborative Vision and Purpose

Our Vision

Working together as providers to achieve tangible improvements to the way care is delivered**,** supporting the Joined Up Care Derbyshire quadruple aim

Our Purpose and function

To **add value** to the ICS and beyond by:

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

Principles/ways for JUCD collaborative working	We will put the interests of our population and the **system first**, and be driven by the needs of our communities rather than our organisations We will design and deliver services that **improve people's experience** and outcomes from care and **address health inequalities** We will develop solutions that **improve the working lives**, health and wellbeing of our people We will take **joint ownership of our shared resources**/Derbyshire pound, and drive improvements to **productivity and efficiency** We will deliver care as **close to home** as possible

National leadership principles	Compassionate	Curious	Collaborative
Our leadership behaviours	Be inclusive, actively listening to one another and valuing different partners' perspectives Be open and honest about our challenges and what we cannot do Challenge each other respectfully and with compassion Support each other and seek to solve problems collectively Behave with kindness	Aim for the highest standards Support innovation and creativity Make decisions based on data and the evidence base Look forward, being prepared to challenge the status quo Be ambitious, and willing to make difficult decisions together Drive a culture of continuous improvement	Positively promote partnership and collaborative working across our organisations Support each other to remove barriers to transformation Act with integrity and do what we say we will Where there is conflict, be prepared to concede to reach consensus

Provider Collaborative priorities

Productivity and efficiency supported by continuous improvement approach

- Primary secondary care interface
- NHS Impact - Joined Up Improvement, shared training and skills development programme
- System ePMO and programme management approach

Sustainable, integrated care including fragile services

- Ophthalmology single service PID
- Haematology mutual aid
- NALD Partnership
- CAMHS shared working, workforce sustainability and efficiencies
- SLT single service & MSK improvement programme

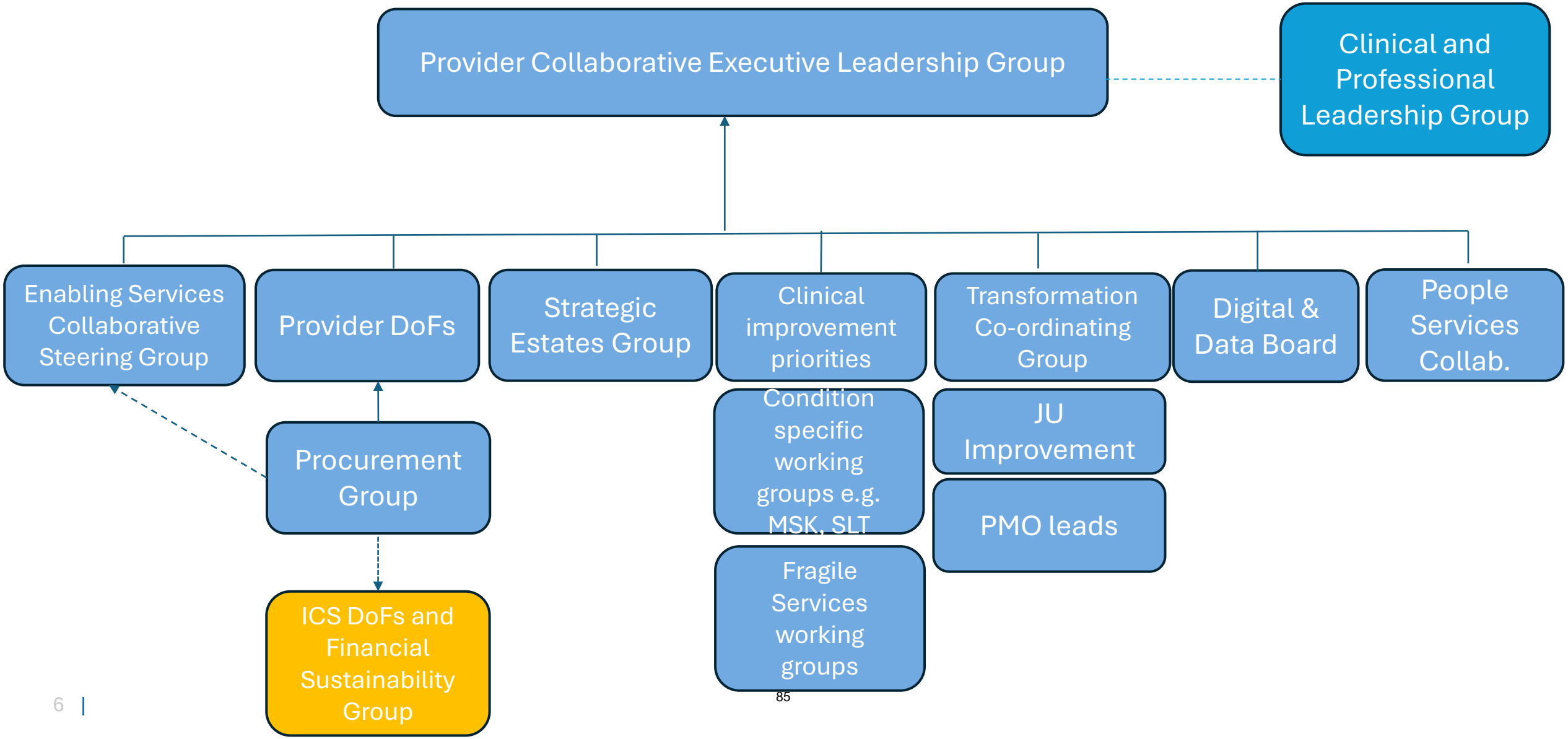
At scale corporate and enabling functions

- Shared procurement workstream underway
- People services (recruitment and supply, reservists, Academy) standardisation and harmonisation
- Estates strategy and efficiencies workstream
- Shared functions 'at scale' model in development

- Priorities reviewed December 2023, 2024/2025 work programme reflects these
- Focus on clinical and financial sustainability
- Collaborative work complements individual provider efficiency work
- Beginning to develop at scale models, significant impact in the medium term, building our contribution to 2025/2026 sustainability

Provider Collaborative Priority	Workstream	SRO	Programme Lead
Productivity and efficiency, supported by continuous improvement approach	NHS Impact/continuous improvement	Tamsin Hooton Provider Collaborative Programme Director	Susan Whale, Director of PMO and Improvement
	System programme management and ePMO function	Tamsin Hooton Provider Collaborative Programme Director	Susan Whale, Director of PMO and Improvement
	Primary/Secondary Care interface	PC SRO TBC	Tamsin Hooton Provider Collaborative Programme Director
Sustainable, integrated care models including fragile services	Fragile Services	Tamsin Hooton Provider Collaborative Programme Director	Tamsin Hooton/various
	MSK	Gis Robinson, Executive MD, UHDB	Trish Bailey , DCHS
	SLT	Lucy Smith, Head of Therapies, CRH	Kate Cook/Lucy Smith
At scale corporate and enabling functions	At scale enabling functions model	Darren Tidmarsh, Deputy CEO DCHS Simon Crowther Deputy CEO UHDB	Tamsin Hooton Provider Collaborative Programme Director
	Estates	Simon Crowther Deputy CEO UHDB/ James Sabin CFO DHCFT	Cath Benfield, Strategic Finance Lead,, Matt Scarborough, ICS estates lead
	Procurement	Stuart Ellis, Commercial and Strategy Director DSFS	Programme Lead to be appointed
	People Services	Amanda Rawlings , Executive Director of Workforce UHDB, Darren Tidmarsh, Executive Director of People	Lyndsey Beardsley (Academy?) Faith Sango
	Digital and Data	Jim Austin, Chief Information & Transformation Officer, DCHS	Dawn Atkinson, Programme Manager

Working Groups for Collaborative Workprogramme (Sep 2024)



Workstream: NHS Impact/Continuous Improvement	**SRO:** Tamsin Hooton (PC)	**Programme/Management lead:** Susan Whale
Governance (working groups and reporting arrangements): Overseen through Transformation Co-ordinating Group, which reports into PCLB and NHS Executives. Joined Up Improvement (Exchange and Network meetings) report into TCG.		**Project Status:** (planning/live/complete) Live

Objectives/Aims:

- To develop the capacity and capability to deliver improved care across the collaborative and wider JUCD system
- To develop a shared system approach to continuous improvement, including use of shared methodologies/approaches

Deliverables/Outputs	**Metrics/Impact**	**Milestones/Timelines:**
1. System self-assessment against NHS Impact 2. NHS Impact development plan 3. Training and development plan with clear priorities and plan for delivery (including QI methodology for system teams, change management/system leadership, using data for improvement, population health management and core management skills) 4. Develop Joined Up Improvement	1. Evidence of completed self-assessment (NHS E return) and status e.g. developing. Action plan to progress to maturing by April 2025 2. Plan in draft and agreed by PCLB/NHS Executives 3. Numbers of people trained	1. Complete June 2024 2. IMPACT action plan September 2024 3. Training/development priorities agreed June 2024, aim to develop and deliver training to priority groups of people by March 2025 4. Relaunch JU Improvement October 2024

Workstream: System programme management and ePMO function	**SRO:** Tamsin Hooton	**Programme/Management lead:** Susan Whale
Governance (working groups and reporting arrangements): Led through Transformation Co-ordinating Group (which reports into the PCLB), provides assurance and reporting into System Finance and Estates Committee		**Project Status:** (planning/live/complete) Live

Objectives/Aims:

- To ensure that there is a consistent approach to programme management and benefits realisation across system improvement and transformation work, whether this is provider or ICB led
- To ensure effective reporting, risk management and escalation in relation to system improvement and financial efficiencies

Deliverables/Outputs	**Metrics**	**Milestones/Timelines:**
1. Reliable monthly CIP/efficiency reports 2. Completed benefits realisation plan for 2024/2025 3. Improved reporting functionality of e-PMO 4. Review of e-PMO system	1. Reports to TCG/SFEDC (Y/N) 2. Benefits Realisation Plan which covers all transformation including PC 3. Ability to analyse CIP and benefits by type 4. Completed review with recommendations about future ePMO tool	1. Monthly, ongoing 2. End of Q2 2024/2025 (note delay) 3. September 24 4. Review initiated Q3, decision making on recommendations Q4

Workstream: Primary/secondary care interface	**SRO:** [Chris Weiner (ICS)]	**Programme/Management lead:** Tamsin Hooton
Governance (working groups and reporting arrangements): Responsibility for delivery/implementation sits with PCLB, linking into ICB Working Group. Provider Collaborative:Improving Equitably workshops and provider improvement groups (latter to be established) report to PCLB.		**Project Status:** (planning/live/complete) planning
Objectives/Aims: • To improve communications between different parts of the JUCD provider collaborative • To improve productivity and reduce wasted clinical and patient time • To ensure that patient care is delivered in the most appropriate way, and reduce inequalities in access and experience caused by interface issues		
Deliverables/Outputs	**Metrics**	**Milestones/Timelines:**
Single points of contact in place/being piloted in each main provider	NHS E self-assessment against 4 expectations Measures of GP practice satisfaction with interface with secondary care Measure of time spent on interface issues (TBD) Patient experience of interface between providers (TBD)	Agreed focus, named leads and groups in place (July 2024) Providers to agree SPC models/initial improvement approach (August 2024) Test and review progress (October 2024)

Workstream: Fragile Services	**SRO:** Tamsin Hooton	**Programme/Management lead:** various per service
Governance (working groups and reporting arrangements): PCLB oversees work. Reporting made for assurance into ICB Fragile Services Oversight Group (chaired by Chris Weiner)		**Project Status:** Live

Objectives/Aims:

- To ensure that there is a robust process for identifying and risk assessing fragile services
- To work in partnership to stabilise and sustain clinical services within the ICS where this is within the ability of JUCD providers to do so
- To develop and implement plans to address fragility in agreed priority areas

Deliverables/Outputs	**Metrics**	**Milestones/Timelines:**
1. Derbyshire Ophthalmology model 2. Haematology (mutual aid) 3. CAMHS partnership 4. Neuro Divergence partnership and transformation 5. Stroke rehab – single model for JUCD that meets national guidance 6. Provider mapping of fragile services, agreement of services for collaborative/partnership work	1. Business case for single JUCD service 2. OP referral rates, waiting times data 3. Spend on locums, waiting times 4. Waiting times for assessment, LOS 5. Acute LOS, numbers of people offered rehab	1. PID agreed June 2024 w detailed milestones, business case October 2024 2. Review referral trends Aug ’24, agree further actions Sept 24 3. Options presented to PCLB July 24 4. TBC 5. Case for change July 24, agreed model March 25 6. Update mapping and risk assessment bi-monthly

Workstream: Musculo-Skeletal (MSK)	**SRO:** Gis Robinson	**Programme/Management lead:** Trish Bailey
Governance (working groups and reporting arrangements): MSK Steering Group, reports into Planned Care Delivery Board as well as directly to PCLB, note this is a 'system priority' with some elements provider-led and some ICB-led.		**Project Status:** Live

Objectives/Aims:

- Improve people's access to and experience of care through collaborative delivery of a MSK model that maximises prevention, supports self-management and ensures timely access to clinical assessment and treatment in the right setting
- To reduce waiting times and reduce unnecessary secondary care activity to support elective recovery

Deliverables/Outputs	**Metrics and Impact**	**Milestones/Timelines:**
1. Review CATS model to develop single point of assessment and referral underpinned by collaborative clinical networks 2. Strengthened pathways for out of hospital management and community treatment incl. weight management, joint injections 3. Digital platform to support SPA, triage and referral management	1. Increase community management of MSK, reduce GP OP referrals 2. Increase in proportion of referrals and procedures closed in community setting 3. Support elective recovery, reduce waiting times	1. Refreshed PID August 2024. 2. Agree changes to model in parallel with ICB determination of commissioning and contracting intentions *October/November 2024* 3. Agree joint injection model/contracting *December 24* 4. Commence work on digital solution – July 2024 - *end point tbc*

Workstream: **Speech and Language Therapy (SLT)** Children's Pathway Collaboration	**SRO:** Jayne Needham	**Programme/Management lead:** Kate Cook Lucy Smith

Governance (working groups and reporting arrangements): SLT Children's Project Group reporting into Provider collaborative and AHP Council	**Project Status:** Live

Objectives/Aims:
Work up a full business case for Childrens' SLT to become one single provider delivered by DCHS to standardise and improve SLT Childrens' s services across Derby and Derbyshire ensuring a sustainable and equitable service is delivered.

Deliverables/Outputs	**Metrics**	**Milestones/Timelines:**
• Business case to be produced for Childrens' SLT to become one single provider delivered by DCHS • Plan and mobilise for a smooth service transfer to DCHS • Standardise delivery of SLT Children's services across Derby and Derbyshire • Improve productivity to help support reduction in waiting lists • Strengthen leadership expertise • More flexible use of resource across services to address health inequalities • Robust SLT workforce structure with improved training / learning opportunities	• Reduced waiting lists & times • Reduce health inequalities/inequalities of access across geography	• Business case to be finalised mid-August • Discussion at organisational boards Sept 24 • Service transfer 1st Jan 25

Workstream: At scale enabling functions model	**SRO:** Darren Tidmarsh and Simon Crowther	**Programme/Management lead:** Tamsin Hooton
Governance (working groups and reporting arrangements): Enabling Services Collaborative Steering Group (reports into PCLB) linking to collaborative/partnership groups for separate functions		**Project Status:** (planning/live/complete) Planning
Objectives/Aims: • To obtain best value from enabling services through at scale delivery of a range of enabling services • To improve the productivity and efficiency of services through collaboration at scale • To ensure that the JUCD enabling services model adopts innovation and best practice and is fit for the future		

Deliverables/Outputs	**Metrics and Impact**	**Milestones/Timelines:**
1. Establish collaborative governance structure and leadership for the work 2. Secure external expertise to help scope the benefits and value proposition, including benchmarking 3. Options appraisal including quantified benefits and risks to support provider decision making 4. Business Case for shared services model	SHORT TERM 2024/2025 Stronger approach to shared working. Evidence based assessment of scale of opportunities for improvement. Collaboratively produced plan for future delivery model. MEDIUM TERM Improved value, quality and productivity (benchmarked opportunity of c .£33m)	1. Steering Group established 16/7/24. Paper to provider Boards September/Oct 2024 2. Spec for external support agreed 16/7. Work to commence Sep – Dec 2024 3. Options appraisal drafted for consideration January 2025 TBC 4. Business case including implementation approach drafter for provider board decision making – TBC

Workstream: Estates	**SRO:** James Sabin	**Programme/Management lead:** Cath Benfield/Matt Scarborough

Governance (working groups and reporting arrangements
Strategic Estates Group (SEG) oversees workplan, reporting into PCLB for direction and delivery, and to ICB SFEDC for assurance and co-ordination into wider system strategic planning/JFP delivery. Relevant sub-groups support SEG.
Note need to clarify and agree governance, responsibilities and leadership roles with ICB/system.

Objectives/Aims: To understand the condition and the cost of our current estate footprint and create a baseline to inform our strategic estates planning and to support the prioritisation of limited capital resources. Drive better utilisation and deliver on rationalisation and consolidation opportunities which are clinically informed and aligned to system strategy. Ensure progress is made towards our agreed net zero carbon objectives. Develop a system plan to support, retain and develop our facilities management and estates workforce

Deliverables	**Metrics**	**Milestones/Timelines:**
Significant cost reductions from better utilisation, consolidation and configuration of our estate through a clinically led review of future requirements and alignment to wider ICS Strategy	Reduce cost of estate / BLM Red'n in void space / no of sites	Baseline established Q2 24/25 Work up initial list of opportunities into detailed proposals Q3 24/25 System wide workshops to explore opportunities Q3 24/25
System wide property charter / sharing agreement	Agreement approved and in use	Q3 2024/25
Progress towards net zero carbon objectives	Redn in directly controlled CO2 emissions	80% redn on 1990 baseline by 2032
Disposal pipeline – generating capital receipts for reinvestment on freehold disposals	Inc in capital receipts / redn in no of sites	Ongoing – initial leasehold opps scoping Q2 24/25
Dynamic risk based medium term prioritised capital plan	Plan in place , robust process to review	Initial plan Q2 24/25
Strategy for system wide FM and Estates workforce	Workforce plan in place- key deliverables TBC[3]	TBC by workstream lead

Workstream: Procurement	SRO: Stuart Ellis, Commercial & Strategy Director DSFS	Programme/Management lead: To be appointed
Governance (working groups and reporting arrangements): Collective terms of reference in place providing a mandate. Updates via PLCB. Periodic update to Derbyshire DoF's group for operational escalation or at DoF's request.		**Project Status:** (planning/live/complete) Part live / Part planning
Objectives/Aims: The Collaborative Procurement Steering Group is a forum for partner procurement leads to come together to develop, oversee and deliver a work programme to drive financial improvement through maximising opportunities for collaboration on material procurement activities across JUCD. The group acts as a forum for shared decision making about procurement activities between providers, and reports through Provider DoFs into the PCLB.		
Deliverables/Outputs	**Metrics and Impact**	**Milestones/Timelines:**
Develop approach to collaboration on: -Joint forward workplan; -Aligning of contracts and timescales; -Consistent / effective contracts database -JUCD Procurement Strategy formation; -Effective contract management including Supply Chain (s) in broadest sense -Support of national agenda and forums, including PSR/PCR23 -Developing shared governance including for clinical (CPEG) input -shared resource opportunities	- Consolidated forward workplan maximising value - Tenders facilitating timeline consolidation with joint specifications - Strategy in place - Consistent effective contract management - Visible collective 'dashboard' - Joint working agreements in place	- Workplan evolving for 24/25 testing approach and blockages, 25/26 workplan by December 24. - Compliant tender publishing by October 24 - Consistent robust contract management by June 25 - Performance dashboard by April 25 in pilot form - Joint working agreements April 25 - Strategy setting out next stages of evolution by June 25

Workstream: Digital Programme	SRO: Jim Austin	Programme/Management lead: Various per project/programme

Governance (working groups and reporting arrangements):	Project Status:
Digital and Data Board (D3B) reports to the PCLB for direction, delivery and assurance and ICB Finance, Estates and Digital Committee for assurance and challenge.	Planning

Objectives/Aims:
To determine the scale of opportunity for converging and scaling ways of working in digital and technology services.

Deliverables/Outputs	Metrics and Impact	Milestones/Timelines:
1. Contract/licence/solution convergence - (through the enabling Procurement Workstream – Simon Crowther & Stuart Ellis) and benefits (cost reductions) will be reflected in provider budgets not the digital programme budget	• Inclusion of digital/IT contracts/solutions on Atamis database • Contract review/renewal scheduled agreed and opportunity scoped	TBC
2. Organisational changes - (e.g. Helpdesk consolidation across the geography) noting convergence requires cultural change acceptance which currently is not present	• Business case developed identifying efficiency opportunity • Business and workforce change process agreed	TBC
3. Robotic Process Automation /Artificial Intelligence - system level driven workstream required to drive innovation and efficiency metric development	• Impact assessment of current RPA/AI including business change processes • Scaling and acceleration plan agreed	TBC

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 083

Report Title	Progress against Plan (H1 strategic review)							
Author	Chris Clayton, Chief Executive							
Sponsor (Executive Director)	Chris Clayton, Chief Executive							
Presenter	Chris Clayton, Chief Executive							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	None							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	NHS Executive Team							

Recommendations
The ICB Board are recommended to **NOTE** the progress against plan (H1 Review) for assurance.
Purpose
This report details the outcomes from the NHS system's review of performance during the first half (H1) of the 2024/25 financial year, in the context of our published Operational Plan.
Background
The ICB, on behalf of the Derby and Derbyshire NHS system, submitted its operational plan for 2024/25 to NHS England in May. A comprehensive review has taken place on our stated performance objectives for the year, including workforce, activity and finance to ensure we have shared understanding of the position and to identify any additional or corrective actions required to ensure delivery of our the plan. The review has been undertaken collaboratively across NHS partners, led by our Chief Operating Officers, Chief Finance Officers and Chief People Officers, alongside our clinical leadership across nursing and medical disciplines, and we set out our intent for this quadrumvirate approach to continue going forward. A senior leadership seminar was held on 18th October 2024 to review the outputs from the stocktake.
Report Summary
The key outputs from the H1 review are included below. It has been the result of significant effort from during September and October, with teams across the NHS system collating the stocktake alongside other existing work pressures, and the result has been critical in enabling us to understand our current position, to identify where we have additional risks to manage, and to also provide assurance. The seminar in October recognised two important elements, those being the

need to manage absolutely here and now challenges and to manage the H2 position and the process we undertake to develop our 2025/26 operational plan.

Successes

The stocktake has identified a range of successes delivered by the system this year, noting that in challenging circumstances we continue to make positive progress and that these should be maintained, supported and built upon. These are borne out of detailed planning, and delivered through constant attention to our agreed priorities and programmes by teams across the NHS family. The headlines of this identify that:

- there is above-plan performance in acute same day emergency care services
- our GPs have seen an above-plan increase in appointments,
- there is above-plan use of our community mental health pathways
- we have been managing an increase in demand within our A&E departments,
- there has been achievement of much of our activity plan for elective care,
- strong performance against our plan for 62-day cancer treatments and;
- achievement of nearly all targets for mental health, learning disability and autism.
- We have significantly improved clarity on our holistic people plan position, with our workforce coming int o line with plan, with further stability expected during the second half of the financial year (H2). There remain some challenges relating to the use of bank workforce.
- We are broadly on plan with our financial position, representing a significant achievement across partners.

In reviewing this information, it is recognised that there is need for further information on quality and safety impacts in relation to performance.

Managing Today

In the here and now, it is recognised that the urgent and emergency care system is pressurised, and associated costs are driving both our financial position and impacts in other areas, including planned care and community activity. The NHS Chief Executives have agreed a programme of actions to ensure we continue to give attention to this area of care as one of the system's identified priorities. These actions include:

- Continuing our communications to assist patients in navigation to the right place of care.
- Decompressing our system, ensuring that our system is working hardest to support the avoidance of harm to our most vulnerable patients.
- Immediate actions agreed include reviewing our triaging of patients into co-located UTCs and reviewing the medically fit for discharge thresholds.
- Vaccination teams to link with trusts to check we are on plan with delivery to mobilise the campaigns and encourage all staff to have their vaccinations.
- Review options to improve UTC activity and accessibility, in particular at Ilkeston. This action is now complete.
- Review infection prevention and control issues.

Our approach to H2

For the second half of the year (H2), three collective priorities have been identified, which will be owned by our three delivery boards and overseen by the NHS Executive Team:

1. To continue to provide safe and effective emergency care over the course of the H2 period recognising the need for us to balance and prioritise operational and clinical risk to achieve this.
2. To deliver continued improvements in our cancer, mental health and elective care position to ensure we continue to attend to the needs of those patients awaiting important non-emergency care.

3. To do the above operational priorities whilst living within the limits of our resource position principally focused for H2 on our people and our available finances.

In managing the H2 period, we have agreed a series of mandates for our system delivery Boards:

- For the urgent and emergency care delivery board to continue its focus on decompression of hospitals, including the focus on out of hospital care pathways including our integrated discharge and community transformation work.
- For the planned care delivery board to consider the acute hospital occupancy position, particularly for inpatient elective and cancer procedures and link across both the non-elective and elective care pathways to understand the global position. To continue our improvement work on cancer in the context of the overall waiting list position
- For the mental health, learning disability and autism delivery board to continue the work that spans both the non-elective and elective care pathways but particularly, having a focus on flow across our system. This includes building on our work on community care pathways but indeed focusing on flow in and flow out of acute mental health settings.
- Our Chief People Officer team to continue their current work on delivering the H2 plan with a key focus around reducing our overall sickness rates.
- For the finance community to continue focus on key actions in delivering the £50m deficit plan position.

Partners will be sharing this update through their Executive teams and Boards, and the NHS Executive Team will continue to track progress against these actions and continue to provide assurance on progress.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Please indicate above which strategic risk(s) the paper supports and also make reference here to any risks within the ICB's risk register, which can be found here.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☐
Details/Findings *What is the full cost of this project/commitment/business case? How is this funded? And is the funding recurrent/non-recurrent? Is there a financial benefit expected elsewhere in the System?*		**Has this been signed off by a finance team member?** *Please indicate, by name and job title, the finance lead that has contributed to this paper.*

Is there a clear exit strategy from this project if funding is expected to cease?	

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

Give details of any instances where staff have been conflicted, or where conflicts have been raised at meetings where the report has been discussed

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?

When the ICB delivers their functions, the ICB must have due regard in:

- *eliminating unlawful discrimination*
- *advancing equality of opportunity between people who share a protected characteristic*
- *encouraging good relations between those who share a protected characteristic and those who do not*

Please discuss any implications or risks that have been identified in regard to these duties.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 084

Report Title	Review of Intensive & Assertive Community Treatment within Community Mental Health Teams							
Author	Bie Grobet, Associate Director of Mental Health, Learning Disability, Autism and Children's Commissioning Phil Sugden, Assistant Director of Quality – Community Lee Doyle, Managing Director, DHcFT							
Sponsor (Executive Director)	Prof Dean Howells, Chief Nurse Officer Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Presenter	Prof Dean Howells, Chief Nurse Officer							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 – Outcome of Review Appendix 2 – Intensive and Assertive Treatment CMHT Action Plan							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Executive Team Meeting Mental Health, Learning Disability & Autism System Delivery Board							

Recommendations
It is recommended that the Board: • **NOTE** the outcomes of the ICB Maturity Index Self-Assessment Tool for Community Mental Health Service Review submitted to NHSE on the 30th of September 2024; • **APPROVE** the intensive and assertive community treatment action plan, developed as part of the review of CMHTs; and • **NOTE** that the action plan will have regular oversight within Executive Management Team Meetings of both the ICB and DHcFT and will report into the Mental Health and Learning Disabilities and Autism Delivery Board.
Purpose
NHS England has published new guidance to support Integrated Care Boards (ICBs) in enhancing community mental health services. The guidance, issued on 26 July 2024, is aimed at ensuring that patients with serious mental illness (SMI) receive intensive and assertive community treatment and follow-up, particularly those who face engagement challenges. https://www.england.nhs.uk/publication/guidance-on-intensive-and-assertive-community-mental-health-treatment/ The ICB and Derbyshire Health Care NHS Foundation Trust (DHcFT) have been working alongside local stakeholders and partners to carry out the review of CMHTs and the outcome of the review has been communicated to the Regional NHS England Mental Health team. The review has been conducted in line with the national guidance around providing intensive support to people

with a serious mental illness. The ICB and DHcFT have submitted a not assured position and an action plan has been developed as a result of the review.

The action plan provides practical steps of how the Trust and the ICB will address any potential gaps in provision, highlighted as part of the review process.

Background

The ICB and DHcFT conducted the Maturity Index Self-Assessment Tool to assist DHcFT in evaluating their current service provision and capacity. The assessment focuses on the safe and adequate delivery of assertive and intensive community support for individuals with serious mental illness, particularly those who are difficult to engage.

The tool comprises 14 domains, each containing exploratory questions and prompts. These are based on an initial review of NHS England Midlands Region CMHT submissions, including CMHT operational policies, standard operating procedures, information on assertive outreach and intensive support, dual diagnosis and substance misuse guidance, risk assessment processes, and DNA/Cancellation/Missed Contacts procedures. Additionally, it incorporates insights from the NHS England Adult Mental Health Team's presentation at the first Midland Community Services Review Task and Finish Group in June 2024.

Completing the tool will help ICBs address the questions in the 14 domains, which will be included in national policy guidance. ICBs are required to submit their responses to NHS England to confirm that their policies and practices have been reviewed.

The ICB Review Outcome Template and the ICB Maturity Index Self-Assessment Tool ensure that recommended actions are integrated into senior governance structures for both the Trust and the ICB. The primary objectives of these tools are to ensure the availability of appropriate intensive and assertive mental health care and treatment to meet the needs and support the wellbeing of Assertive Outreach and Intensive Community Support.

The maturity matrix facilitates a comprehensive review and structured dialogue between ICB, DHcFT and NHS England, aiding in the evaluation of their readiness to provide effective Assertive Outreach and Intensive Community Support. This helps the ICB to align with the 2024/25 operational planning guidance, particularly the requirement to review community mental health services by Q2 2024/25 to ensure clear policies and practices are implemented this patient group. The ICB Maturity Index Self-Assessment Tool will inform NHS England's decision-making regarding support for Assertive Outreach cases in community mental health teams.

Report Summary

The primary objective of the ICB Review is to ensure that appropriate intensive and assertive mental health care and treatment are available to meet the needs and support the wellbeing of people with Severe Mental Illness. The review serves as an opportunity to reflect on the community provisions in place for individuals with severe and relapsing mental illness. They should also identify specific actions that services need to take to ensure that people are receiving and engaging in the care they need.

Safety is a pivotal consideration. It is vital that DNAs (Did Not Attend) are never used as a reason for discharge from care for this vulnerable patient group. All ICBs are asked to rapidly check that existing service policies and practices are clear on this issue and confirm this to the NHS England regional mental health team.

The tool aids the ICB in aligning with the 2024/25 operational planning guidance, specifically the need to review community services by Q2 2024/25.

The Outcome of the review is detailed in Appendix 1 and the action plan is detailed in Appendix 2.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☒	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☐	Inclusive leadership	☐
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?			
None identified.			
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?			
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable.			

Review of Intensive & Assertive Community Treatment within Community Mental Health Teams: Outcome of Review

Outcome of Review:

Q) Following your review, are you assured that the services in your area are able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up?

A) No

What gaps in their ability to meet the needs of this group were identified?

Although the review assures that services in the Trust can meet the needs of service users requiring Intensive and Assertive treatment to some extent, most policies do not heavily focus on the risk to others.

The key policies support a proportionately assertive approach based on risk. However, it is unclear if there are Standard Operating Procedures (SoPs) or expectations about what this means in practice, making it uncertain if staff can operationalise the request adequately.

The lack of governance around Assertive Outreach approaches could lead to variance across the Trust in terms of expectations and application. Given the complexity of this area, it may be beneficial to establish a Trust-wide (or System-wide) Community of Practice around Assertive Outreach approaches. This would help upskill and maintain staff and improve the quality of care provided. Currently, there is no policy or procedure for Assertive Outreach, nor is there a training matrix to identify specific or mandated training for Assertive Outreach workers.

What are the barriers/challenges identified in providing intensive and assertive community mental health care as described in the national guidance?

Some teams are better equipped than others to work in this manner. The Assertive Outreach model needs to be audited and improved, with standards and expectations set for teams such as Assertive Outreach and CMHTs to work towards. Engagement needs to be proportional, as excessive attempts could invite human rights challenges, so a balance is necessary. Additionally, there is a need to identify and correct variances between policy expectations and practice. Audits are part of this process and need to be supported for development.

The CMHT is currently using MaST and the High-Risk Patients report to ensure all Assertive Outreach patients are correctly identified in the Trust. An ongoing Task and Finish group is reviewing the criteria for allocating Assertive Outreach cases in CMHT and the need to review current caseloads to ensure that those on Assertive Outreach caseloads need that support. This review will further inform the resources needed to support these service users and the Assertive Outreach Care Coordinators. The CMHT staff working with Assertive Outreach caseloads are requesting peer supervision and more medical input to manage their complex caseloads. There is potential to identify a larger group of people who meet the criteria for Assertive Outreach, which will have implications for workforce and finances to meet the needs of this group.

There is limited access to psychology for Assertive Outreach, as some areas do not have a clinical psychologist, and CMHTs do not have CBTp-trained staff. Additionally, there is no in-house CBTp supervisor to provide these interventions.

What next steps have been identified to improve care for individuals in scope of the review following the completion of your review?

Following the review were areas of good practice identified that you would like to share, including any innovative approaches or use of digital tools?

MaST (Management and Supervision Tool) is a decision support tool designed to help mental health staff make better decisions about resource allocation and patient care in community mental health services. It helps with identifying patients at highest risk of deterioration in their mental health, support improved caseload management and aid decision-making about resource allocation based on service user needs. Implementing and embedding the use of MaST in the Trust supported data quality and flow and would further enhance pro-active caseload management.

What additional support is required from NHSE to meet the needs of the individuals in scope?

- Nationally agreed criteria for Assertive Outreach caseloads, this will enable correct identification of cases that are eligible for AO support.
- Nationally agreed training for AO workers. This will help to promote the specialism of the Assertive Outreach offer.
- Support and further need to review the resources available to support AO cases within the community.
- Review of Resources: Support and further review the resources available to support AO cases within the community.

Proposed Next Steps:

DHcFT and the ICB have initiated the assurance process but recognise that more work is required to achieve full assurance. Additional work will be conducted through a Task and Finish group, including a face-to-face workshop which was held on 24th October 2024. This group will report to the MH and LDA Delivery Board. The aim is to test assumptions with clinical and support teams to ensure the caseload for assertive and intensive support is fully captured and to identify any early gaps.

The following leads have been identified:

- Clinical Executive Lead: Dr. Arun Chidambaram (DHCFT)
- Provider Management Lead: Lee Doyle (DHCFT)
- Mental Health Commissioning Lead: Bie Grobet (ICB)
- Derby and Derbyshire MH and LDA Delivery Board: Chaired by Prof. Dean Howells

An action plan (Appendix 2) has been developed, which will receive regular oversight in each of our Executive Meetings (ICB and DHcFT) and relevant governance structures. The action plan is formally presented to the Board.

Findings and Actions Plan

Domain	What was the finding	What is the action	Who will be responsible for the action	When will the action be completed	Has the action been completed	Comments
1. Function of assertive outreach / intensive case management	There is need for an Assertive Outreach Treatment Standard Operational Policy, which clearly define the criteria for Assertive Outreach cases. There is need to implement Assertive Community Treatment (ACT) principles within the CMHT framework and proactive engagement strategies to ensure continuity of care. Lack of Housing support in	The AWA CMHT is currently reviewing the criteria for the management of Assertive Outreach cases, once this piece of work is completed, this will be part of the Assertive Outreach Standard Operational Procedures. More needs to be done regarding joint working for Substance Misuse cases who may require CMHT input. Teams need to clearly indicate in the Care plan if a service user is being supported by Assertive Outreach, so that other divisions and other system partners can easily access this information. Although there is no dedicated Assertive Outreach psychologist/Occupational Therapy, if cases need Assertive Outreach input,	Head of Nursing for AWA CMHT & Substance Misuse and Deputy Area Service Manager for AWA and Older Adults CMHTs	31 March 2025	Ongoing	Generally, the AWA CMHTs including Assertive Outreach cases are working well to co-produce care plans where possible and where there is consent, but this is inconsistent across the localities. There are audits in place to monitor compliance and quality. These are reviewed by the Head of Nursing and shared at COAT. This is already in place for Assertive Outreach caseloads. There is however a need to make sure that all the allocated Assertive Outreach cases are correctly aligned in SystmOne for reporting. There are currently 144 Assertive Outreach cases identified within AWA CMHT, for more accurate figures there is need for data

Domain	What was the finding	What is the action	Who will be responsible for the action	When will the action be completed	Has the action been completed	Comments
	CMHTs, has been highlighted as a concern, which also affect caseload management. Clarity of how Assertive Outreach cases will be supported via the Right Care Right Person. Some metrics could be taken from MaST Substance Misuse teams are not part of the CMHTs which covers Assertive Outreach caseloads. There is need to clearly define how Assertive Outreach workers will be supported,	this will be referred on to the psychology/Occupational therapy teams. Peer support workers for Assertive Outreach teams. **Physical Health checks** - identifying AO cases meeting needs and having more info on patients Physical Health monitoring clinic do assessment for AO cohort	HoN, ASM Substance Misuse and Mental Health Together Lead HoN, Deputy ASM for CMJTs, – Community Delivery Team mtgs to link up with Primary Care			cleansing and audit to make sure that everyone who meets the identified criteria for Assertive Outreach is correctly allocated.

Domain	What was the finding	What is the action	Who will be responsible for the action	When will the action be completed	Has the action been completed	Comments
	especially if they are supporting cases out of hours.					
2. Clinical Pathways	Limited psychological offer due to high waiting lists in CMHTs. Supported living is a gap, as most of the Assertive Outreach cases will need support with housing. More need to be done with all system partners to make sure that there is a system-wide care plan for such service users.	Pathways for forensic supervision Pathways of how a person steps up and down depending on the need. Engagement with primary care regarding Assertive Outreach cases. There is need for a complex case panel for CMHTs which will also support Assertive Outreach cases. Assertive Outreach SOP to clarify ASD, homelessness support pathways.	Clinical Directors General Manager for AWA CMHTs, Head of Nursing for AWA CMHT & Substance Misuse and Deputy Area Service Manager for AWA and Older Adults CMHTs	31 July 2025	On-going	Currently Assertive Outreach cases are triaged from MDM which are either the operational or clinical leads. There is however need for clarity of who is eligible for Assertive Outreach. There is a need for Assertive Outreach SOP. Any cases in the Short-Term Offer of Living Well that may be suitable for Assertive Outreach would be identified via the daily huddles and a plan agreed for further assessment.

Domain	What was the finding	What is the action	Who will be responsible for the action	When will the action be completed	Has the action been completed	Comments
3. Workforce	There is need to upskill and support staff in the management of ASD and ADHD cases with dual diagnosis. Feedback loops to give assurance that polices are being read by staff when shared.	Review of Assertive Outreach workforce. Review of Assertive Outreach job descriptions. Decision regarding the move away from CPA and how Assertive Outreach cases will be managed. Review of Assertive Outreach Role specific training needs.	General Manager for AWA CMHT	31 July 2025	On-going	Clinical Directors General Manager for AWA CMHTs, Head of Nursing for AWA CMHT & Substance Misuse and Deputy Area Service Manager for AWA and Older Adults CMHTs HoN and Deputy ASM are currently mapping out the current AO caseload in AWA CMHTs. There are some teams that have clinicians with a mixed caseload (AO cases & CMHT cases).
4. Risk assessment and safety planning	There is need for clear guidance of how to engage family where consent is not given and when to breach a person's confidentiality	Training packages for Risk assessment and safety planning Correct identification of carers and significant family members using Carer Dashboard in systmOne Clarity of when to break patient's confidentiality if they have capacity and there is no evidence of risk to themselves or others	Head of Nursing for AWA CMHT & Substance Misuse and Deputy Area Service Manager for AWA and Older Adults CMHTs	On-going	On-going	Staff must adhere to the discharge principles in the Discharge, Transfer and leave Policy for people with Mental Health difficulties, CPA policy and Living Well SOP. These policies support multi-professional and multi-agency working. The Division has implemented Discharge Audit which are fed back through COAT and PRM.

Domain	What was the finding	What is the action	Who will be responsible for the action	When will the action be completed	Has the action been completed	Comments
5. Legislation	Need for further engagement with local authority and housing providers to improve working relationships	Dedicated social services and Housing support for Assertive Outreach cases.	Associate Director Mental Health, LDA and CYP -ICB.	31 July 2025	Ongoing	All identified Assertive Outreach cases have care co-ordinators who liaise with housing & sub misuse if required. Multi agency working relationships need to improve around housing needs.
6. Interface with other services	Housing support for Assertive Outreach cases . Primary Care having access to patients open to Assertive Outreach Joint Working with Substance Misuse	Dedicated social services and Housing support for Assertive Outreach cases. For Primary care to have access of all patients that are under Assertive Outreach Increase interface with Substance Misuse teams.	General manager for AWA CMHT, Managing Director,	31 March 2025	Ongoing	Substance Misuse teams are working closely with CMHTs to facilitate joint working and to increase more referrals to the substance misuse teams.

Domain	What was the finding	What is the action	Who will be responsible for the action	When will the action be completed	Has the action been completed	Comments
7. Recovery and personalisation	For all Assertive Outreach patients to have a safety plan and care plans that are co-produced and reviewed on a regular basis Dilution with the CMHTs (no expertise within the team to deal with AO cases)	Define Roles and responsibility of Assertive Outreach workers in the team and for them to have ring fenced caseloads. Dedicated training for Assertive Outreach worker. Review of Assertive Outreach staffing skill mix, so that there is availability of psychological therapies.	Head of Nursing for AWA CMHT & Substance Misuse and Deputy Area Service Manager for AWA and Older Adults CMHTs	31 July 2025	On-going	All clinical staff have access to mandatory training and role specific training i.e. COMHAD. However, Assertive Outreach Workers do not have specific training to support their work with this cohort of people.
8. Meeting the needs of diverse populations	Need to work with Equality Diversity Inclusion Trust led to review Workforce Race Equality Standards data and consider Equality Diversity System Review.	Work on Health inequalities, to map out health inequalities across the Trust. Need for complex case panel required to support with managing cases which may fall into this category (criminal justice system, CMHT, inpatients under a section of the MHA)	Medical Director, Clinical Directors Area service Managers and the Living Well programme team in Working Age Adults	31 March 2025	On-going	Current work underway re: Health Inequalities strategy. Living Well STO are currently working on Phase 2, which will facilitate rapid re-referrals to CMHTs and self-referrals. Referrals are triaged on a daily basis and clinical priority is identified to respond as per the Living Well

Domain	What was the finding	What is the action	Who will be responsible for the action	When will the action be completed	Has the action been completed	Comments
	Current commissioning gap for ASD and ADHD support across Derbyshire					SOP and the waiting time standard of 28 days.
9. Medication management	Pharmacists and pharmacy technicians (depending on expected outcomes) are currently available for clinical queries at request, and have a developing team of pharmacists supporting CMHTs, this will need to cover Assertive Outreach.	Further extension into services would need to consider funding for this i.e cover for any back fills and long-term funding for pharmacy technician supporting e.g with depot audits.	General manager	Ongoing	Ongoing	Medication management for this group is effectively managed in MDTs and the use of MaST, ePMA makes it easier to review and support depot injection & clozapine administration for this group.

Domain	What was the finding	What is the action	Who will be responsible for the action	When will the action be completed	Has the action been completed	Comments
10. Experts by Experience	Challenges to get expert by experience from this group of patients	To work with Volunteering and Lived Experience team	Area Service Managers	Ongoing	On-going	
11. Discharge from services	Processes would need to be reviewed re: number of non-agreed discharges to ensure trends can be identified and addressed.	Clear pathways for step down step up, waiting lists for patients who need Assertive Outreach Treatment	Executive Leadership Team. Area Service Managers	31 July 2025	On-going	The proposed Assertive Outreach SOP will clearly address pathways for stepping up and down of AO cases. Within the Community Mental health Teams, step up/down would be done via the MDM process. The implementation of the Community rehab team is currently on pause. There is need for review of the Community rehab offer and how this will support Assertive Outreach cases.
12. Data	The Trust has a BI data hub that captures this information but there is need to further present it in such a way that	More needs to be done for all staff to understand data in the Trust. Increase use of MaST in CMHTs	Assistant Director of Clinical Professional Practice Clinical Digital Team IM&T	Ongoing	Ongoing	AWA CMHT have an audit cycle which include case note audits which seek assurance for quality-of-care plans, use of Outcome measure, co-production of safety plans. The use

Domain	What was the finding	What is the action	Who will be responsible for the action	When will the action be completed	Has the action been completed	Comments
	staff fully understand it and make it relatable to their services.					of Goal Based Outcome, ReQol and Dialog is now being embedded practice in AWA CMHTs. Developed a clear data report for outcome measures which demonstrates changes in someone journey and look at the presentation within MaST.
13. Policy variation control	Gap between policy and practice (how do we know staff are following them, are they updated, are staff contributing to those policies and procedures)	To re-circulate the CPA Policy and Procedure (an Access Policy when ratified) and link Operational policies/SOPs to this policy.	Head of Nursing for AWA CMHT & Substance Misuse	31 March 2025	On-going	This will help to provide clarity re practice and reflected within quality audits such as care planning and carers engagement. Meeting with Care standards co-ordinator Involvement lead and the Trust to further review how we work with families, especially in cases where consent is not given. DNA policy already updated and re-published. Teams are

Domain	What was the finding	What is the action	Who will be responsible for the action	When will the action be completed	Has the action been completed	Comments
						now using Use of data reporting to monitor DNA's. Access Policy was implemented
14. Governance	Pathway of how AO cases work their way through CMHTs or FCMHT (how good is integrated working across services)	Identified the need to write an AO SOP which will have clear criteria for AO cases	Service Manager/ Clinical Lead Area Service Managers Head of Nursing for AWA CMHT & Substance Misuse and Deputy Area Service Manager for AWA and Older Adults CMHTs	31 July 2025	On-going	AO workers feedback into team MDMs however, there is need for AO staff to have dedicated time for the management of their caseload. Each CMHT should have a dedicated AO workers with solely AO cases, will have a dedicated weekly huddle to review the activity of the week and identify people of specific concern and/or risks This approach is not consistent across all areas due to either having a lone Assertive Outreach worker.

Date Completed:	**23/10/2024**	**Review Date:**	**Task and Finish Group Dates**

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 085

Report Title	Integrated Performance Report
Authors	Phil Sugden, Assistant Director of Quality – Community Sam Kabiswa, Assistant Director, Planning and Performance Jennifer Leah, Director of Finance – Strategy & Planning Sukhi Mahil, Associate Director – Workforce Strategy, Planning and Transformation and CPLG Management Lead
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer
Presenters	• Quality – Prof Dean Howells, Chief Nurse Officer and Deji Okubadejo, Clinical Lead Member • Performance – Craig Cook, Director of Strategy and Planning and Maragaret Gildea, Non-Executive Member • Finance – Keith Griffiths, Chief Finance Officer and Jill Dentith, Non-Executive Member • Workforce – Lee Radford, Chief People Officer and Margaret Gildea, Non-Executive Member

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?	Quality & Performance Committee Population Health & Strategic Commissioning Committee Finance, Estates & Digital Committee People Services Collaborative Delivery Board

Recommendations

The ICB Board are recommended to **NOTE** the Performance Report and Committee Assurance Reports.

Purpose

To update the ICB Board on the Month 4 performance against:

- quality standards in areas like planned, cancer, urgent and emergency and mental health care;
- the 2024/25 operational plan objectives/commitments;
- the position against the 2024/25 financial plan including income and expenditure, efficiencies, capital and cash; and
- the workforce plan position.

Background

Quality & Performance

The 2024/25 Operational Plan set clear measurable objectives which are fundamental to the NHS' contribution to improving health outcomes. The Plan was submitted to NHSE on 2nd May.

In summary, our plan:

- commits the NHS in Derby and Derbyshire to delivering operational performance that is compliant with the national ask, in most cases;
- from a workforce perspective, the combined effect of CIP across the 4 JUCD Foundation Trusts generates a reduction in WTEs of 3.6% (927 WTEs) when comparing March 25 to March 24. However, when accounting for the effect of funded initiatives (e.g. Dormitory Eradication, Community Diagnostic Centres and transfer of staff from Local Authority (DCHS specific) the overall workforce is planned to be 0.02% higher in March 25 relative to March 24; and
- from a financial perspective, JUCD has submitted a 2024/25 financial plan to deliver a £50.0m deficit in line with the system Revenue Financial Plan Limit set by NHSE, which was agreed through system CEOs. This is underpinned by a 5% CIP across all organisations.

The report attached represents an assessment of progress against our 24/25 planning objectives as at Month 6 (Urgent Care) and Month 5 (all other areas). It is based on published data which is still limited at this stage due to data time lags. Where the plans are not being met the key interventions have been outlined by the ICB Delivery Teams.

Finance

On the 12th June 2024 JUCD submitted a financial plan to deliver a planned deficit of £50.0m, in line with the Revenue Financial Plan Limit set for the ICS. Non-recurrent deficit funding has been received in Month 06 to enable the system to deliver a breakeven position for the year.

Workforce

Whilst the system needs to monitor the position against the workforce plan submitted to NHSE earlier this year, a more rounded understanding of the alignment between the Whole Time Equivalent (WTE) numbers and the finance pay bill is necessary. This report, is therefore summarised in two parts:

- M6 position against workforce plan; and
- Actual workforce position compared to pay-bill. This aims to provide the most reasonable overview based on the current mechanisms that are in place.

In addition, given the level of scrutiny on agency spend and usage, the report includes a breakdown against the four main KPIs.

Report Summary

Quality

The following headlines from the Quality slides should be noted:

- National Oversight Framework (NOF) Change of Segmentation: Quarter 1 of 2024/25, Derbyshire Healthcare Foundation Trust were placed into NOF Segment 3.
- The CQC published the ratings for Derbyshire Adult Social Care Services. Overall Derbyshire County Council was rated as 'Good' whilst Derby City Council were rated as 'Requires Improvement'.
- Maternity: UHDB held a well-attended stakeholder event "Shaping Maternity Services Together".
- ICB Maturity Index Self-Assessment Tool for the Community Mental Health Service Review: Derbyshire Health Care Foundation Trust and Derby and Derbyshire ICB submitted the completed Self-Assessment Tool on the 30th September to NHSE.
- Q2 24/25 NHSE CHC assurance meeting: The ICB presented a detailed and comprehensive report for the quarterly assurance meeting. NHSE confirmed that they are assured that the ICB is providing a good quality CHC service to the population of Derby & Derbyshire.

Performance

Performance is generally not in line with the planned trajectory for most objectives. Annex 1 provides a snapshot of performance for key areas of the operational plan including risks to delivery and actions being taken to mitigate. Key considerations are:

Urgent and Emergency Care

A&E 4-hour performance: Both Acute providers are behind trajectory in delivering the 4-hour target. We end the half year period 5% behind our planned trajectory – across all commissioned UEC provision. Across the ED/UTC provision, there has been 1% less demand than planned in the first 6 months of the year. However, there is variation at a Provider level, with both Acute Trusts managing 0.7%-1.1% more demand than planned, the Derby Urgent Treatment Centre managing 9.7% more demand than planned and the Community Trust managing 13% less demand than planned.

Category 2 ambulance response: For the period Apr – Sept, EMAS has achieved an average performance of 35 mins across its entire portfolio this is 5 mins adverse to target.

General and Acute Beds: Both Acute Trusts have supplied more G&A beds than planned (+17 on average across UHDB and +49 on average at CRH).

Handover delays: 6,972 hours were lost in the first 5 months of the year, which is 52% more than planned.

Planned Care, Cancer and Diagnostics

Referral to treatment waiting times: The overall waiting list is higher than planned at CRH and within plan at UHDB. However, both Trusts are behind trajectory in delivering the 65-week target.

Diagnostic waiting times: The overall waiting list is higher than plan at CRH and within plan at UHDB. However, the proportion of people waiting longer than 6 weeks is higher than planned at both Trusts.

Cancer waiting times: Both Trusts have been achieving their plan for 62-day treatments, CRH narrowly missed trajectory in August. For the 28-day faster diagnosis target, CRH fell slightly short, with UHDB achieving their trajectory.

Mental Health, Autism and Learning Disabilities

Most of the performance trajectories in the 24/25 plan assumed maintenance of 23/24 performance levels – apart from out of area placements which assumed a step change in performance. So far this year, most targets have been achieved. However, there are challenges with IAPT performance and SMI health checks.

Primary and Community Care

GP Appointments: Our 2024/25 plan assumed that General Practice would deliver the same level of appointments as in the previous year. YTD, at August, 2.8% more appointments have been delivered than planned.

Adult Community Service Waiting Times: At the end of August 24, the number of 52 weeks waits is tracking higher than plan. As context, our 2024/25 plan assumed that the number of 52+ week waits would be higher at the end of the year than the start – due to the known issue about tier 3 weight management.

Finance

At Month 06 the system reported a year-to-date adverse variance of £2.8m against a plan of £19.8m. The annual forecast is to deliver the updated planned breakeven position by the end of the financial year.

The key drivers of the YTD position include Urgent & Emergency Care Demand and Non-Elective Pressures of £5.6m (UHDB) resulting from remaining in OPEL 4 with Full Capacity Plan protocol in place.

Workforce

2024/25 Workforce Plan Position: Month 6: The total workforce across all areas (substantive, bank and agency) was 582.89 WTE below the 2024/25 M6 workforce plan. Whilst the net position is below plan, there are some areas that are slightly above plan; CRH (Substantive, +6.91 WTEs and Bank, +18.37 WTEs), DHcFT (Bank, +14.1 WTEs) and EMAS (Bank, +2.53 WTEs).

Compared to M5, there was an increase in substantive positions (70WTE), a decrease in bank (-58WTE) and a decrease in agency usage (-31WTE). The majority of the change in the M6 position was observed in Registered Nursing, Midwifery and Health Visiting (+24WTE), AHPs (+23WTE), Other Scientific, Therapeutic and Technical (+8WTE), Support to Clinical (+22WTE), Medical and Dental staff (+6WTE). There were also decreases in Registered/Qualified Healthcare Scientists (-7WTE) NHS Infrastructure Support (-7WTE).

The growth in substantive workforce corresponds with reduction in bank and agency staff. This suggests that the agency controls and targeted actions to reduce agency usage are having an impact. This will continue to be monitored and supported through the work of the system wide agency reduction steering group, alongside individual Trust actions.

The Primary Care workforce position at M5 was 189 WTE below the Q2 plan.

Actual workforce position compared to pay-bill position: The M6 total pay bill is underspent by £186k (YTD -£4.2m). This is due to overspends in temporary staffing (Bank and Agency) of -£2.6m, which is offset by underspends in substantive and other pay costs (£2.8m).

The main drivers for the M6 pay position relate to CRH, EMAS and UHDB, with the majority of the overspend being observed in Bank staffing across all organisations. The positions are being investigated with finance colleagues to understand the variances described below:

- CRH: £2.3m of the YTD £3.0m overspend is backed by additional income. The remaining £0.8m is due to undelivered CIPs and has been largely offset by non-pay delivery. The trust has exceeded the agency ceiling YTD due to required support for fragile services. A director-led quality impact assessment of bank and agency usage is in progress to identify areas where costs can be safely reduced.
- EMAS: Plans to reduce overtime costs have not materialised, due to the need to retain Q4 resources into Q1. The shortfall will be offset by non-pay schemes, with a forecast increase in delivery from Q2. Schemes currently being developed include procurement and sickness absence.
- UHDB: Substantive costs have not reduced as planned due to CIPs not being able to be implemented. Higher levels of bank staff costs incurred due to backfill for staff covering UEC activity.

NHSE has confirmed the final pay award allocations and the related updated PFR plan and actual adjustments will be transacted in M7.

Agency Usage: The 2024/25 priorities and operational planning guidance set out clear expectations with regards to agency usage reductions; these were to:

- reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill in 2024/25
- improve agency price cap compliance and eliminate off-framework agency use (where this exceeds national framework rates) by July 2024.

We continue to submit weekly returns to NHSE in relation to the four KPIs. These returns are monitored and reviewed regularly, with ongoing discussions taking place where particular issues are identified. The M6 position against the 4 KPIs are:

Agency KPI	M6 Position
Total Agency Spend	JUCD planned to spend £2.36m on agency staff. The actual spend was £2.42m. This is an underspend against M6 plan of £63K (YTD overspend of -£2.6m). There was an increase in agency usage by 31WTE from the previous month but remained under the planned usage by 50WTE.
Agency spend as a % of total staff spend	Agency cost amounted to 1.8% of total pay costs, which is 1.4% under the national target of 3.2%. YTD the position remains below the national target at 2.1%.
% of Off Framework shifts	Exit strategies have been put in place and enacted for the majority of the Off Framework usage. At the start of 2024/25 JUCD were utilizing on average 120 off framework shifts each month. A small number of shifts continued beyond the 1 July 2024 deadline and in M6 there were 29 shifts remaining (0.7% of the total agency shifts). This is a reduction of 66 shifts compared to M5. The reasons for M6 use relates to: • 23 shifts for 1 WTE Oncology Consultant at UHDB, notice has been served to the agency and will be on framework by the end of November 2024. • 5 shifts relate to a CAMHS Consultant at CRH and the consultant is now on Framework • 1 shift relates to 1 HCA at DCHS where the shift was utilized due to a last moment staffing shortage and was true break glass. The exit strategies in place will result in all off framework usage ceasing by the end of November 2024. The position will continue to be monitored to ensure any future usage is true break glass and by exception.
% Non-price cap compliant shifts	There were 4,322 non price cap compliant shifts, 45.6% of the total agency shifts. This is a reduction of 278 shifts compared to M5.

Actions

- Further work is underway to align the WTE positions to the pay-bill. This includes focusing on temporary staffing usage and associated costs in fragile services. The aim is to identify opportunities for improvements where there may be inappropriate temporary staffing usage and to support identification workforce transformation opportunities.
- The next significant area of focus in the agency reduction programme is on non-price cap compliance reductions; working towards the national requirement to eliminate all non-price cap general nursing shifts by the end of January 2025 and all specialised nursing by the beginning of April 25. All providers have been asked to write to agencies, advising that the Trust will cease using the agency if the agency does not come within the price cap within the agreed timeline. As part of this exercise providers have been asked to identify the specific nursing categories that will be targeted. The breakdowns will be tracked through the Agency Reduction Steering Group monthly to monitor progress and highlight any areas of concern going forward.

Risks

- Ongoing re-banding issues (Bands 2 to 3 and potentially other bands) resulting in significant increases in the pay bill.
- Further industrial action, impacting on the pay-bill position, particularly with regards to the ability to significantly reduce the need for temporary staffing which will incur greater costs.

Identification of Key Risks

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

SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☒
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☒	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

Any other risks are detailed within the report.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒

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

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

Not applicable to this report.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

Not applicable to this report.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings

Not applicable to this report.

Derby and Derbyshire Integrated Care Board

Performance Report

November 2024

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

Quality

Prof Dean Howells, Chief Nurse Officer
Dr Deji Okubadejo, Clinical Lead Member

How are we doing?

Derby and Derbyshire Integrated Care Board

The following are noted as headlines:

1	**National Oversight Framework (NOF) Change of Segmentation:** Quarter 1 of 2024/25, Derbyshire Healthcare Foundation Trust were placed into NOF Segment 3. Mandated support will see review meetings jointly chaired between the ICB and NHSE with the first meeting held October 2024. The next steps will be to jointly agree the exit criteria and improvement plan against the areas flagged around quality, operational and financial performance.
2	**CQC** published the ratings for Derbyshire Adult Social Care Services. Overall Derbyshire County Council was rated as 'Good' whilst Derby City Council were rated as 'Requires Improvement'. Both Local Authorities issued statements which were published on their websites.
3	**Maternity:** UHDB held a stakeholder event "Shaping Maternity Services Together". Over 50 Patient Partners, service users and stakeholders attended to openly discuss experiences and maternity service quality improvements.
4	**ICB Maturity Index Self-Assessment Tool for the Community Mental Health Service Review:** Derbyshire Health Care Foundation Trust and Derby and Derbyshire ICB submitted the completed Self-Assessment Tool on the 30th September to NHSE. Additional work in the format of a Task and Finish group (including Face to Face workshop) reporting into Derby and Derbyshire MH and LDA Delivery Board will test out assumptions with clinical and support teams to assure the caseload for assertive and Intensive support is fully captured and to test out any early gaps identified. Initial action plan developed, which will have regular oversight in each of our Executive Meetings (DDICB and DHCFT) and relevant governance structures and will be formally presented and signed off at Derby and Derbyshire ICB Public Board on 21 November 2024.

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

Derby and Derbyshire Integrated Care Board

Key Messages					
	Concern/Issue New or Ongoing and Escalation Level	Programme/Specialty	Organisation/Place/ System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
1	Ongoing Enhanced Surveillance	Safer Maternity Care	Maternity Service	Assurance	UHDB • Monthly tier 3 meetings continue led by NHS England and DDICB. UHDB are working towards a CQC reassessment in early 2025 for the regulations to be considered for removal. • Positive downward trajectory of stillbirths and neonatal deaths over 2 quarters • NHSE MIA's continue to work with the trust to assist in progression of improvement. NHS Midlands working with the trust on QI for postpartum haemorrhage, triage, Each Baby Counts escalation pathway, Antenatal Clinic capacity and demand and IOL. Fetal monitoring support is to be stepped down as practice embedded. • Medical Obstetric staffing has significantly improved although gaps remain. The trust continue to ensure quality and safety is maintained. CRH • CRH have accepted a NHS Midlands offer of support to review Obstetric Anal Sphincter Injury management and Perinatal Pelvic Health Service pathway implementation. A date needs to be agreed by the trust to progress this work. • An extended perinatal thematic review was completed internally for those stillbirths occurring in 23/24. No safety themes were identified. Sherwood Forest Hospitals Trust has offered to peer review the data to provide assurance for DDICB. Timelines to be shared with the LMNS.
2	Ongoing Enhanced Surveillance	IPC	System	As a Derbyshire System at 16/10/2024: • CDI cases YTD for DDICB system are 224. CRH - 24 cases and UHDB 120 cases. • MRSA blood stream infections – 10 cases reported against a zero tolerance • Number of Gram-negative infections continue to present a stabilising picture with the exception of increased rates for E Coli in July	• NHSE HCAI Thresholds for 24/25 released on 23/8/24. There is a significant increase in the thresholds for the acute trusts, however the DDICB system thresholds have remained largely the same. • UHDB & CRH continue to implement PSIRF methodology for IPC related events eg HCAIs. DCHS are currently reviewing their approach due to low number of incidences • UHDB & CRH remain on enhanced monitoring and support as per the NHSE Midlands IPC escalation matrix. Recovery plans remain in place at both Trusts and assurance obtained relating to the implementation of Trust focused recovery plans is obtained at each Trust's internal IPC Committees, and IPC System Assurance Group. • A further NHSE visit to UHDB to review level of surveillance is planned for 23/10/24 • CRH has identified a small improvement in CDI case numbers. Two patient deaths reported during Q1 are currently with the Coroner for further review. CRH working through the 'Learning through deaths' process with IPC team and will report back through Trust Infection Prevention Control Committee (TIPCC) and CQRG. • Benchmarking (via model health system) at end of Q1 showed that the Derbyshire system is in the third quartile (1st quartile is best , 4th is worst) for performance against all systems nationally for all infections except Klebsiella which is in quartile 2. Overall, this position indicates our system performance is largely consistent. Data for Q2 will be available at the end of October.

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

Derby and Derbyshire Integrated Care Board

Key Messages					
	Concern/Issue New or Ongoing and Escalation Level	Programme/Specialty	Organisation/Place / System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
3	New	Adult Social Care Services	Local Authority	CQC published the ratings for Derbyshire Adult Social Care Services. Overall Derbyshire County Council was rated as 'Good' whilst Derby City Council are rated as 'Requires Improvement'.	**Derbyshire County Council** announced their rating in their weekly stakeholder brief and in a statement on their website. They report that the assessment team said the county council's adult social care services evidenced a good standard of care and support with many people experiencing good, joined-up care. The CQC report highlighted a number of areas where the council worked well, including: Hospital discharge Preventing, reducing and delaying people from going into longer term care. Using direct payments to help people access support to help them live the lives they wanted. Areas highlighted for development included working with people with 'lived experience' to help shape services and letting people know the outcome of safeguarding referrals. **Derby City Council** have issued a statement in which they recognise the CQC's finding. The rating has also been the subject of media attention. Issues highlighted through the media include: Shortage of specialist housing provision Challenges relating to occupational therapy resources Long waiting times for assessment Negative feedback from carers

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

Derby and Derbyshire Integrated Care Board

Key Messages					
	Concern/Issue New or Ongoing and Escalation Level	Programme/Specialty	Organisation/Place / System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
4	New	Mental Health	DHcFT	ICB Maturity Index Self-Assessment Tool for the Community Mental Health Service Review. The purpose of the Maturity Index Self-Assessment Tool is to self-assess current level of service provision and capacity in relation to adequately and safely providing the function of assertive and intensive community support for people with serious mental illness, where engagement is a challenge.	Derbyshire Health Care Foundation Trust and Derby and Derbyshire ICB have started the assurance process but recognise there is more work required to get full assurance. Additional work in the format of a Task and Finish group (including Face to Face workshop) reporting into Derby and Derbyshire MH and LDA Delivery Board to test out assumptions with clinical and support teams to assure we have captured the caseload for assertive and Intensive support fully and to test out any early gaps identified. The following leads have been identified: - Clinical Executive Lead: Dr Arun Chidambaram (DHCFT) - Provider Management Lead: Lee Doyle (DHCFT) - Mental Health Commissioning Lead: Bie Grobet (DDICB) - Derby and Derbyshire MH and LDA Delivery Board (chaired by Prof Dean Howells) Initial action plan developed, which will have regular oversight in each of our Executive Meetings (DDICB and DHCFT) and relevant governance structures and will be formally presented and signed off at Derby and Derbyshire ICB Public Board on 21 November 2024. Ongoing oversight of action plan through DHcFT CQRG & MH, LD&A Board.

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
Maternity - UHDB held a stakeholder event "Shaping Maternity Services Together". Over 50 Patient Partners, service users and stakeholders attended to openly discuss experiences and maternity service quality improvements. **Q2 24/25 NHSE CHC assurance meeting** – the ICB presented a detailed and comprehensive report for the Quarterly assurance meeting. NHSE confirmed that they are assured that the ICB is providing a good quality CHC service to the population of Derby & Derbyshire. Integrated care board review of intensive and assertive community treatment for people with severe mental health problems. Working alongside local stakeholders and partners, a review will be completed and submitted to NHSE by 30 September 2024. **Nottinghamshire Healthcare Foundation Trust CQC Publication:** CQC published the Rapid Review (Part 2) in relation to Patient Care within the Trust. There are a number of recommendations for the Provider, Commissioners and NHSE. DDICB N&Q completed initial scoping of recommendations against care within Derbyshire with outcomes and updates to be reported to DDICB System Quality & Performance Committee and Mental Health, Learning Disability/Autism Board. **National Oversight Framework (NOF) Change of Segmentation:** From Quarter 1 of 2024/25, Derbyshire Healthcare Foundation Trust were placed into NOF Segment 3. This is based on the ICB's assessment of the Trust's delivery against the performance measures set out in the NOF and, within Joined Up Care Derbyshire, is the same rating as University Hospitals of Derby and Burton and the overall system rating. Mandated support will see review meetings jointly chaired between the ICB and NHSE with the first meeting in October 2024. The next steps will be to jointly agree the exit criteria and improvement plan against the areas flagged around quality, operational and financial performance.

Performance

Craig Cook, Director of Strategy and Planning
Margaret Gildea, Non-Executive Member

Planning Compliance with Operational Plan – Cancer and Planned Acute Care

Derby and Derbyshire Integrated Care Board

Objective	Level	Actual	Plan	Actual	Plan	Actual	Plan	actual	plan	actual	plan
		Apr-24		May-24		Jun-24		Jul-24		Aug-24	
No person waiting longer than 65 weeks on an RTT pathway at the end September 2024.	CRH	239	359	251	290	259	177	269	111	195	51
	UHDB	868	795	1,015	563	924	436	719	294	588	60
	DDICB	1,057	1,054	1,126	802	1,050	571	900	377	756	131
Total RTT incomplete waiting list	CRH	28,450	29,680	28,707	29,655	29,173	29,390	30,677	29,178	30,189	28,966
	UHDB	107,129	109,019	106,758	111,511	107,470	113,440	107,494	115,280	107,568	113,511
	DDICB	125,086	129,941	124,396	131,346	125,944	132,189	127,622	133,031	126,326	131,759
Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	CRH	69.9%	76.5%	70.3%	77.3%	68.6%	78.9%	67.4%	81.2%	61.6%	83.3%
	UHDB	74.5%	79.5%	74.4%	81.4%	76.7%	82.6%	75.3%	82.4%	76.6%	82.5%
Total diagnostic waiting list	CRH	7,240	6,616	7,336	6,250	7,178	6,121	7,941	6,223	7,927	6,392
	UHDB	22,426	21,505	22,744	20,744	22,862	20,306	21,124	21,304	20,844	21,906
	DDICB	27,226	26,020	27,717	25,131	27,413	24,693	27,116	25,419	26,541	25,951
Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	CRH	77.2%	75.3%	77.3%	76.7%	72.1%	77.5%	70.6%	74.6%	74.2%	74.7%
	UHDB	71.2%	74.2%	75.6%	75.0%	76.1%	75.3%	77.1%	74.8%	77.5%	75.1%
Improve performance against the headline 62-day standard to 70% by March 2025	CRH	76.9%	71.2%	79.2%	70.2%	80.6%	72.8%	75.4%	71.9%	70.9%	71.3%
	UHDB	60.2%	57.3%	64.8%	59.2%	68.2%	59.5%	68.8%	59.4%	71.4%	61.9%

Referral to treatment waiting times

The overall waiting list is higher than planned at CRH and within plan at UHDB. However, both Trusts are behind trajectory in delivering the 65-week target.

Diagnostic waiting times

The overall waiting list is higher than plan at CRH and within plan at UHDB. However, the proportion of people waiting longer than 6 weeks is higher than planned at both Trusts.

Cancer waiting times

Both Trusts have been achieving their plan for 62-day treatments, CRH narrowly missed in August.
For the 28-day faster diagnosis target, CRH fell slightly short, with UHDB achieving their trajectory.

Cancer, Diagnostics and Planned Acute Care

Derby and Derbyshire Integrated Care Board

Performance Requirements	Actions Being Taken, Risks & Mitigations
No person waiting longer than 65 weeks on an RTT pathway by Oct-24	➢ Maximising use of the Independent Sector and Mutual Aid Capacity to ensure longest waiters are seen. ➢ Significant insourcing and outsourcing at both acute trusts to build capacity. ➢ Work developing on the Waiting Well agenda to validate and manage patients on waiting lists. ➢ Work developing to address waiting list growth over the last 4 years and developing a system approach to managing demand e.g. through use of clinical waiting list validation or developing community pathways. ➢ Opportunity to develop Advice & Guidance to support system Value Weighted Activity and Elective Recovery Fund position. ➢ Getting It Right First Time and Friends & Family Test Productivity plans in place across trusts – high level plan to developed and manged through new Elective Improvement Group.
Cancer Waiting Times	➢ Operation recovery and improvement plans in place to support achievement of Cancer constitutional standards. ➢ 31day Radiotherapy standard remains a risk at UHDB due to workforce challenges but 4th LINAC now reopened. Additional capacity in place but will not fully recovery till Quarter 4. ➢ UHDB focus “perfect Week” in Gynaecology to test plans to optimise pathway efficiency in development. ➢ Plans in development to develop approach to achieve Long Term Plan Objective to support achieving 75% of cancers being diagnosed at Stage 1 or 2 by 2028 (currently 53%) to include Targeted Lung Health Checks and use of targeted funding to support the Prevention (Health Inequalities) agenda.
Diagnostics	➢ System Diagnostics planning workshop planned for early November. This is expected to focus on endoscopy, audiology and direct access to diagnostics. ➢ Open MRI Scanner live from Nov-24 in Ilkeston CDC. ➢ Additional 2 CT Scanners go live in FNCH Nov-24.

Planning Compliance with Operational Plan – Urgent and Emergency Care

Derby and Derbyshire Integrated Care Board

Objective	Level	Actual	Plan	Actual	Plan	Actual	Plan	actual	plan	actual	plan	actual	plan
		Apr-24		May-24		Jun-24		Jul-24		Aug-24		Sep-24	
Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	CRH	62.13%	69%	65%	70%	68%	70%	65%	71%	62%	72%	54%	72%
	UHDB	67.72%	69%	66.44%	71%	64.93%	71%	65%	72%	66%	71%	65%	72%
	One Medical	99.7%	99%	99.8%	99%	99.37%	99%	99.98%	99%	100%	99%	100%	99%
	DCHS	99.58%	100%	98.30%	100%	98.17%	100%	98.42%	100%	99.53%	100%	99.53%	100%
Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	ICB	00:33:54		00:36:22		00:40:23		00:34:14		00:28:55			
	EMAS	00:33:49	00:34:00	00:34:51	00:34:00	00:38:04	00:23:00	00:36:08	00:20:00	00:30:53	00:21:00	00:40:59	00:31:00
Increase virtual ward capacity.	ICB	165	181	170	181	170	181	170	181	170	181	170	181
Increase virtual ward utilisation.	ICB	33%	37%	45%	40%	74%	45%	61%	49%	54%	61%	58%	67%
Average general and acute bed occupancy rate (adult & paeds)	CRH	96.80%	93%	96.0%	94%	95%	98%	96%	97%	95%	96%	96.4%	94%
	UHDB	94.60%	92%	93.3%	91%	93%	94%	93%	91%	93%	91%	93.7%	93%
Percentage of beds occupied by patients no longer meeting the critera to reside - adult	CRH	16%	20%	16%	21%	16%	20%	18%	18%	14%	15%	19%	14%
	UHDB	8%	7%	8%	7%	8%	7%	7%	7%	8%	7%	8%	6%

A&E 4-hour performance

Both Acute providers are behind trajectory in delivering the 4-hour target. We end the half year period 5pp behind our planned trajectory – across all commissioned UEC provision.

Across the ED/UTC provision, there has been 1% less demand than planned in the first 6 months of the year. However, there is variation at a Provider level, with both Acute Trusts dealing with 0.7%-1.1% more demand than planned, the Derby Urgent Treatment Centre dealing with 9.7% more demand than planned and the Community Trust dealing with 13% less demand than planned.

EMAS

For the period Apr – Sept, EMAS has achieved an average performance of 35 mins across its entire portfolio this is 5 mins adverse to target.

General and Acute Beds

Both Acute Trusts have supplied more G&A beds than planned (+17 on average across UHDB and +49 on average at the CRH).

During the period CRH have had average occupancy at 96% and UHDB 94%.

On average, the number of people who do not meet the criteria to reside is lower this year across both Trusts, relative to the same time last year.

Urgent Care

NHS
Derby and Derbyshire
Integrated Care Board

Performance Requirements	Actions Being Taken, Risks & Mitigations
UHDB 78% within 4 hours	➢ Improving Patient Transport Service workflow requests to avoid delayed/aborted journeys. ➢ Regular internal P78 and Tier 3 meetings with regional and ICB team to review and agree remedial actions. These include: ▪ Reviewing the detailed project plan developed to address performance gaps. ▪ Increased focus on 4 hour breaches by admitted/non-admitted using BI data and tools. ▪ Improvements identified for streaming to assessment areas and in-reach pathways. ▪ Plans to increase Same Day Emergency Care capacity. ▪ Aligned to both the Non-Elective Care Performance Group and the Operational Performance Group for governance, oversight and escalation.
CRH 78% within 4 hours	➢ **Same Day Emergency Care pathways** –Work underway to increase the activity pushed through to SDEC from ED and UTC daily, Reviewing the benefit of moving SDEC to the front door. ➢ **Ambulatory Redesign** - Increased beds waits and resus activity has adversely impacted on maintaining a flow enhancing staffing profile within Ambulatory. Plans are in place to trial an extra HCA in Triage area to speed up triage of patients. ➢ **Urgent Treatment Centre Capacity** – Continued embedment of System One to support increased throughput of activity and performance. Daily focus to maximise GP Out Of Hour diversions once UTC closes at 23:00. Discussions taken place with DHU re: maximising all service capacity. ➢ **Escalation beds** – Reprovision of these beds to temporarily accommodate patients for inpatient wards (Beds identified as being available later) and later discharges from Emergency Medical Unit and Medicine Short Stay. ➢ **Overnight breaches** – Focussed work continues ensuring the department is on top of the waits in the afternoon and that all patients requiring admission have plans. Thresholds for breaches for evening and overnight are now set and communicated. ➢ **Other** – Stand up of a weekly Exec-led Taskforce to understand short, medium and longer terms work plan for UEC improvement.
System 78% within 4 hours	➢ Continuation of clinical call validation through our Clinical Navigation Hub (CNH) SPoA, deflecting >69% CAT 3 & 4 ambulances to alternative appropriate pathways with care closer to home, including Call Before Convey from October 2024. CNH is also deflecting >91% of NHS111 calls with PC Validation to either closure of care, self-care, pharmacy or UTC. CNH to support 45-minute handover plans ➢ NHSE Sprint calls are taking place weekly with Acutes reviewing performance and actions to deliver P78. ➢ Continued integration with Place and Urgent Community Response, with enhanced frailty/falls provision. Increasing direct referrals from NHS111 and 999 through CNH. ➢ Supporting prevention, improved population health and High Intensity Use schemes. ➢ Improving P1 and D2A capacity to ensure speedier discharges. ➢ Improving Acute internal pathways. ➢ Implementation of SHREWD for system-wide monitoring of pressures and improved escalation procedures. ➢ Continue to support Urgent Treatment Centre development. ➢ A project is underway to analyse the causes of the rise in demand.

Urgent Care

Derby and Derbyshire Integrated Care Board

Performance Requirements	Actions Being Taken, Risks & Mitigations
NHS 111/DHU	➢ Continuation of NHS111 good performance ➢ Undertake a review on the number of ED referrals
45-minute handover process	➢ All system partners have committed to supporting this initiative and its implementation; *Ambulance crews to transfer the patient into ED by a maximum 45 minutes after arrival if not off loaded with crew having done handover with ED team* ➢ Working group to be established to: ➢ Understand the impact to each organisation and the capacity required to enable go live ➢ Undertake a review of internal escalation processes, including approach to risk, at the acute trusts and EMAS ➢ Agree local timeline following implementation of UEC rapid action plan and confirmation of system readiness ➢ Agreement to dynamically manage risk to maintain under 45-minute handovers ➢ Agree a Standard Operating procedure ➢ Develop system comms plan ➢ Complete a joint system EQIA ➢ Review and update escalation protocol and relevant policies ➢ Cascade any changes via on-call training across the system

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

NHS Derby and Derbyshire Integrated Care Board

Objective	Level	Actual	Plan	Actual	Plan	Actual	Plan	actual	plan	actual	plan
		Apr-24		May-24		Jun-24		Jul-24		Aug-24	
Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025	ICB	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%
Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	ICB					59%	68%				Quarterly Target
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement	ICB	70.0%	69.6%	69.6%	67.8%	71.0%	68.1%	69.4%	66.4%	68.9%	66.4%
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 48% achieving reliable recovery	ICB	50.0%	51.9%	48.0%	50.5%	49.5%	50.6%	49.9%	49.2%	47.5%	48.8%
Increase the number of people accessing transformed models of adult community mental health in 2024/25 (Quarterly Target).	ICB	11,920	7,885	12,065	7,934	12,035	7,984	12,220	8,033		8,082
Increase the number of women accessing specialist perinatal services in 2024/25 (12 month rolling).	ICB	1,190	1,111	1,195	1,111	1,200	1,111	1,220	1,111		1,111
Increase the number of children and young people accessing a mental health service in 2024/25 (12 month rolling).	ICB	14,500	13,825	14,720	13,925	14,435	13,600	14,220	13,530		13,440
Ensure that 75% of individuals listed on GP registers as having a learning disability will receive annual health check (Quarterly Target).	ICB	3%		6.6%		9.9%	12%	5%		9%	Quarterly Target
Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults for every 1 million	DHCFT	33		31		*31*	34	32		30	Quarterly Target
Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 12–15 under 18s for every 1 million population	DHCFT	3		3		*3*	3	3		4	Quarterly Target
Reduce out of area placements	ICB	10	30	10	28	10	26	15	26	15	26

Most of the performance trajectories in the 24/25 plan assumed maintenance of 23/24 performance levels – apart from out of area placements which assumed a step change in performance.

So far this year, most targets have been achieved. However, there are challenges with IAPT performance and SMI health checks.

Mental Health

Derby and Derbyshire Integrated Care Board

Area	Performance Requirements	Actions Being Taken, Risks & Mitigations
Adult MH Community Services	Talking Therapies Increase in access	➢ The reprocurement tender has closed and submissions are being evaluated. ➢ Excessive timelags between 1st and 2nd treatments (over 90 days) accounts for 21% of patients against target of 10%. Plans have been agreed with providers to improve the position.
	Recover dementia diagnosis rate to 66.7%	➢ Dementia risk reduction work continues, this will be a key aim of the next strategy and a toolkit to aid population information and action in lifestyle interventions is in development, through the Dementia Risk Reduction Planning sub-group.
	Improve Access to Perinatal Services	➢ Consideration of additional roles to support growing demands of the service are being evaluated. ➢ Additional assessment clinics continue to be offered with inpatient staff supporting ➢ Service to continue strategic direction to address health inequalities and potential barriers to access.
	Community MH Services increase in access	➢ All sites have now mobilised Phase One of the Living Well CMHF Transformation. ➢ A divisional Productivity action plan addresses data quality issues, increased flow through the service and capacity creation.
	SMI Annual Health Checks increase in access	➢ Health Positive Pilot has begun to see patients which further interaction with Primary Care colleagues taking place to access more surgeries in target areas. Positive feedback is already being received from patients. ➢ SMI Strategic Delivery Group – round up meeting being held this month to look at key activity and objectives. ➢ SMI Applied Informatics Project –Digital & IG Leads looking to system sign off for IG processes to begin solution design. Meetings currently paused while this work is completed. There is currently a block in getting the sign off for this project to continue. Awaiting update from DDICB Digital Lead on progress.
Adult MH Urgent Care Services	Reduction in use of Out of Area Placements	➢ A Transformational Delivery Board is in place to oversee the workstreams making changes to impact patient flow. These cover a range of issues both within the community and inpatient areas. Some of these are longer standing whereas others are informed by the recent MADE event. The action plan is available separately. ➢ Operationally on a day to day basis the work remains ongoing to enact discharge plans on admission – with a discharge tracking tool being recently implemented, reduce the clinically ready for discharge – to include system escalation meetings and a purposeful admission and gatekeeping process to ensure all admissions are appropriate. ➢ Quality Improvement methodology is also being used to underpin and enhance the development for all programmes of work, to include an offer for all staff being trained in QI.
Children & Young Peoples Services	CYP Increase in Access	➢ ARFID and disordered eating stakeholder meeting has been held for decisions on how to progress agreed ways of working when responding to referrals and consultations. ➢ Clinicians from across DHcFT, CRHFT and UHDB are now meeting to outline a pathway for CYP with disordered eating presentations.

Learning Disabilities and Autism

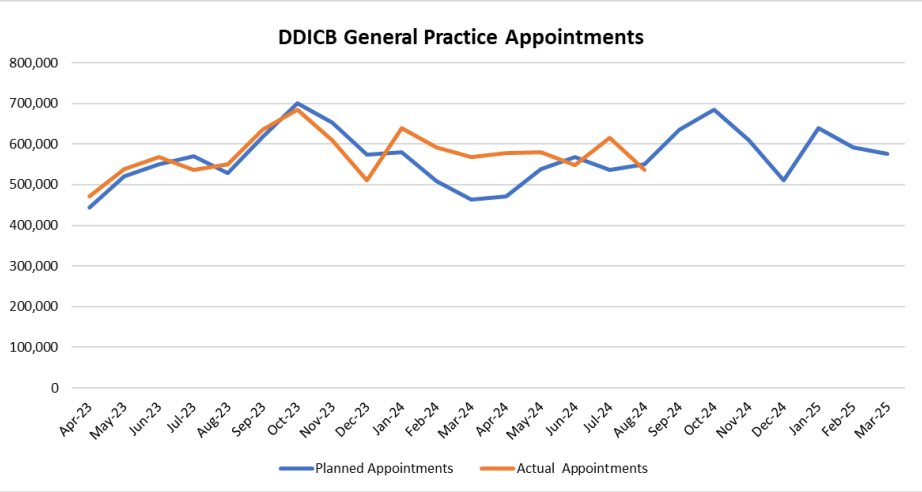
Derby and Derbyshire Integrated Care Board

Area	Performance Requirements	Actions being taken, Risks & Mitigations
Inpatient services	Number of adults in ICB commissioned beds	System will continue with recovery action plan approach to performance management and assurance for 24/25.
	Number of adults in Secure inpatient care	
	Number of CYP In Specialised /secure inpatient care	
Reduction in health inequalities	Number of annual health checks	➢ GP AHC quality project findings have been distributed to key stakeholders, the findings of this will inform part of the AHC action plan for 24/25, details of this action plan are being finalised and a System AHC steering group is being considered. Partners across the system are working to understand and resolve any potential coding errors. ➢ New questions around AHC have been embedded in the SEND policy and documentation. Further work is ongoing to build a process in with children's nursing to send reminders at 14years around eligibility for AHC. ➢ DHcFT and DCHS continue to support primary care with training and development of new ways of working around AHC.
LeDeR Program	Achievement of LeDeR timescales & standards	➢ A request was made for volunteer LeDeR Reviewers but no offers were made. Funding for external reviewers has now been spent. ➢ These have been escalated to LeDeR Steering Group/Governance Panel and Mental Health Delivery Board.

Planning Compliance with Operational Plan – Primary and Community Care

Derby and Derbyshire Integrated Care Board

Objective	Level	Actual	Plan	Actual	Plan	Actual	Plan	actual	plan	actual	plan
		Apr-24		May-24		Jun-24		Jul-24		Aug-24	
Increase General Practice appointment activity	ICB	578,772	471,753	580,127	538,841	547,219	568,802	615,537	536,175	536,107	549,860
% of appointments delivered on same day	ICB	41%		41%		40%		41%		42%	
% of appointments delivered within 2 weeks	ICB	75%	75%	76%	75%	75%	75%	76%	75%	76%	75%
Increase dental activity - improving units of dental activity (UDAs) towards pre-pandemic levels	ICB			*174,893*		*274,827*	381,960	*402,720*		*509,453*	Quarterly Target
Community Waiting List - Over 52 Weeks	ICB	2,020		2,159		2,281	2,226	2,340		2,993	Quarterly Target
Community Waiting List - total size	ICB	25,821		25,447		25,510		23,602		26,738	



GP Appointments

Our 2024/25 plan assumed that General Practice would deliver the same level of appointments as in the previous year. YTD, at August, 7% more appointments have been delivered than plan.

Adult Community Service Waiting Times

At the end of August 24, the number of 52 weeks waits is tracking higher than plan. As context, our 2024/25 plan assumed that the number of 52+ week waits would be higher at the end of the year than the start – due to the known issue about tier 3 weight management.

Primary Care/Dental Recovery Plan Update

Derby and Derbyshire Integrated Care Board

Performance Requirements/Theme	Actions Being Taken, Risks & Mitigations:
Primary Care Access Recovery Plan 24/25	➢ Primary Care Access Recovery Plan work is on target. A mid year report is going to the ICB's Board in November to summarise progress and set out action to deliver to target by April 2025 ➢ DDICB is working with the LMC, GP Provider Board and colleagues from NHSE to work with practices to ensure that we progress access to patient records for those practices who remain concerned about clinical safety and legal risk. ➢ We are combining work on the Primary Care Access Recovery Plan with the new GP clinical model which has been developed by General Practice and agreed by the ICB. Both of these aim to develop a sustainable model that will improve access for the long term. ➢ Work is ongoing with PCNs that have an Additional Roles Reimbursement Scheme (ARRS) underspend to maximise their allocation and recruitment in 2024/25. ➢ Establish a baseline of permanent ARRS staff vs temporary, with additional overtime etc. Investigate an increase of permanent staff. ➢ We will apply greater flexibility to the ARRS scheme and support PCNs to recruit other direct patient care, non-nurse and non-GP Multi-Disciplinary team roles to increase capacity and incorporate the new opportunity to recruit GPs.
Primary Care – Dental Commissioning	➢ The Derbyshire Oral Health Needs Assessment is now finalised. We are using it to inform our plans to improve access, particularly our 3 year plan. East Midlands Dental Commissioning Principles have been developed and agreed by the East Midlands Joint Commissioning Group ➢ Draft Dental Commissioning 3 year Plans have been developed and work is continuing to finalised for formal governance approval in November 2024 by East Midlands Joint Commissioning Committee. We are focusing on areas of greatest need, areas where access is particularly poor, and key cohorts of patients who have specific issues accessing services. ➢ Commissioning Decision Tree and Quality Framework being developed to underpin dental commissioning arrangements. ➢ We have implemented the national dental recovery plan for 24/5, including uplifting UDA rates and new patient premiums ➢ We have also agreed further plans for 24/5 using non-recurrent investment for 24/5 whilst longer term plans are finalised and implemented e.g. 110% over performance, increased commissioning of urgent care dentistry and the development of a dental service for people living in care homes.

Constitutional Standards – Urgent Care

Derby and Derbyshire Integrated Care Board

ICB Dashboard for NHS Constitution Indicators				Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire ICB				Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England		
Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	76%	Sep-24	↑	75.1%	75.3%	5	76.4%	76.0%	0	74.4%	75.1%	5	74.2%	74.8%	108
	A&E 12 Hour Trolley Waits	0	Sep-24					99	614	50	912	5,090	30	38,880	226,919	50

EMAS Dashboard for Ambulance Performance Indicators				Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25	Current Month	YTD	consecutive months non-compliance
Area	Indicator Name	Standard	Latest Period	East Midlands Ambulance Service Performance (NHSD&DICB only - National Performance Measure)				EMAS Performance (Whole Organisation)			EMAS Completed Quarterly Performance 2024/25				NHS England		
Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Sep-24	↓	00:09:15	00:09:03	51	00:09:23	00:09:01	50	00:09:02	00:09:02			00:08:25	00:08:15	41
	Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Sep-24	↓	00:15:46	00:15:34	12	00:16:30	00:15:53	7	00:15:58	00:15:54			00:14:58	00:14:41	0
	Ambulance - Category 2 - Average Response Time	00:18:00	Sep-24	↓	00:40:22	00:35:42	50	00:41:10	00:35:54	51	00:35:42	00:36:09			00:36:02	00:32:26	50
	Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Sep-24	↓	01:23:49	01:13:57	50	01:27:06	01:15:21	50	01:15:05	01:16:10			01:16:20	01:08:27	42
	Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Sep-24	↓	06:26:48	05:41:34	50	06:21:00	05:25:20	50	05:20:47	05:23:13			05:13:54	04:29:37	42
	Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Sep-24	↓	04:15:35	04:31:21	42	05:58:23	04:32:46	42	04:06:36	04:53:55			05:51:39	05:10:29	42

Key:			
	Performance Meeting Target	Performance Improved From Previous Period	↑
	Performance Not Meeting Target	Performance Maintained From Previous Period	→
	Indicator not applicable to organisation	Performance Deteriorated From Previous Period	↓

Constitutional Standards – Planned Care & Cancer

Derby and Derbyshire Integrated Care Board

Key:			
	Performance Meeting Target	Performance Improved From Previous Period	↑
	Performance Not Meeting Target	Performance Maintained From Previous Period	→
	Indicator not applicable to organisation	Performance Deteriorated From Previous Period	↓

ICB Dashboard for NHS Constitution Indicators				Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Area	**Indicator Name**	**Standard**	**Latest Period**	**NHS Derby & Derbyshire ICB**				**Chesterfield Royal Hospital FT**			**University Hospitals of Derby & Burton FT**			**NHS England**		
Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Aug-24	↑	57.6%	57.2%	79	54.5%	53.8%	64	54.8%	54.2%	80	58.3%	58.7%	102
	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Aug-24	↑	4,843	26,576	55	1,430	6,771	53	3,768	21,864	54	282,664	1,485,772	208
	Number of 78 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Aug-24	↑	22	93	41	0	8	0	20	68	41	3,335	18,304	41
	Number of 104 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Aug-24	↔	0	3	0	0	1	0	0	2	0	124	885	41
Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Aug-24	↑	29.80%	27.88%	75	37.87%	32.37%	53	23.54%	23.97%	54	23.93%	22.85%	132
28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of All Referrals	75%	Aug-24	↓	75.4%	74.9%	0	72.1%	74.3%	1	76.1%	75.5%	0	73.5%	75.6%	1
31 Days Cancer Waits	First & Subsequent Treatments Administered Within 31 Days Of Decision To Treat	96%	Aug-24	↓	86.6%	87.6%	26	91.8%	94.5%	2	85.2%	85.8%	26	91.7%	91.1%	26
62 Days Cancer Waits	First Definitive Treatment Administered Within 62 Days Of All Referrals	85%	Aug-24	↓	69.1%	67.9%	26	70.9%	76.6%	26	71.4%	66.8%	26	69.2%	67.4%	26

Mental Health Scorecard

Derby and Derbyshire Integrated Care Board

Pathway	Indicator	Target	Actual	National Benchmark	Latest period	Provider Breakdown										RAP Date Agreed	RAP Recovery Date
						DHcFT	DCHS	CRH	Everyturn	Trent	Vita	UHDBFT	Action for Children (Build Sound Minds)	Compass	Kooth		
NHS Talking Therapies (IAPT)	Recovery Rate	50%	53%	50.7%	Jun-24	53%			49%	54%	51%						
	Reliable Recovery rate (E.A.4a)	51%	49.5%	48.0%	Jun-24	51%			44%	49%	54%						
	Reliable improvement rate (E.A.4b)	67%	71%	67.7%	Jun-24	75%			71%	67%	72%						
	Waiting times - 6 weeks	75%	88%	92.4%	Jun-24	87%			86%	91%	99%						
	Waiting times - 18 weeks	95%	100%	98.4%	Jun-24	99.6%			99%	100%	100%						
	1st to 2nd treatment >90 days	10%	25%	23%	Jun-24	40%			51%	*	34%						
	Recovery Rate - White	50%	54%	52%	Q4 23/24												
	Recovery Rate - BAME	50%	46%	48%	Q4 23/24												
CYP Community	Access - 1+ Contact (E.H.9)	13,600	14,435		Jun-24	3,485	5	1,615				2,440	2,810	2,615	Unavailable		
CYP Eating Disorder	Waiting Time - Urgent - 1 week *	95.0%	100%		Aug-24	100.0%											
	Waiting Time - Routine - 4 weeks *	95.0%	100%		Aug-24	100.0%											
Dementia	Diagnosis Rate (E.A.S1)	68.0%	68.5%	65.4%	Aug-24												
Perinatal	Access Rate (rolling 12 months)	10.0%	11.0%	8.3%	Jun-24	11.0%											
Perinatal and Maternal Mental Health Services	12-month rolling access number (E.H.15)	1,111	1,200		Jun-24	1,200										✓	****
EIP	2 week waits *	60%	100.0%		Aug-24	100.0%											

* Unvalidated, provisional data

Please note:

- Blank cells show data items that are still being sourced.
- Grey cells show data items that are not relevant due to that service not being provided by that provider, no agreed target or no national benchmark.

Mental Health Scorecard

NHS
Derby and Derbyshire
Integrated Care Board

Pathway	Indicator	Target	Actual	National Benchmark	Latest period	DHcFT	RAP Date Agreed	RAP Recovery Date
Out Of Area Placements and Inpatients	Inappropriate OOA Placements *	26	23		Aug-24	23		
	Adult Acute Long LoS (60+ days) *	8	10		Aug-24	10		
	Older Adult Acute Long LoS (90+ days) *	8	11		Aug-24	11		
	Discharges followed up within 72 hours *	80%	85%		Aug-24	85%		
	Admissions with no prior contact (all)		25%	12.7%	Jun-24	25%		
	Admissions with no prior contact (White British)		28%	11.0%	Jun-24	28%		
	Admissions with no prior contact (BAME)		20%	13.9%	Jun-24	20%		
SMI	12-month rolling SMI physical health checks (E.H.13)	68%	59%	59.0%	Q1 24/25			
IPS	Individual Placement Support (Cumulative Access).		340		Jun-24	340		
Community Mental Health	Access number for adults & older adults with SMI (2+ contacts) *	11,521	13,135		Aug-24	13,135		
Learning Disabilities & Autism	Number of adults in ICB commissioned inpatient care *	18**	11		Aug-24		✓	***
	Number of adults in secure inpatient care	15**	19		Aug-24			
	Number of CYP in specialised/secure inpatient care *	3**	4		Aug-24			
	CTR - Post admission Adult *	75%	100%		Aug-24			
	CTR - Post admission CYP *	75%	100%		Aug-24			
	CTR - 6mth follow up - ICB Commissioned *	75%	82%		Aug-24			
	CTR - 12 mth follow up - Secure Inpatient	75%	-		Aug-24			
	CTR - 3mth follow up – CYP *	75%	100%		Aug-24			
	Number of Annual Health Checks to be completed for people (14+) with LD	747	852		Q1 24/25		✓	***
	Number of Annual Health Checks to be completed for people (14+) with LD (Percentage, Quarterly target)	12.00%	9.88%		Q1 24/25			
	LeDeR - Completion 6 months from Notification of death *	100%	80%		Apr-24			
	Autism Median Waiting Time - Referral to Assessment *		121 Weeks		Aug-24			
	Adult autism assessments per month *	26	77		Aug-24			

* DHCFT Data, Unvalidated.
** Updated to 2024/25 trajectories
*** TBC following review

Data Source

Area	Objective	Data Source
Primary and Community Care	Increase General Practice appointment activity	Appointments in General Practice - NHS England Digital
	% of appointments delivered on same day	
	% of appointments delivered within 2 weeks	
	Increase dental activity - improving units of dental activity (UDAs) towards pre-pandemic levels	eDEN Dental data via NHSBSA
	Community Waiting List - Over 52 Weeks	Statistics » Community Health Services Waiting Lists (england.nhs.uk)
	Community Waiting List - total size	
Mental Health, Autism & Learning Disabilities	Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025	https://future.nhs.uk/MHRH/view?objectID=43647696
	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	https://www.england.nhs.uk/statistics/statistical-work-areas/serious-mental-illness-smi/
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement	https://digital.nhs.uk/data-and-information/publications/statistical/nhs-talking-therapies-monthly-statistics-including-employment-advisors
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 48% achieving reliable recovery	
	Increase the number of people accessing transformed models of adult community mental health in 2024/25 (Quarterly Target).	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set
	Increase the number of women accessing specialist perinatal services in 2024/25 (12 month rolling).	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set
	Increase the number of children and young people accessing a mental health service in 2024/25 (12 month rolling).	https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics
	Ensure that 75% of individuals listed on GP registers as having a learning disability will receive annual health check (Quarterly Target).	https://digital.nhs.uk/data-and-information/publications/statistical/learning-disabilities-health-check-scheme
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults for every 1 million population	Local data used from DHcFT
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 12–15 under 18s for every 1 million population	
	Reduce out of area placements	https://future.nhs.uk/MHRH/view?objectID=26200112
Planned Acute Care and Cancer	No person waiting longer than 65 weeks on an RTT pathway at the end September 2024.	https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
	Total RTT incomplete waiting list	
	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
	Total diagnostic waiting list	
	Value Weighted Activity relative to 19/20 base	https://future.nhs.uk/NHSEPaymentsystemsupport/groupHome
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	Data from the CWT-Db on a monthly and quarterly basis.
	Improve performance against the headline 62-day standard to 70% by March 2025	
Urgent and Emergency Care	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fstatistics%2Fstatistical-work-areas%2Fae-waiting-times-and-activity%2F&data=05%7C01%7Cmatt.whitston%40nhs.net%7C77d55a7e84d54e8d9ec008daf21af378%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638088494801862708%7CUnknown%7CTWFp Local Data
	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators).
	Increase virtual ward capacity.	Foundry (Virtual Ward Dashboard)
	Increase virtual ward utilisation.	
	Average general and acute bed occupancy rate	Statistics - NHS England - Critical care and General & Acute Beds – Urgent and Emergency Care Daily Situation Reports 2023-24
	Percentage of beds occupied by patients no longer meeting the critera to reside - adult	Statistics » Discharge delays (Acute) (england.nhs.uk)

Finance

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

Month 6 System Finance Summary – Financial Position

Derby and Derbyshire Integrated Care Board

JUCD submitted a financial plan to deliver a deficit of £50m, in line with the Revenue Financial Plan Limit set for the ICS. £50m Non-recurrent Revenue Deficit Support funding was received in M06 resulting in a revision to the plan and a new breakeven position for the year.

At M06 the system is reporting a year-to-date adverse variance to plan of £2.8m (14.1%). In M06 £1.4m non-recurrent funding was received to support mitigate the £2m cost of Industrial Action as a result of Junior Doctor strikes in June / July 2024.

Key driver of the year-to-date financial position include Urgent and Emergency Care Demand pressures with £2.2m of unplanned cost year to date attributed to the continued reliance on escalated beds on ward 312 at UHDB. Total UEC costs are significantly higher than this, however have been mitigated within organisational positions.

All organisations remain committed to delivering the updated breakeven plan by the end of the year.

Profile Category	YTD Plan £'m	YTD Actual £'m	Var £'m	YTD Revenue Deficit Support Allocation £'m	Revised YTD Plan £'m	Revised YTD Actual £'m	Revised YTD Variance £'m	Full Year plan/FOT £'m	Full Year Revenue Deficit Support Allocation £'m	Revised Full Year Plan/FOT £'m
ICB	**6.1**	**6.2**	**0.1**	**0.0**	**6.1**	**6.2**	**0.1**	**23.8**	**0.0**	**23.8**
CRH	(12.2)	(12.2)	0.0	9.1	(3.2)	(3.1)	0.0	(19.6)	14.5	(5.0)
DCHS	(1.8)	(1.1)	0.8	0.0	(1.8)	(1.1)	0.8	0.0	0.0	0.0
DHcFT	(4.2)	(4.1)	0.1	0.0	(4.2)	(4.1)	0.1	(6.4)	0.0	(6.4)
EMAS	2.8	2.6	(0.2)	0.0	2.8	2.6	(0.2)	0.0	0.0	0.0
UHDB	(37.1)	(40.8)	(3.7)	17.7	(19.4)	(23.1)	(3.7)	(47.8)	35.5	(12.4)
JUCD ICS Surplus/ (Deficit)	(46.6)	(49.4)	(2.8)	26.8	(19.8)	(22.6)	(2.8)	(50.0)	50.0	0.0

Month 6 System Finance Summary – Efficiencies

Derby and Derbyshire Integrated Care Board

The system is £1.1m behind the planned £61.5m to date. The annual efficiency plan is to deliver £169.7m. All organisations are forecasting to achieve their full efficiency targets by the end of the year.

Efficiency plans are weighted towards the end of the financial year. At M06 only 36% has been planned to be delivered rather than 50% on a straight-line basis.

The level of recurrent efficiencies is behind plan to date with 50% delivered recurrently against the planned 62%. This puts pressure on future financial years.

Efficiencies M06 Position	YTD Plan £'m	YTD Actual £'m	Var £'m	Full Year plan £'m
ICB	15.8	16.6	0.8	47.0
CRH	5.5	5.2	(0.2)	19.8
DCHS	3.5	3.7	0.3	11.6
DHcFT	5.4	4.5	(0.8)	12.5
EMAS	8.0	6.9	(1.1)	16.1
UHDB	23.3	23.3	(0.0)	62.7
JUCD Total	**61.5**	**60.4**	**(1.1)**	**169.7**

Recurrent YTD Actual £'m	Non-Recurrent YTD Actual £'m	Total YTD Actual £'m
13.8	2.8	16.6
2.4	2.8	5.2
1.6	2.1	3.7
3.1	1.4	4.5
3.3	3.7	6.9
5.7	17.6	23.3
29.9	**30.5**	**60.4**

Month 6 System Finance Summary – Capital

Derby and Derbyshire Integrated Care Board

At month 6 the year to date spend is £7.3m behind plan, largely resulting from underspends at DCHS due to the timing of major construction projects.

There is a £2m planning risk for IFRS16 Right of Use assets relating to leasing needs above the allocation received. Planning also included an allowable 5% over-commitment on system capital which at M06 equates to £1m.

Cost pressures of up to £3.2m in 2024/25 have been identified in relation to mental health dormitories. Progress has been made with the funding agreement for the £3.3m planned spend in 2025/26 however, this has yet to be finalised. There remains a risk that the system will not be able to achieve 100% eradication of Dorms.

Opportunities to bridge the gap for 2024/25 are being considered including reduction in commitments in 2024/25 and scheme slippage into 2025/26.

Capital by Provider Month 06 Position	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's
NHS Derby and Derbyshire ICB	0.0	0.0	**0.0**
Chesterfield Royal Hospital	2.9	1.7	**1.1**
Derbyshire Community Health Services	12.7	6.9	**5.8**
Derbyshire Healthcare	5.5	4.9	**0.5**
EMAS	1.5	1.4	**0.1**
University Hospital of Derby and Burton	11.8	12.0	**(0.2)**
JUCD Total	**34.3**	**27.0**	**7.3**

Month 6 System Finance Summary – Cash

Derby and Derbyshire Integrated Care Board

The cash balances at month 6 include £11.7m held for capital commitments.

The revenue deficit support funding received in M06 has been allocated across the system according to cash need and has therefore reduced the requirement for additional cash support at CRH and UHDB

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

Organisation	September 2024 Cash Balance Net of Subsidiaries £m's
Chesterfield Royal Hospital	24.9
Derbyshire Community Health Services	30.8
Derbyshire Healthcare	19.2
East Midlands Ambulance Service	16.9
University Hospitals of Derby And Burton	10.6
Derby and Derbyshire ICS Total	**102.4**

Workforce

Lee Radford, ICB Chief People Officer
Margaret Gildea, Non-Executive Member

2024/25 Workforce Plan Position Month 6 (NHS Foundation Trusts including EMAS)

Derby and Derbyshire Integrated Care Board

ICB Total	Reporting Period: Sep 2024					
	Month M6			Trend		
	Plan	Actual	Variance from plan	Previous month	Changes in actual vs previous month	Trend (Actual) previous 12 months
Workforce						
Total Workforce (WTE)	30,604.46	30,021.57	582.89	30,040.92	↓	
Substantive (WTE)	28,813.97	28,333.14	480.83	28,263.23	↑	
Bank (WTE)	1,512.85	1,459.69	53.16	1,518.13	↓	
Agency (WTE)	277.64	228.74	48.90	259.56	↓	
Cost						
Pay Cost (£'000)	134,143	133,956	187	134,517	↓	

- The total workforce across all areas (substantive, bank and agency) was **582.89 WTE below plan.**
- Compared to M5, there was an increase in substantive positions (69.92 WTE), a decrease in bank (-58.44 WTE) and decrease in agency usage (-30.82 WTE) . Much of the increase in substantive positions was from Registered Nursing, Midwifery and Health Visiting (23.7 WTE), Support to Clinical (22.28 WTE) Medical and Dental staff (5.94 WTE) and Scientific, Therapeutic and Technical (24.53 WTE). Whereas there were decreases in NHS Infrastructure Support (-6.53 WTE).

- Whilst the WTE position is below plan, for Pay Cost, there is also an **underspend of £187K,** when rounded. This is due to overspends in CRH (£85K), EMAS (£114K) and UHDB (160K). There are underspends in DCHS (-£184K) and DHcFT (-£360K).

2024/25 Workforce Plan Position M6: Provider Summary

Derby and Derbyshire Integrated Care Board

	2024/25	M6 Plan	M6 Actual	Variance from plan
ICB	Workforce (WTE)			
	Total Workforce	30,604.46	30,021.57	582.89
	Substantive	28,813.97	28,333.14	480.83
	Bank	1,512.85	1,459.69	53.16
	Agency	277.64	228.74	48.90
	Cost (£)			
	Pay Cost (£'000) ^	£134,143	£133,956	£187
CRH	Workforce (WTE)			
	Total Workforce	5,012.24	5,025.22	-12.98
	Substantive	4,607.61	4,614.51	-6.90
	Bank	305.86	324.23	-18.37
	Agency	98.77	86.48	12.29
	Cost (£)			
	Pay Cost (£'000) ^	£21,484	£21,568	-£84
DCHS	Workforce (WTE)			
	Total Workforce	3,948.02	3,868.15	79.87
	Substantive	3,825.43	3,776.78	48.65
	Bank	95.16	69.81	25.35
	Agency	27.43	21.56	5.87
	Cost (£)			
	Pay Cost (£'000) ^	£14,826	£14,641	£185
DHcFT	Workforce (WTE)			
	Total Workforce	3,308.81	3,173.14	135.67
	Substantive	3,094.12	2,964.25	129.87
	Bank	164.16	178.26	-14.10
	Agency	50.53	30.63	19.90
	Cost (£)			
	Pay Cost (£'000) ^	£13,926	£13,565	£361
EMAS	Workforce (WTE)			
	Total Workforce	4,468.79	4,368.47	100.32
	Substantive	4,392.13	4,295.47	96.66
	Bank	52.66	55.19	-2.53
	Agency	24.00	17.81	6.19
	Cost (£)			
	Pay Cost (£'000) ^	£18,196	£18,310	-£114
UHDB	Workforce (WTE)			
	Total Workforce	13,866.61	13,586.59	280.02
	Substantive	12,894.69	12,682.13	212.56
	Bank	895.01	832.20	62.81
	Agency	76.91	72.26	4.65
	Cost (£)			
	Pay Cost (£'000) ^	£65,712	£65,872	-£160

- The **total** system position is 583WTE below **the M6 plan**.
- All Providers were below plan on **substantive** workforce, with the exception of CRH where there was a marginal above WTE plan position (6.9WTE).
- Both DCHS and UHDB were below M6 plan for **bank** staff.
- All providers were below M6 plan for **agency**

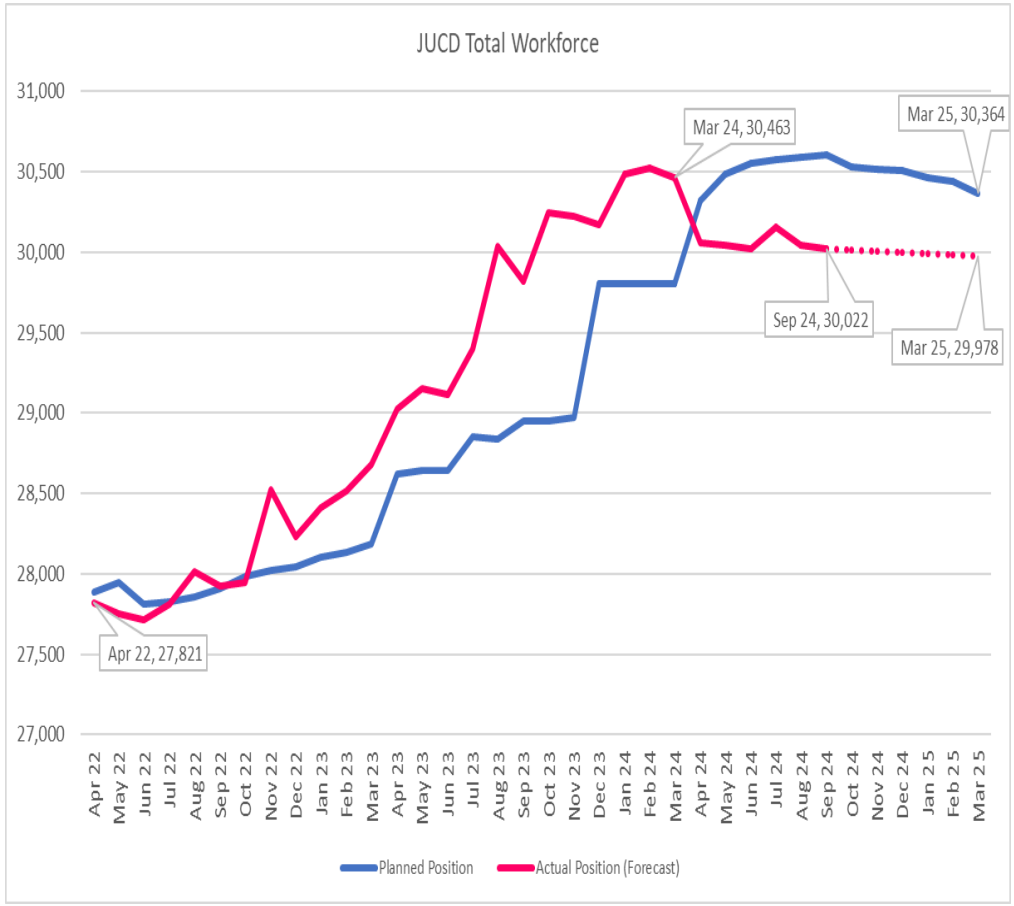
2024/25 Workforce Plan Position M6: Provider Narratives Headlines

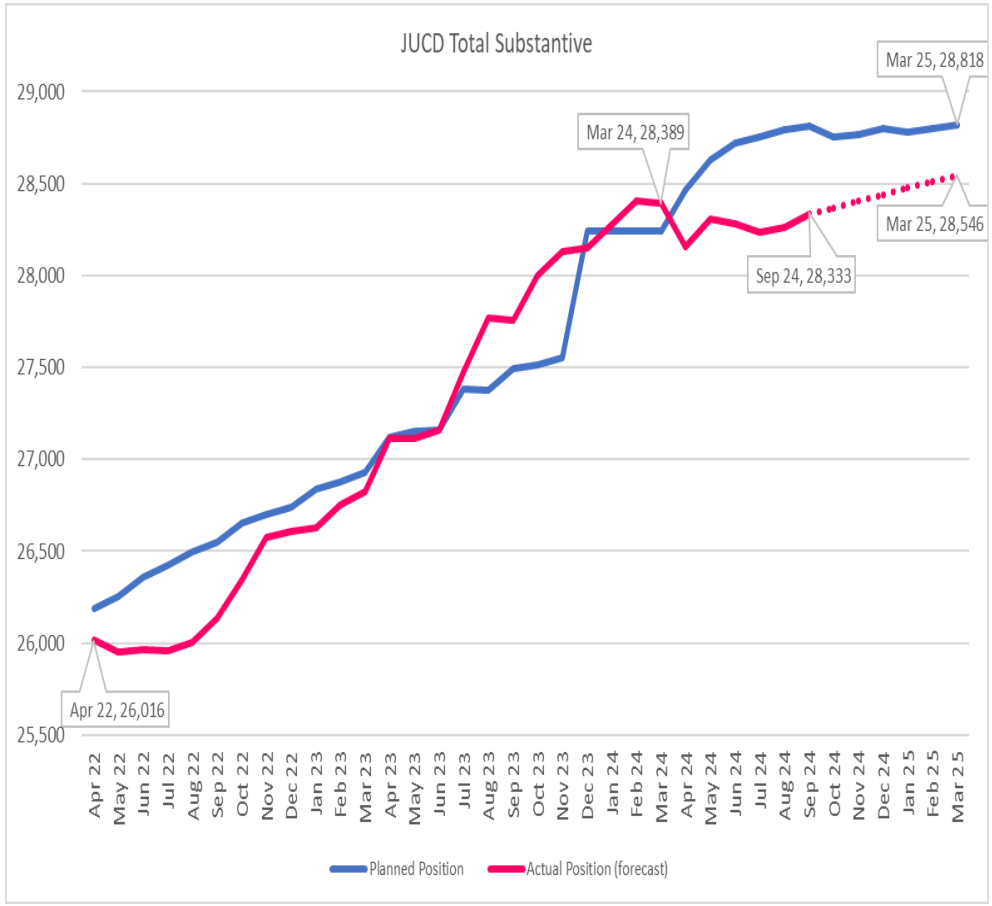
(Note M6 narrative not received from EMAS, H1 stock take updates used. See individual Trust positions for further details)

NHS Derby and Derbyshire Integrated Care Board

	Supporting Provider Narrative
CRH	• Drift to plan is due to unrealised workforce CIP, acuity, activity including surge capacity, recruitment to vacancies, additional resident doctors as mandated by NHSE and LTFT resident doctors to mitigate the need for temporary staffing. • Total workforce is 8.93 WTE above plan • Substantive: Decrease in 1 WTE from M5. • Bank: Slight increase is in nursing due to acuity, sickness and opened beds on EMU/AFU/SDEC. Reduction in HCSW bank. Drivers of nursing bank are acuity, sickness, vacancies in specialities (ED, Theatres, Paeds, Birth Centre). • Agency: slight reduction in agency, and 11.8 WTE below plan. Increase in nursing agency due to increase in surge capacity, beds on EMU and ongoing issues in ED, Theatres and Midwifery. Decrease in all other staff groups. Drivers of medical agency at resident doctor grade is in ED and Gen Med, linked to vacancies, sickness, or teaching and Consultant locums are supporting our fragile services • Pay spend: slight increase in substantive & bank. Reduction in agency spend. • Vacancies: 286 vacancies budgeted vs contracted. Main vacancies based on the ledger are nursing and admin. • Need to do further work on vacancy reporting as ledger is not accurate enough.
DCHS	• DCHS remains under plan on substantive workforce. The plan has been updated to reflect 16.62wte TUPE on the infrastructure workforce from DCHS to DHCFT. (M1 growth of 135wte, due to TUPE service from DCC) • Vacancy rate increasing to >6% • Reduced bank and agency in M6, Approx half of vacancies are resulting from NR vacancy process and half are from hard to fill posts, some of which are resourced through temp staffing. • Compliance with no off-framework agency and compliance with framework price caps generally good. • Triangulation between WF nos. and Pay costs is good. • YTD actuals remain below plan supporting back loaded CIP (from M7).
DHcFT	• Plan 3308.81wte v Actual 3173.14wte = Variance 135.67wte • 129.87wte Substantive - *Recruitment pause in place and tighter vacancy control measures along with Dorms recruitment trajectory* • (14.10)wte Bank - *Diff due to zonal obs. Plan was for agency, actually using bank* • 19.90wte Agency - *Diff due to zonal obs. Plan was for agency, actually using bank* • 135.67wte
EMAS	• Below plan on substantive WTEs by 167 but showing a pay overspend of £0.9m (YTD). This is because the vacancy funding is being used on overtime and bank to ensure that frontline resourcing matches 2023/24 Quarter 4 resourcing which is a national requirement contained in the planning guidance. • Below plan – Front line A&E OPs 134WTEs, Emergency Operations Centre (EOC) 63 WTEs, PTS 53 WTEs. Other areas are slightly above plan (85WTEs). Utilising establishment funding for 167 WTEs to support overtime to ensure delivery • Front line turnover is low • Delays in implementing the 2024/25 CIP and continuing A&E turnaround delays are also contributing to the overspend. • Plan V actual split on 1/12 but that is not the actual profile of people coming in
UHDB	WTE • PWR for M6 shows substantive being under plan by 213 WTE and variable staffing by 68 WTE • Future Recruitment in line Community Diagnostic Hubs • UHDBs hosting of 360 Audit staff 70 WTE was not included in the plan but would be excluded from PWR • Main areas of Agency use - Anaesthetics, Medicine and 1-2-1 patient care in Women's and Children's PAY • Overspends on Medicine areas predominantly UEC driven • We have paid 37 WTE less substantive than we did in March 24 and 134 WTE fewer variable staff. • Recruitment to CDCs is delayed so we are underspent on pay which is offset by less income • Under plan /Underspend on Agency usage

JUCD Workforce Forecast

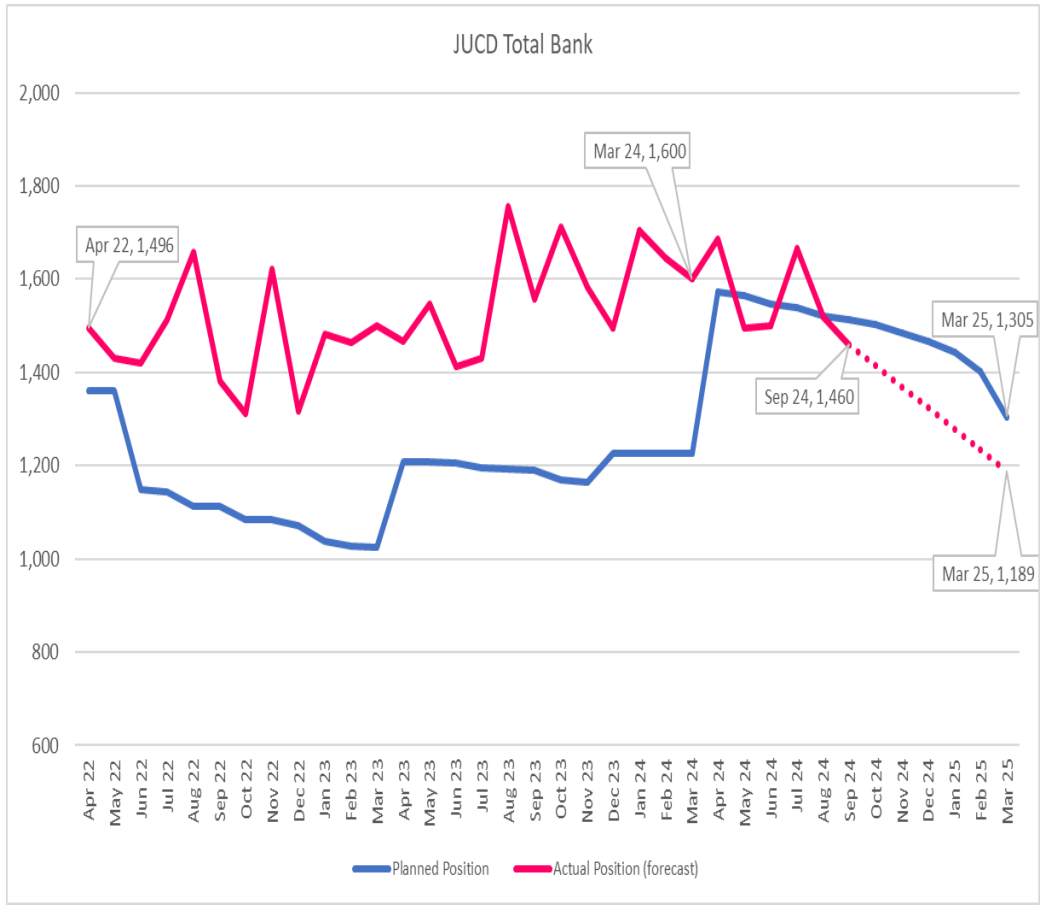


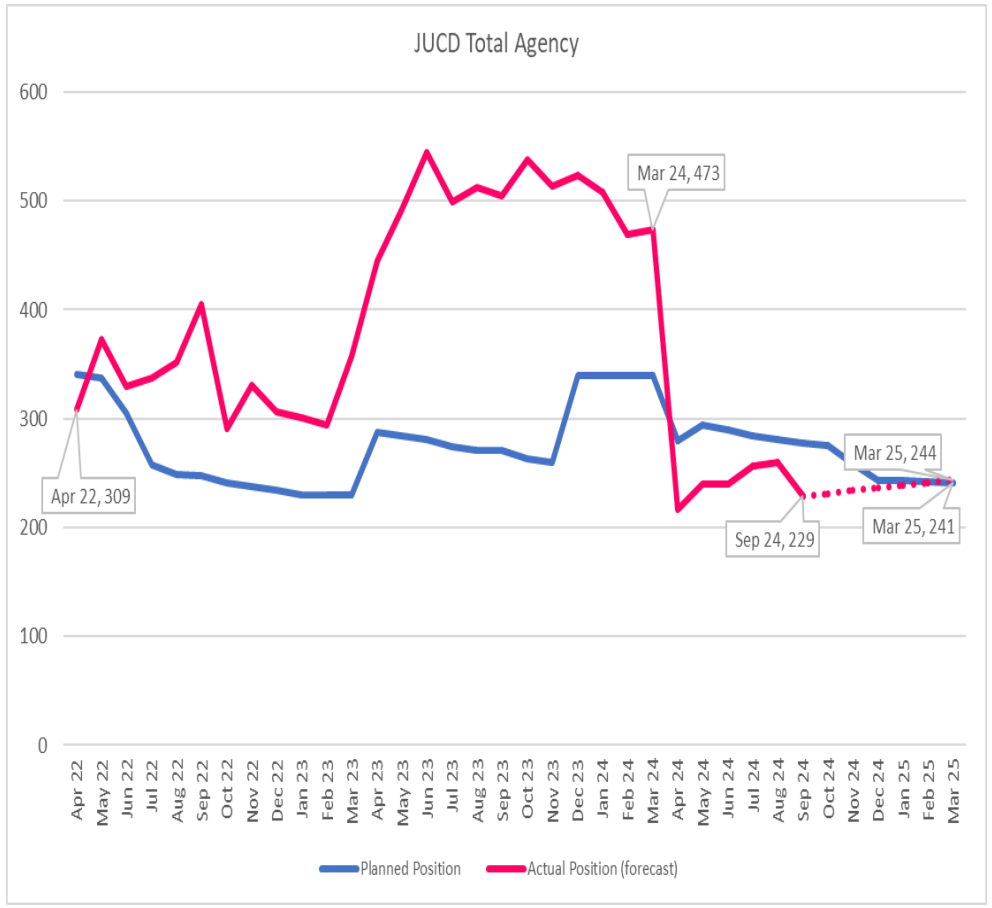


- All Providers except CRH are below plan for the total workforce, resulting in the system position at M6 being (582.89 WTE) less than plan.
- The current forecast (dotted line) is demonstrating a M12 position of 29,978 WTE, which is 386 WTE below the year-end plan. However, we know that there are fluctuations in-year and this is the current prediction using the change in position between M1 and M6.

- All Providers except CRH are below plan on substantive workforce. The total system position at M6 is (480.83 WTE) below plan.
- The M12 position is predicted to be 28,546 WTE, which is 272 WTE below year-end plan. However, we know that there are fluctuations in-year and this is the current prediction using the change in position between M1 and M6.

JUCD Workforce Forecast





- DCHS (25.35 WTE) and UHDB (62.81 WTE) are under plan, whereas CRH (-18.37 WTE), DHcFT (-14.1 WTE) and EMAS (-2.53 WTE) are over plan. This results in the total system position for the Bank workforce at M6 as (53.16 WTE) below plan.
- Using the change between M1 and M6, we forecast a M12 position of 1,189 WTE, which is 116 WTE below year-end plan.

- All Providers continue to make concerted efforts to ensure effective agency controls are in place and all Trusts are under plan at M6.
- The Agency workforce position for the system at M6 is (49 WTE) below plan.
- Using the change between M1 and M6, we forecast a M12 position of 244 WTE, which is 3 WTE above year-end plan.

2024/25 Primary Care Workforce (M5)

Derby and Derbyshire Integrated Care Board

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

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-24)	Apr-24	May-24	Jun-24	Jun-24	Jul-24	Aug-24	Sep-24	Sep-24	Oct-24	Nov-24	Dec-24	Dec-24	Jan-25	Feb-25	Mar-25	Mar-25
Workforce (WTE)	Total WTE	Total WTE			Total WTE	Total WTE			Total WTE	Total WTE			Total WTE	Total WTE			Total WTE
Total Workforce	3,670	3,466	3,477	3,485	3,646	3,467	3,511	0	3,700	0	0	0	3,725	0	0	0	3,750
GPs excluding registrars	770	743	748	742	759	741	779		788				785				775
Nurses	380	343	344	345	369	343	342		367				367				365
Direct Patient Care roles (ARRS funded)	686	597	592	605	667	600	598		674				689				713
Direct Patient Care roles (not ARRS funded)	281	271	270	271	286	266	265		291				295				299
Other – admin and non-clinical	1,552	1,512	1,523	1,521	1,566	1,517	1,526		1,580				1,590				1,598

Summary

- At M5, the total workforce was 189 WTE below Q2's plan. The gap was observed mainly from Direct Patient Care roles (ARRS funded) (-76WTE), Other – admin and non-clinical staff (-54WTE) & Direct Patient Care roles (Non-ARRS funded) (-26 WTE)

Caveats to the data:

- Primary Care data is up to M5 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

M6 actuals (WTE) comparison to pay-bill (£)

Derby and Derbyshire Integrated Care Board

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.

***In order to align with finance reporting, 'other' pay costs (other staff costs and employee benefits) are now reflected in the total pay-bill costs.

Data Sources:

Provider Finance Returns (PFR)
Finance - Deputy DoFs (extracted from Finance Ledgers)
Provider Workforce Returns (PWR extracted from)

	Total Workforce						Funded Establishment *	Vacancy **	Vacancy Rate **	Funded Establishment v Total Workforce Variance
	WTE			Pay Spend (£,000)						
	Plan	Actual	Variance	Plan	Actual	Variance	WTE	WTE	%	WTE
JUCD	30,604.46	30,021.58	**582.89**	£134,143.28	£133,957.94	£185.34	30,431	2,097	6.89%	409
CRH	5,012.24	5,025.22	**-12.99**	£21,484.00	£21,568.78	-£84.78	4,905	290	5.91%	-121
DCHS	3,948.02	3,868.15	**79.87**	£14,825.64	£14,641.47	£184.17	4,012	235	5.85%	143
DHcFT	3,308.81	3,173.14	**135.67**	£13,925.65	£13,565.69	£359.95	3,338	373	11.19%	165
EMAS^	4,468.79	4,368.47	**100.32**	£18,196.00	£18,310.00	-£114.00	4,469	173	3.88%	100
UHDB	13,866.61	13,586.59	**280.02**	£65,712.00	£65,872.00	-£160.00	13,708	1,026	7.48%	121

	Substantive						Bank						Agency						Other ***					
	WTE			Pay Spend (£,000)			WTE			Pay Spend (£,000)			WTE			Pay Spend (£,000)			WTE			Pay Spend (£,000)		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
JUCD	28,814	28,333	**481**	£126,384	£124,302	£2,082	1,513	1,460	**53**	4,592	7,098	-2,506	278	229	**49**	2,362	2,426	-64	0	0	**0**	805	132	673
CRH	4,608	4,615	**-7**	£19,984	£19,528	£456	306	324	**-18**	601	1,294	-693	99	86	**12**	471	878	-407	0	0	**0**	428	-131	559
DCHS	3,825	3,777	**49**	£14,374	£14,099	£275	95	70	**25**	357	399	-42	27	22	**6**	95	143	-49	0	0	**0**	0	0	0
DHcFT	3,094	2,964	**130**	£12,593	£12,362	£231	164	178	**-14**	693	765	-72	51	31	**20**	580	387	193	0	0	**0**	60	52	8
EMAS	4,392	4,295	**97**	£17,833	£17,985	-£152	53	55	**-3**	213	219	-6	24	18	**6**	83	32	51	0	0	**0**	67	74	-7
UHDB	12,895	12,682	**213**	£61,601	£60,328	£1,273	895	832	**63**	2,727	4,421	-1,694	77	72	**5**	1,134	986	148	0	0	**0**	250	137	113

The **M6 total pay bill is underspent by £186k.** This is due to overspends in temporary staffing (Bank and Agency) of £-2.6m, which is offset by underspends in substantive and other pay costs (£2.8m). The funded establishment is based on the substantive staff needed to run the services and typically there will be some flex factored into the planned pay budgets to manage vacancies and staff absences. The total workforce system position is showing as 409 WTEs under established (CRH are over established by 121 WTEs). With regards to the vacancies (funded establishment less substantive staff in post) there are 2,097 WTE vacant posts.

Year To Date Pay Bill Position

	Total			Substantive			Bank			Agency			Other		
	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ICB Total	£801,698	£805,996	-£4,298	£754,566	£740,973	£13,593	£27,617	£44,240	-£16,623	£14,548	£17,189	-£2,641	£4,967	£3,593	£1,374
CRH	£130,613	£133,607	-£2,994	£121,120	£117,902	£3,218	£3,659	£7,700	-£4,041	£3,121	£5,812	-£2,691	£2,713	£2,192	£521
DCHS	£88,536	£87,165	£1,371	£85,794	£84,279	£1,515	£2,145	£2,202	-£57	£597	£684	-£87	£0	£0	£0
DHcFT	£83,945	£82,540	£1,405	£76,013	£73,922	£2,091	£4,167	£4,817	-£650	£3,412	£3,483	-£71	£352	£317	£35
EMAS	£106,856	£107,898	-£1,042	£104,678	£105,538	-£860	£1,278	£1,433	-£155	£498	£490	£8	£402	£437	-£35
UHDB	£391,748	£394,786	-£3,038	£366,960	£359,331	£7,629	£16,368	£28,088	-£11,720	£6,920	£6,720	£200	£1,500	£647	£853

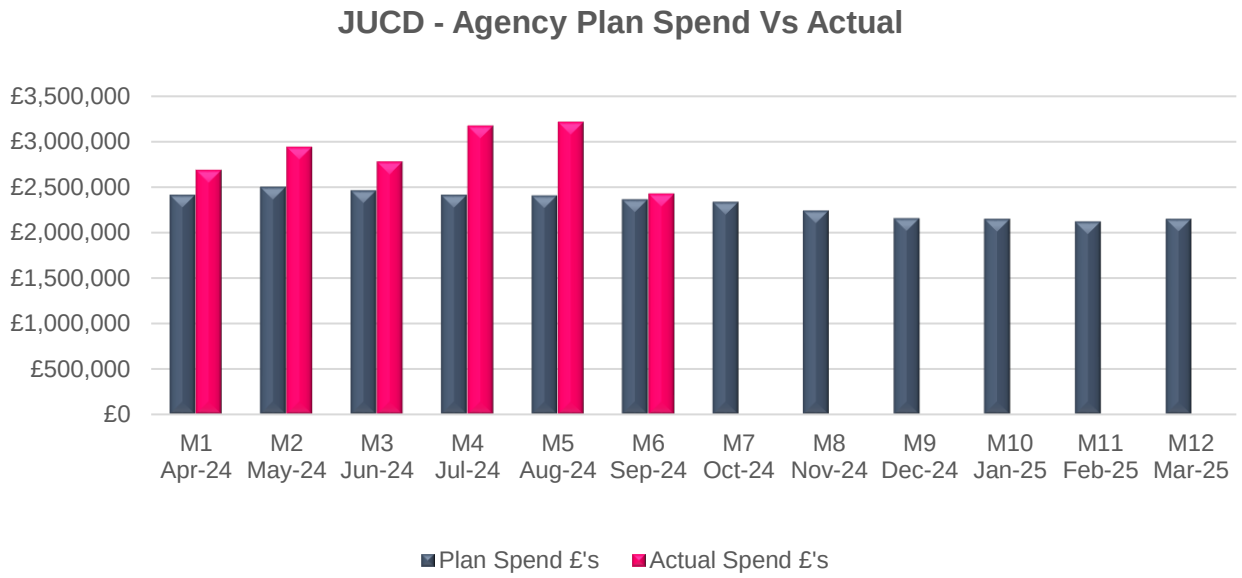
From the table above the YTD total overspend on temporary staffing (Bank and Agency) £19.3m. The substantive staffing and other pay costs are within budget (£15m); however, the overall YTD position is £4.2m overspent. The main drivers for this position being CRH, EMAS & UHDB, with the majority of the overspend being observed in Bank staffing across all organisations:

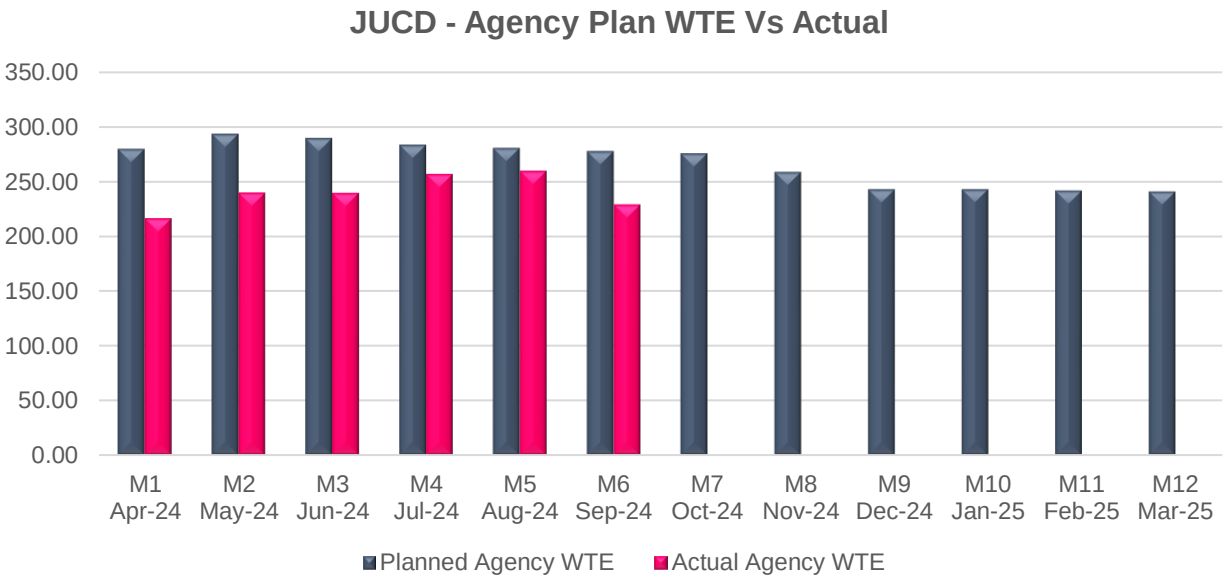
Based on data provided by finance, FOT is £3.6m adverse to plan (£0.6m adverse to plan at M05) due to forecast overspends in bank and agency costs.

NHSE has confirmed the final pay award allocations and the related updated PFR plan and actual adjustments will be transacted in M07.

Work continues to better align understanding of the pay and WTE variances.

2024/25 M6 JUCD Agency Breakdown





KPI Summary:

Total Agency Spend:

- JUCD planned to spend £2.36m on agency staff in M6. The actual spend was £2.42m This is an overspend against plan of £63k

- YTD JUCD have a current overspend of £2.7m on agency staff.

- As of the end of M6, JUCD have reached 62.2% of planned agency spend.

Agency spend as a % of total staff spend:

- In M6 JUCD agency cost amounted to 1.8% of total pay costs, 1.4% under the national target of 3.2%. YTD 2.1%.

% of Off Framework shifts:

- Off framework usage was 29 shifts in M6, 0.7% of total agency shifts.

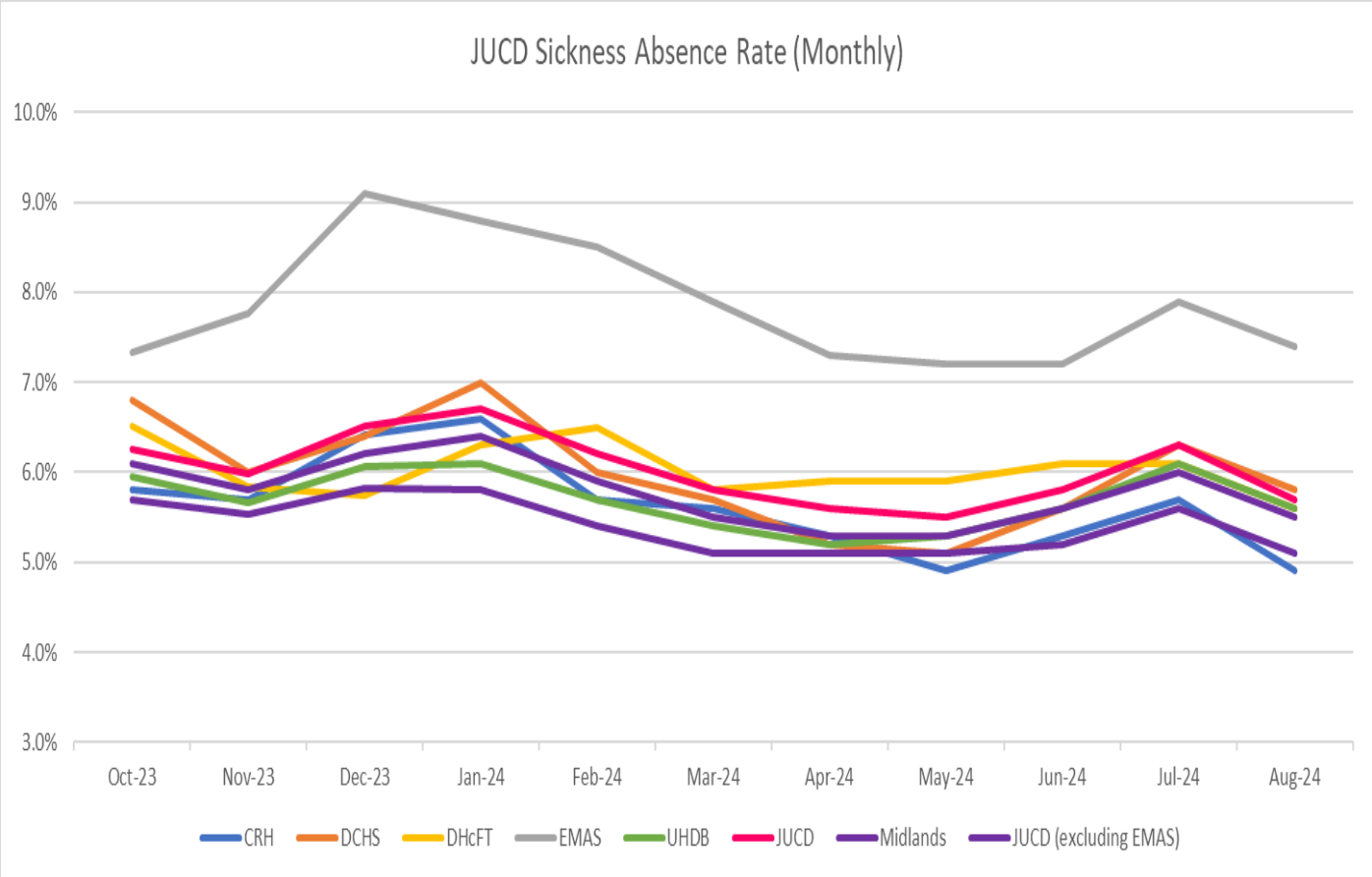
- The areas where off Framework usage was observed are, Healthcare Assistants, Registered/ Qualified Scientific, Therapeutic and Technical & Medical and Dental.

% non price cap compliant shifts

- There were 1,971 non price cap compliant shifts, 45.6% of the total agency shifts.

Workforce Plan KPIs: Sickness (M5)

Note: HEE ESR Data is only available at present to M5



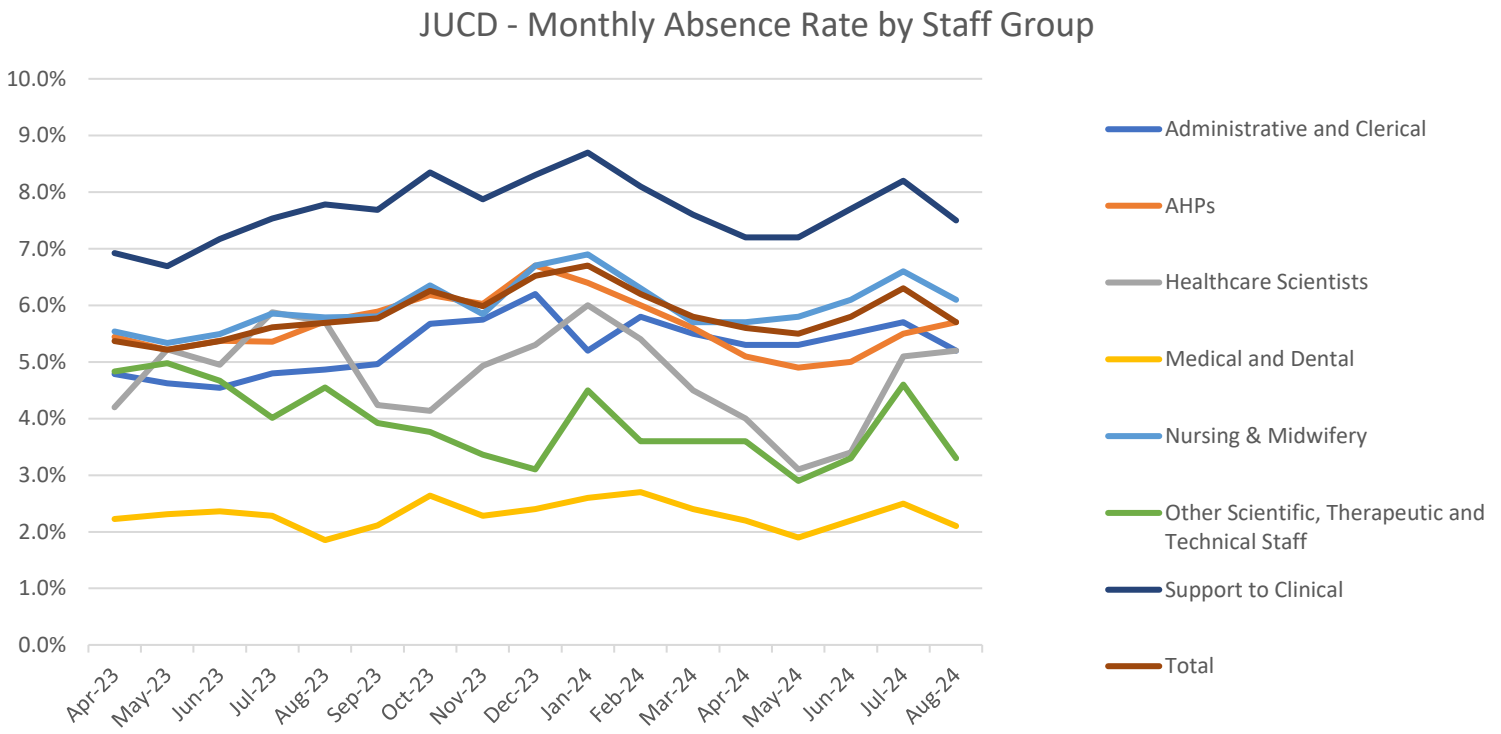
- Source: HEE Portal ESR
- Note CRH only commenced with ESR in November 2020 so data is only from that point
- Since January 2021 the sickness trends are consistent across all Trusts with the exception of EMAS
- The Derbyshire position is slightly higher that the Midlands position, which is mainly due to the DHcFT and EMAS positions. Further understanding of sickness and the actions being taken is required to understand the impact on the temporary staffing usage.

Monthly Absence Rate	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
CRH	4.8%	4.8%	5.0%	5.1%	4.8%	5.1%	5.8%	5.7%	6.4%	6.6%	5.7%	5.6%	5.3%	4.9%	5.3%	5.7%	4.9%
DCHS	5.4%	5.1%	5.2%	5.5%	5.5%	5.7%	6.8%	6.0%	6.4%	7.0%	6.0%	5.7%	5.2%	5.1%	5.6%	6.3%	5.8%
DHcFT	5.7%	5.6%	5.3%	5.8%	5.9%	5.9%	6.5%	5.8%	5.7%	6.3%	6.5%	5.8%	5.9%	5.9%	6.1%	6.1%	5.6%
EMAS	7.3%	7.0%	7.4%	7.6%	8.1%	7.7%	7.3%	7.8%	9.1%	8.8%	8.5%	7.9%	7.3%	7.2%	7.2%	7.9%	7.4%
UHDB	5.0%	4.9%	5.1%	5.3%	5.3%	5.5%	6.0%	5.7%	6.1%	6.1%	5.7%	5.4%	5.2%	5.3%	5.6%	6.1%	5.6%
JUCD	5.4%	5.2%	5.4%	5.6%	5.7%	5.8%	6.3%	6.0%	6.5%	6.7%	6.2%	5.8%	5.6%	5.5%	5.8%	6.3%	5.7%
Midlands	4.9%	4.8%	4.9%	5.1%	5.3%	5.4%	5.7%	5.5%	5.8%	5.8%	5.4%	5.1%	5.1%	5.1%	5.2%	5.6%	5.1%
JUCD (excluding EMAS)	5.1%	5.0%	5.1%	5.3%	5.3%	5.5%	6.1%	5.8%	6.2%	6.4%	5.9%	5.5%	5.3%	5.3%	5.6%	6.0%	5.5%

Workforce Plan KPIs: Sickness by Staff Group (M5)

Note: HEE ESR Data is only available at present to M5

Derby and Derbyshire Integrated Care Board



- Source: HEE Portal ESR
- Note CRH only commenced with ESR in November 2020 so data is only from that point
- It is observed Support to Clinical had the highest sickness absence rate among all staff groups, followed by Nursing and Midwifery, whereas Medical and Dental has the lowest
- Further investigation is required into the admin and clerical sickness levels as this appear to be at the higher end

JUCD	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Administrative and Clerical	4.8%	4.6%	4.5%	4.8%	4.9%	5.0%	5.7%	5.7%	6.2%	5.2%	5.8%	5.5%	5.3%	5.3%	5.5%	5.7%	5.2%
AHPs	5.4%	5.2%	5.4%	5.4%	5.7%	5.9%	6.2%	6.0%	6.7%	6.4%	6.0%	5.6%	5.1%	4.9%	5.0%	5.5%	5.7%
Healthcare Scientists	4.2%	5.2%	5.0%	5.9%	5.7%	4.2%	4.1%	4.9%	5.3%	6.0%	5.4%	4.5%	4.0%	3.1%	3.4%	5.1%	5.2%
Medical and Dental	2.2%	2.3%	2.4%	2.3%	1.9%	2.1%	2.6%	2.3%	2.4%	2.6%	2.7%	2.4%	2.2%	1.9%	2.2%	2.5%	2.1%
Nursing & Midwifery	5.5%	5.3%	5.5%	5.9%	5.8%	5.8%	6.3%	5.8%	6.7%	6.9%	6.3%	5.7%	5.7%	5.8%	6.1%	6.6%	6.1%
Other Scientific, Therapeutic and Technical Staff	4.8%	5.0%	4.7%	4.0%	4.5%	3.9%	3.8%	3.4%	3.1%	4.5%	3.6%	3.6%	3.6%	2.9%	3.3%	4.6%	3.3%
Support to Clinical	6.9%	6.7%	7.2%	7.5%	7.8%	7.7%	8.3%	7.9%	8.3%	8.7%	8.1%	7.6%	7.2%	7.2%	7.7%	8.2%	7.5%
Total	5.4%	5.2%	5.4%	5.6%	5.7%	5.8%	6.3%	6.0%	6.5%	6.7%	6.2%	5.8%	5.6%	5.5%	5.8%	6.3%	5.7%

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 086

Report Title	Remuneration Committee Assurance Report – 8th October 2024							
Author	Kathryn Durrant, Executive Board Secretary							
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer							
Presenter	Margaret Gildea, Senior Non-Executive Member							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Not applicable							
Assurance Report Signed off by Chair	Margaret Gildea, Chair of the Remuneration Committee							
Which committee has the subject matter been through?	Remuneration Committee, 8th October 2024							

Recommendations
The ICB Board are recommended to **NOTE** the Remuneration Committee Assurance Report.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Remuneration Committee on the 8th October 2024.
Background
The Remuneration Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
This 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. <u>Remuneration Committee on 8th October 2024</u> The Committee were ASSURED that the ICB is in a positive position, with almost all redundancy issues resolved. The few issues remaining are being managed.

The Committee NOTED a possible redundancy risk for a Very Senior Manager (VSM)/ Functional Director within the ICB. The Committee APPROVED the 'at risk' employee being offered an alternative role, subject to successful ringfence interview.

The Committee NOTED the update on recruitment to the Deputy Chief Medical Officer role.

The Committee NOTED the progress in recruitment of a Joint Chief Finance Officer role with Nottingham and Nottinghamshire ICB. The Committee were ASSURED that recruitment to this role is in progress and there has been some interest in the role. If a suitable candidate is not identified the joint role will be reconsidered.

The Committee APPROVED the search for and recruitment of an interim Chief Finance Officer for NHS Derby and Derbyshire ICB, to cover the gap between the current CFO's retirement and recruitment to the new joint CFO role.

The Committee APPROVED the recommended pay progression for a Functional Director and the nationally recommended pay award for VSMs. The Committee also applied discretion in resolving one issue related to VSM pay.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☒
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☒	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

Any other risks are detailed within the report.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☒	N/A☒

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

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

None identified.

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

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

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

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

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

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

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 087

Report Title	Board Assurance Framework (BAF) – Quarter 2 2024/25 final BAF 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 – ICB Board BAF Strategic Risk Report Appendix 2 – 2024/25 Quarter 2 BAF (Separate PDF item 087)							
Assurance Report Signed off by Chair	Not applicable.							
Which committee has the subject matter been through?	Finance, Estates and Digital Committee Population Health and Strategic Commissioning Committee Quality and Performance Committee People and Culture Committee Public Partnership Committee							

Recommendations
The ICB Board are recommended to: • **RECEIVE** the final Quarter 2 24/25 BAF strategic risks 1 to 10; • **NOTE** the revised risk description for Strategic Risk 5; • **NOTE** the increase in risk score in respect of Strategic Risk 1; • **NOTE** the decrease in risk score in respect of Strategic Risk 5.
Purpose
The purpose of this report is to present to the ICB Board the final Quarter 2 2024/25 BAF strategic risks 1 to 10. The full Board Assurance Framework can be found a**t** Appendix 2 **(**Separate PDF) and on the ICB website here.
Background
A fundamental aspect of the ICB's governance structure is the establishment and implementation of sound risk management arrangements. The effective design and embedment of these arrangements will ensure that the Board is kept informed of the key risks facing the ICB and the wider system and is assured that robust processes are in place to manage and mitigate them. The Board Assurance Framework (BAF) is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's aims and objectives. The BAF

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

Report Summary

This report provides the 2024/25 quarter 2 final position of the Board Assurance Framework. The strategic risks have been reviewed, updated and approved by each responsible Committee and the current risk scores considered and rationale provided.

Changes made during quarter 2 are highlighted on the BAF in blue text.

The Board Assurance Framework Strategic Risk Report (Appendix 1) provides the detail of the quarter 2 position strategic risks, risk movement, rationale and actions completed during quarter 2. Appendix 2 details the full quarter 2 BAF.

The Board are in the process of reviewing the Strategic Risks and the format of Board Assurance Framework. A Board Seminar session was held on the 17th October 2024 which focussed on the ICB's strategic risks, risk appetite and the risk tolerance of the ICB. As a result, the Board Assurance Framework will change during quarters 3 and 4.

For the purpose of this report, the Quarter 2 BAF is presented to the ICB Board in its current format.

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 poorer health outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☒
SR5	There is a risk that the system is not able to maintain an affordable and sustainable workforce supply pipeline and to retain staff through a positive staff experience.	☒	**SR6**	Risk merged with SR5	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

The report covers each strategic risk.

Financial impact on the ICB or wider Integrated Care System

Yes ☒	No☐	N/A☐

Details/Findings
Strategic risk SR4 describe the system's financial risk.
There is a risk that the NHS in Derby and Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move to a sustainable financial position and achieve best value from the £3.4billion available funding.

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.

NHS
Derby and Derbyshire
Integrated Care Board

Board Assurance Framework Strategic Risk Report
Quarter 2 – 2024/25

This report provides a description of the strategic risks currently facing the Derbyshire system and provides the final position for each at quarter 2 2024/25 including the decisions of the relevant committees in relation to any changes in risk scores, risk description and threats.

The ICB has 9 strategic risks in total. 5 strategic risks are scored very high and 4 strategic risks are scored high.

During quarter 2, there has been some movement in risk scores since quarter 1, and a new risk description for risk 5.

Risk No	Description	Q1 2024/25 closing risk score	Q2 2024/25 closing risk score	Risk Movement	Rationale	Additional Comments
SR1 *Quality and Performance Committee*	There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and both upper tier Councils to deliver consistently safe services with appropriate standards of care.	**12**	**16**	↑	The Quality and Performance Committee approved the increase in risk score from a high 12 to a very high 16 on 25th July 2024. This was agreed as a result of the challenging financial constraints across the system and the potential impact this has on the standards of care.	One action has been completed during quarter 2. This relates to action reference 1T4.1A where health and social care consultations were paused and were re-commenced post-election on 4th July 2024. The pause has been lifted on any engagement activity following the election.

SR2 *Quality and Performance Committee*	There is a risk that short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	**16**	**16**	⟺	This risk remains scored at 16. The risk score has been reviewed for the closing quarter 2 position and this was recommended to remain at a very high score of 16. Due to the pressure the system remains under, this score remains appropriate.	No actions were completed during quarter 2.
SR3 *Public Partnerships Committee*	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	**12**	**12**	⟺	The risk score has been discussed and remains at a high 12.	The BAF template now includes an action plan which builds on and simplifies actions listed in previous iterations for this BAF strategic risk. Two actions have been completed during quarter 2: • Action reference 3T1.4A Strengthen connection with ICB procurement governance timetables, key priorities and system transformation programme (ePMO). • Action reference 3T4.2A Secure ICP agenda item on insight framework and approach.

SR4 *Finance, Estates and Digital Committee*	There is a risk that the NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	**20**	**20**		The risk score currently remains at a very high 20, this is consistent to the corporate finance risks 06A and 06B within the ICB's Corporate Risk Register.	No actions were completed during quarter 2.
SR5 *People and Culture Committee*	*New risk description*: There is a risk that the system is not able to maintain an affordable and sustainable workforce supply pipeline and to retain staff through a positive staff experience.	**20**	**16**		The risk score was agreed to decrease to a very high score of 16. This is based upon the significant work undertaken to reduce workforce vacancies across all NHS provides which is a positive development. Vacancies within social care remain high and impacts upon UEC pathways. There is currently no oversight of a total system wide workforce picture for care, VCSE and local authority sectors workforce to inform a full system perspective.	The system gaps in controls and assurances and system controls sources of assurance have been fully revised during quarter 2.
SR7 *Population Health and Strategic*	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	**12**	**12**		The risk score remains at a high 12, this is due to the system financial constraints impacting on	Operation Periscope is currently in development and will help shape the development of the Integrated Assurance and Performance Report to ensure Board

Commissioning Committee	transformation and change required.				the scale of transformation which can be undertaken.	expectations are met along with consistent management reporting across the system. The first draft of the Operation Periscope product is expected by December 2024.
SR8 *Population Health and Strategic Commissioning Committee*	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	**12**	**12**	⟺	The risk score remains at a high 12 due to Operation Periscope being developed and the actions relating to this.	One action has been partially completed during Quarter 2: Action reference 8T1.4A: "Co-ordination and local prioritisation through SIG with leadership provided by internal business intelligence team". The action is partially completed, as related gap 8T1.4C "Strategic Intelligence Group (SIG) needs formalising and structured reporting through to D3B and direct link to ICB Strategic Intent function and ICB planning cell" has now been achieved.
SR9 *Population Health and Strategic Commissioning Committee*	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	**16**	**16**	⟺	The risk score remains at a very high 16, this is due to the requirement for robust population health management plans to be developed to support the tackling of health inequalities in the most deprived population groups, alongside the	One action has been completed during quarter 2. This relates to action reference 9T1.3A in relation to the review of an alternative funding formula compared to Carr Hill and the scope of cost and logistics.

					population as a whole is getting sicker.	This was reconsidered for 2024/25, however it is not affordable at present or in the foreseeable future due to the system financial position.
SR10 *Finance, Estates and Digital Committee*	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	**12**	**12**	⟺	Given the current financial environment and planning out turns, alongside continuing national funding streams, the Committee agreed there is no change the current risk score is proposed.	No actions were completed during quarter 2.

Each responsible Executive and the Committee reviewed and approved their final Quarter 2 2024/25 strategic risks at the Committee meetings held during September and October 2024.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 088

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

Recommendations
The Board are requested to **RECEIVE** and **NOTE:** • Appendix 1, the risk register report; • Appendix 2, which details the full ICB Corporate Risk Register; • Appendix 3, which summarises the movement of all risks in October 2024. **APPROVE CLOSURE** of**:** • Risk 07 relating to the secure storage of staff files; • Risk 24 relating to the requirement to commission and have in place a Designated Doctor for looked after children.
Purpose
The purpose of the Risk Register report is to appraise the ICB Board of the Corporate Risk position.
Background
The ICB Risk Register is a live management document which enables the organisation to understand its comprehensive risk profile and brings an awareness of the wider risk environment. All risks in the Risk Register are allocated to a committee who review new and existing risks each month and agree the latest position on the risk, advise on any further mitigating actions that might be required, or approve removal of fully mitigated risks.

Report Summary

The report summarises any movement in risk scores, new risks to the organisation and any risks approved for closure by the relevant committee.

Click here for the link to the full corporate risk register.

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 poorer health outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☒
SR5	There is a risk that the system is not able to maintain an affordable and sustainable workforce supply pipeline and to retain staff through a positive staff experience.	☒	**SR6**	Risk merged with SR5	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

The report covers each strategic risk.

Financial impact on the ICB or wider Integrated Care System

Yes ☒	No☐	N/A☐

Details/Findings	**Has this been signed off by a finance team member?**
Strategic risk SR4 describe the system's financial risk. *There is a risk that the NHS in Derby and Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move to a sustainable financial position and achieve best value from the £3.4billion available funding.*	Keith Griffiths, Chief Finance Officer

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

No conflicts of interest have been identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

There are no implications or risks which affect the ICB's obligations under the Public Sector Equality Duty.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings

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

CORPORATE RISK REGISTER REPORT

INTRODUCTION

The purpose of this report is to present the ICB Board with a summary of the current risk position, including any movement in risk scores, new risks to the organisation and any risks approved for closure by the relevant committee owning the risk.

The ICB currently has 8 very high risks, 9 high and 3 moderate scoring risks on the corporate risk register.

RISK MOVEMENT

Decreased risks

One risk was decreased in score in September 2024:

1. Risk 20: *(System Quality Group) 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.*

   This risk was proposed to be decreased in risk score from a very high score of 16 (probability 4 x impact 4) to a high score of 9 (probability 3 x impact 3).

   The reason for the decrease in risk score is that the long-standing issue relating to the contingency hotels is currently being managed with relevant escalation processes in place, therefore the decrease in risk score reflects the mechanisms in place. The decrease was approved at the System Quality Group meeting held on 1st October 2024.

Increased risks

No risks were increased in score during September and October 2024.

CLOSED RISKS

One risk was proposed for closure in September 2024:

Risk 07: *(Audit and Governance Committee) 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.*

This risk was recommended to be closed as the staff files are now in one place and securely stored. The closure of this risk was approved at the Audit and Governance Committee meeting held on 10th October 2024.

One risk was proposed for closure in October 2024:

Risk 24: *(System Quality Group) 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.*

This risk was recommended to be closed as Derbyshire Healthcare Foundation Trust (DHcFT) have been successful in appointing a Community Paediatrician into the Designated Doctor for the looked after children role. The closure of this risk was approved at the System Quality Group meeting held on 5th November 2024.

NEW RISKS

One new risk was proposed in September:

Risk 19C*: (System Quality Group) Lack of digital interoperability across information platforms leads to inadequate visibility of discharge information and communication between providers. There are a lack of effective performance indicators to monitor and manage discharge processes. Inadequate data collection and analysis to identify bottlenecks in discharge pathways. Lack of system data intelligence to inform decision making to manage risks when in system escalation.*

The risk was proposed to be scored at a very high score of 15 (probability 5 x impact 3). This new risk was approved at the System Quality Group meeting held on 1st October 2024.

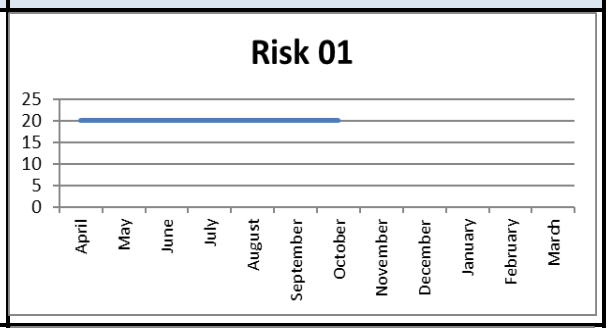
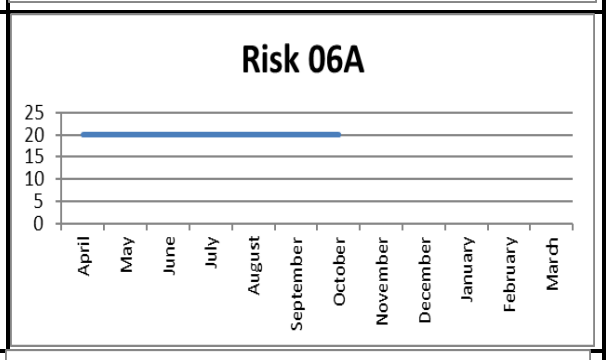
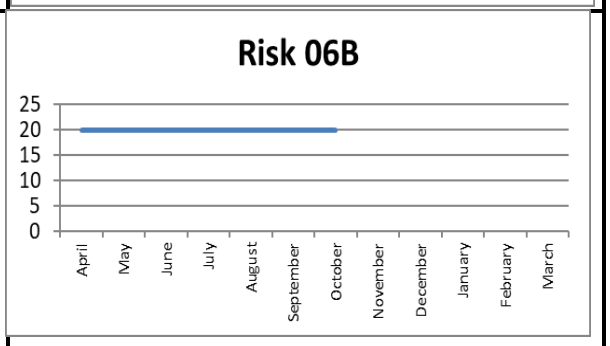
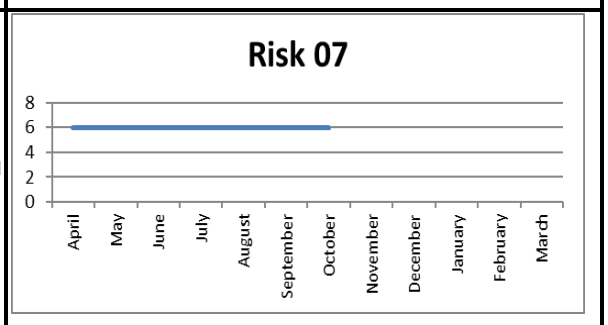
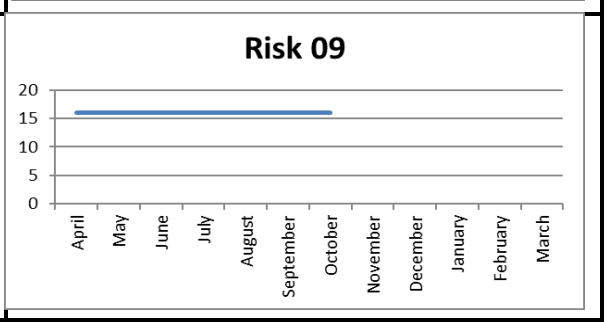
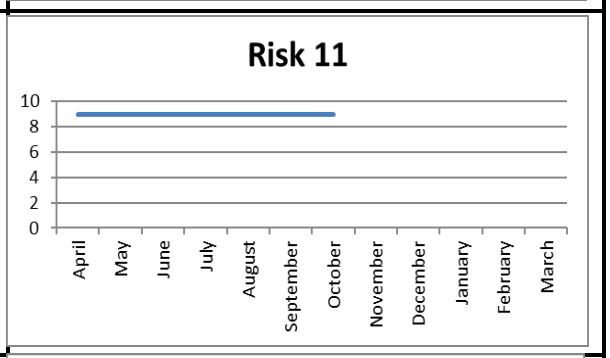
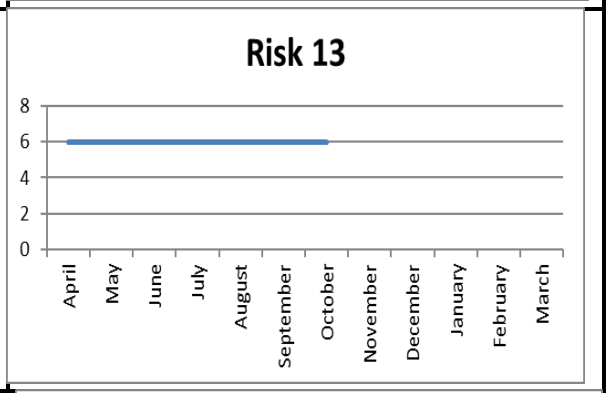
There have been no changes to the remining risks on the ICB corporate risk register.

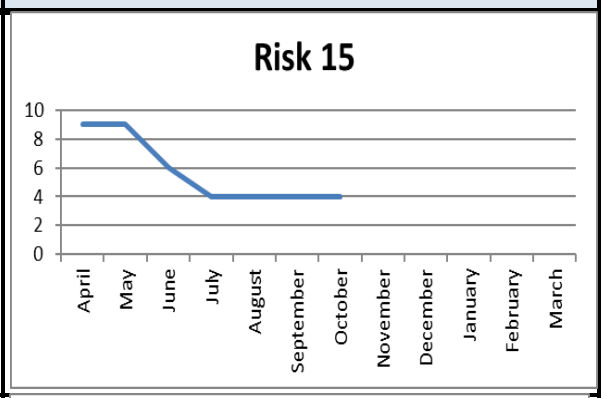
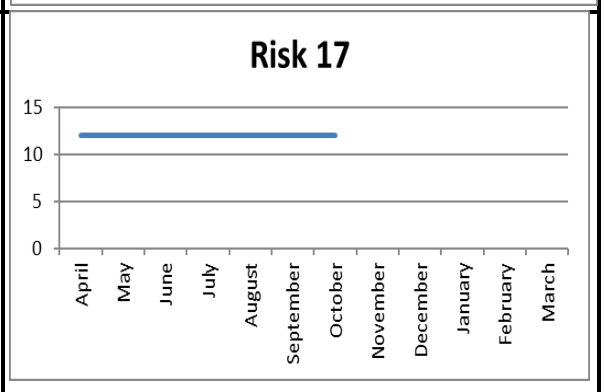
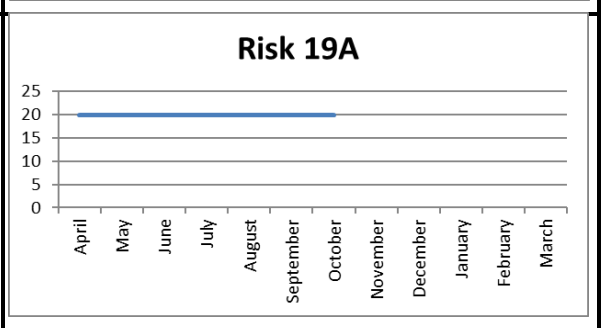
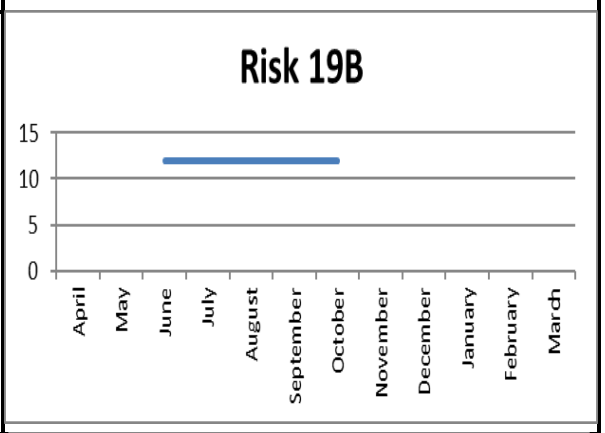
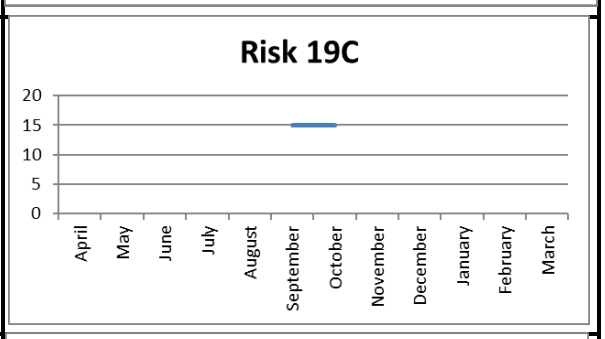
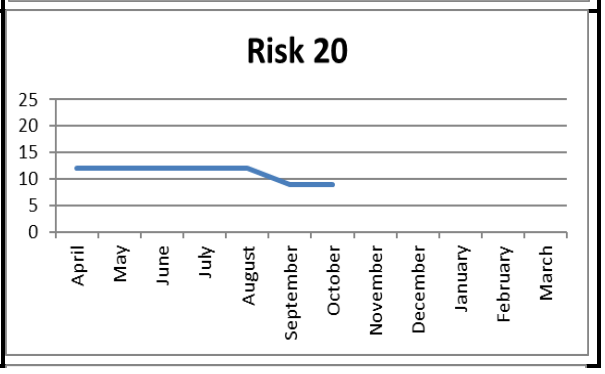
Population Health and Strategic Commissioning Committee (PHSCC)

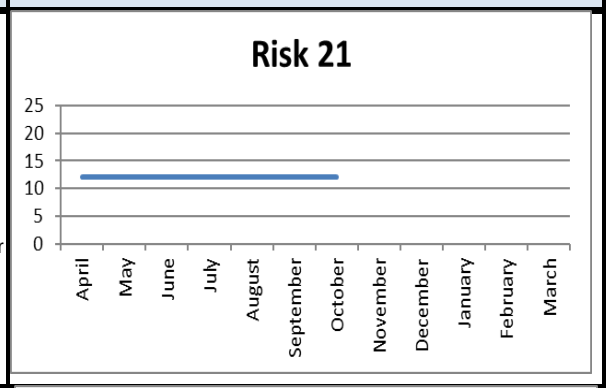
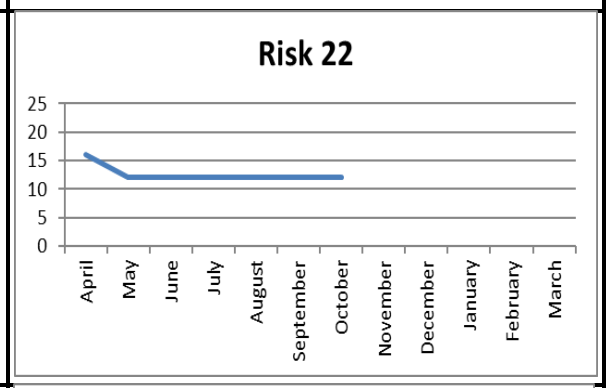
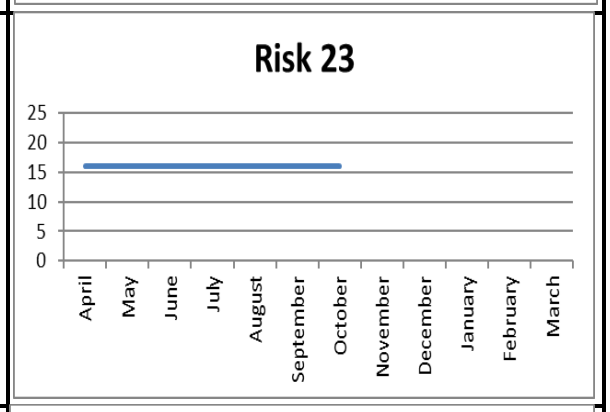
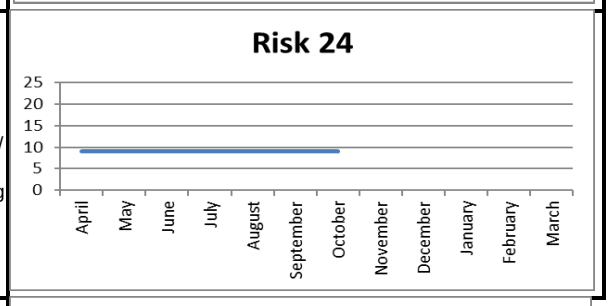
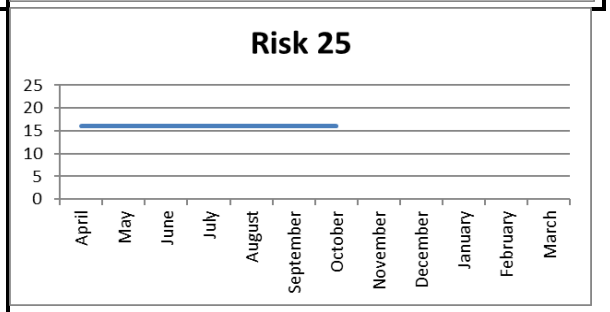
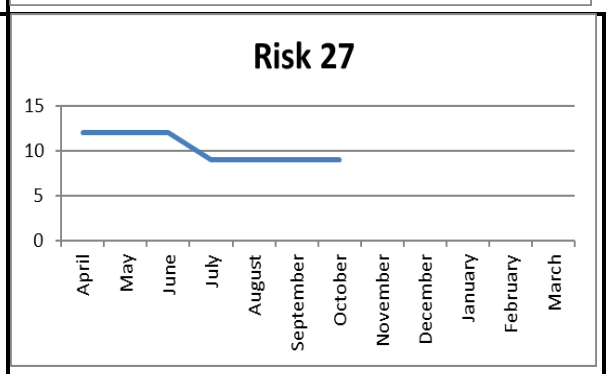
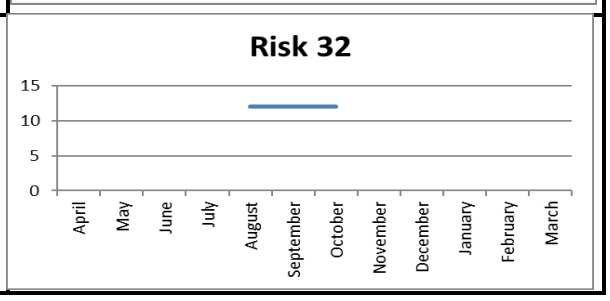
Further work is currently being undertaken to populate several proposed new risks including the initial, current and target risk scores, actions and mitigations along with assigning a risk owner for each of the new risks.

Appendix 3 - Item 088

ICB Risk Register - Movement - October 2024

Risk Reference	Risk Description	Previous Rating (Sept)			Residual/ Current Risk Rating (Oct)			Movement - October	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
01	The Acute providers may not meet the new target in respect of 78% of patients being seen, treated, admitted or discharged from the Emergency Department within 4 hours by March 2025, resulting in the failure to meet the ICB constitutional standards and quality statutory duties, taking into account the clinical impact on patients and the clinical mitigations in place where long waits result.	5	4	20	5	4	20	⇔	The score remains at 20 due to the Acute providers not meeting the 78% target and this is impacting on patient flow.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Amy Grazier Senior Operational Resilience Manager Dan Merrison Senior Performance & Assurance Manager Jasbir Dosanjh	
06A	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position. **Delivery of 24/25 Financial Plan**	5	4	20	4	5	20	⇔	The YTD position and drivers of the deficit remain consistent with previous months.	Keith Griffiths, Chief Financial Officer	David Hughes Director of Finance Derby and Derbyshire ICB Tamsin Hooton, Programme Director, Provider Collaborative	
06B	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position. **Delivery of 2-year Break Even**	4	5	20	4	5	20	⇔	A range of measures are in place to ensure that the system improves its financial sustainability.	Keith Griffiths, Chief Financial Officer	David Hughes Director of Finance Derby and Derbyshire ICB Tamsin Hooton, Programme Director, Provider Collaborative	
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	**RISK RECOMMENDED FOR CLOSURE**	The staff files are now in one place and securely stored.	Helen Dillistone Chief of Staff	James Lunn, Assistant Director of Human Resources and Organisational Development	
09	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	4	4	16	4	4	16	⇔	The Risk Stratification Tool needs redesigning and adapting for Providers and the varying services they provide. The work is continuing, update expected for November.	Prof Dean Howells Chief Nursing Officer	Letitia Harris Assistant Director of Clinical Quality	
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	⇔	Incremental progress continues to be made pending receipt of the national guidance and therefore it is appropriate and realistic for the risk score to remain as a high 9.	Helen Dillistone Chief of Staff	Katy Dunne Head of Corporate Programmes	
13	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.	2	3	6	2	3	6	⇔	Review underway of system transformation programmes to assess existing links and capacity requirements.	Helen Dillistone Chief of Staff	Sean Thornton - Director of Communications and Engagement	

Risk Reference	Risk Description	Previous Rating (Sept)			Residual/ Current Risk Rating (Oct)			Movement - October	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
15	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	2	2	**4**	2	2	**4**	⇔	NHSE have now indicated that the staff transfer will take place in July 2025 rather than April 2025. Changes are expected later in the year when further details and potential impacts are understood.	Helen Dillistone Chief of Staff	Chrissy Tucker - Director of Corporate Delivery	
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**	⇔	Review underway of system transformation programmes to assess existing links and capacity requirements.	Helen Dillistone Chief of Staff	Sean Thornton - Director of Communications and Engagement	
19A	Failure to deliver a timely response to patients due to excessive handover delays. Leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential levels of harm.	5	4	**20**	5	4	**20**	⇔	UEC Board performance: CRH had more delays during August than for the previous year, RDH had significantly higher delays during August, relative to the previous year.	Dr Chris Weiner Chief Medical Officer	Andrew Longbotham	
19B	The risk of delayed or inadequate patient discharge is heightened by factors including, unsuitable home environments, limited availability of community and home care services, and delays in providing necessary equipment. Poor coordination among healthcare providers, insufficient rehabilitation and long-term care options, rigid discharge policies, and ineffective communication and data management is further exacerbated by seasonal increases in patient volumes and inadequate transport services. The result is that the system struggles to effectively manage and support patient transitions from hospital to home or long-term care, leading to potential harm and unmet patient needs.	3	4	**12**	3	4	**12**	⇔	The risk score remains at 12, Strategic Discharge Group recommended decrease to 8 however System Quality Group did not agree and therefore discussions continue.	Strategic Discharge Group	Jodi Thomas Discharge Improvement Lead JUCD	
19C	Lack of digital interoperability across information platforms leads to inadequate visibility of discharge information and communication between providers. There are a lack of effective performance indicators to monitor and manage discharge processes. Inadequate data collection and analysis to identify bottlenecks in discharge pathways. Lack of system data intelligence to inform decision making to manage risks when in system escalation.	5	3	**15**	5	3	**15**	⇔	New risk identified in September. Pathway data group to support the development of a data dashboard as outlined in the logic model. Care Transfer Hub to be developed to monitor and own system data	Strategic Discharge Group	Jodi Thomas Discharge Improvement Lead JUCD	
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.	3	3	**9**	3	3	**9**	⇔	Risk score decreased from 12 in September. No change in the position for October. 4 contingency hotels remain open in the Derby / Derbyshire area.	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children	

Risk Reference	Risk Description	Previous Rating (Sept)			Residual/ Current Risk Rating (Oct)			Movement - October	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
21	There is a risk that contractors may not be able to fulfil their obligations in the current financial climate. The ICB may then have to find alternative providers, in some cases at short notice, which may have significant financial impact.	3	4	12	3	4	12	⇔	The risk level has not changed because GP providers are still reporting financial and workforce challenges to maintain safe and effective services for our population.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Craig Cook Director of Acute Commissioning, Performance and Contracting & Clive Newman Director of Primary Care	
22	National funding for pay awards and the application to staff who are not necessarily on NHS payrolls. Consequently there is a an increasing risk of legal challenge as well as real, emerging loss of morale for over 4,500 staff across the Derbyshire system which could affect recruitment and retention of critical frontline colleagues.	3	4	12	3	4	12	⇔	National pay award funding has been received. An initial review suggests that funding is sufficient. This issue will be reviewed in-month and if funding is sufficient, the risk will be reduced or removed.	Keith Griffiths, Chief Financial Officer	David Hughes Director of Finance	
23	There is an ongoing risk to performance against RTT and the cancer standards due to an increase in referrals into UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.	4	4	16	4	4	16	⇔	Work is ongoing to address the acute waiting list growth through a range of actions managed through PCDB.	Prof Dean Howells Chief Nursing Officer	Monica McAllindon Associate Director of Planned Care	
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	**RISK RECOMMENDED FOR CLOSURE**	DHCFT have now been successful in appointing a Community paediatrician into the Designated Doctor for the looked after children role.	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children	
25	There is a risk of significant waiting times for moderate to severe stroke patients for community rehabilitation. This means, patients may have discharges from acute delayed, be seen by non-stroke specialist therapists and require more robust social care intervention.	4	4	16	4	4	16	⇔	The engagement plan has been implemented. This includes launch of engagement platform, public survey and public meetings.	Dr Chris Weiner Chief Medical Officer	Scott Webster Head of Programme Management, Design, Quality & Assurance	
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	3	9	3	3	9	⇔	There is ongoing work to review processes as part of commissioning cycle.	Helen Dillistone - Chief of Staff	Sean Thornton - Director of Communications and Engagement	
32	Risk of the Derbyshire health system being unable to deliver it's capital programme requirements due to capacity and funding availability.	3	4	12	3	4	12	⇔	System capital prioritisation meetings under the chair of the JUCD provider collaborative finance lead have now reconvened	Keith Griffiths, Chief Financial Officer Derby and Derbyshire ICB	Jennifer Leah Director of Finance	

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 089

Report Title	Audit & Governance Committee Assurance Report – 10th October 2024							
Author	Sue Sunderland, Non-Executive Member							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Sue Sunderland, Non-Executive Member							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Sue Sunderland, Non-Executive Member							
Which committee has the subject matter been through?	Audit & Governance Committee, 10th October 2024							

Recommendations		
The ICB Board are recommended to **NOTE** the Audit & Governance Assurance Report.		
Board Assurance		
Level of Assurance	**The report demonstrates that:**	***Please select***
Full	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required by the Board.	☐
Adequate	• Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required by the Board.	☒

Partial	• Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or • Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required by the Board.	☐
Limited	• Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required by the Board.	☐

Items to escalate to the ICB Board

None.

Purpose

This report provides the Board with a brief summary of the items transacted at the meeting of the Audit & Governance Committee on the 10 October 2024.

Background

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

Report Summary

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

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

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒

SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Any risks highlighted and assigned to the 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 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?

No interests were declared at the meeting.

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

Board Assurance Report

Audit & Governance Committee on 10th October 2024

Overall Board Assurance Level			
Full	**Adequate**	**Partial**	**Limited**
☐	☒	☐	☐

Matters of concern or key risks to escalate	Decisions made
None.	Approved the following policies: Corporate policy reviews re: • Gifts, hospitality & sponsorship – to reflect new guidance on managing conflicts of interest. • Standards of business conduct – as above • Managing conflicts of interest – as above • Procurement - to reflect new Provider Selection Regime regulations. • Risk management – to reflect recommendations from Internal Audit • EPPR – updates to training needs analysis and exercising needs analysis. • Incident response plan – to combine response plans where appropriate. • Incident reporting – minor changes • Persistent contacts - as above • Fraud, bribery & corruption – as above • Raising concerns (whistleblowing) – as above • Freedom of information – as above Digital policies – 1st time for ICB – updated from old CCG policies. • Communications & information security • Digital obsolescence • Information handling & classification • IT security and equipment

	• Removable media HR policy reviews re: • Annual leave – minor changes • Career break – as above • Long service award – as above • Professional registration – as above • Secondary employment – as above • Travel and expenses – as above. • Working time directive – as above • Secondment guidance and procedure -as above
Major actions commissioned or work underway	**Positive assurances received**
We received a detailed interim update on the actions being taken to develop a comprehensive performance management framework supported by relevant and focused data. Linked to key recommendations from a limited assurance Internal Audit report last November this work is not due to be completed until April 2025 in recognition of the significant work required. The Committee however were keen to ensure that work was ongoing and were pleased to note the progress made to date. In particular: • Whilst documentation of the performance management framework has not yet started a lot of work has been undertaken to clarify governance and performance management activities currently operating across different groups and committees from oversight monitoring with NHSE and the region to delivery boards and specific focus meetings. This is leading to changes in focus for some groups – e.g. delivery boards focusing on action and improvement rather than business as usual performance monitoring. This work needs to be completed to ensure consistency in approach and focus and then documented. • The initial focus on data quality has been Operation Periscope which is intended to give the ICB/system a clearer understanding of where we are and which direction we are going in terms of key performance metrics. This will include a shift to	Took reasonable assurance from Internal Audit's Progress report which summarised the current position on the audit and receiving a benchmarking report on Mental Health Act assessments. Took reasonable assurance from the Counter Fraud progress report and reviewed the workplan. Took positive assurance from the review of risks that lie with the Audit and Governance Committee. Took positive assurance from the procurement highlight report that most contracts were on track and compliant with the regulations. Took reasonable assurance from the deep dive into the finance risks, both strategic and operational and discussed the areas where action is being taken. Took reasonable assurance on the Month 5 financial position review which was in line with the position agreed by the system. We note the challenges to delivery that underpin this year's financial plan and will keep this under review. Took positive assurance from our regular reports on:

the use of SPC charts as well as multidisciplinary review teams to inform decision making. The basic level dashboard information should be available by December 24. We agreed a further update would be provided at the February Audit Committee.	• Conflicts of interest • Equality, diversity & inclusion – noting the areas of improvement but also areas where further work is needed and discussing the need for the People Committee to triangulate the results with the output from Freedom to Speak Up and the staff survey.
Comments on the effectiveness of the meeting	
The meeting was well attended and effective contributions were made by all.	

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 090

Report Title	Finance Estates and Digital Committee Assurance Report – 24th September and 22nd October 2024							
Author	Keith Griffiths, Chief Finance Officer							
Sponsor (Executive Director)	Keith Griffiths, Chief Finance Officer							
Presenter	Jill Dentith, Non-Executive Member							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Jill Dentith, Non-Executive Member							
Which committee has the subject matter been through?	Finance, Estates and Digital Committee – 24th September and 22nd October 2024							

Recommendations		
The ICB Board are recommended to **NOTE** the Finance, Estates and Digital Committee Assurance Report.		
Board Assurance		
Level of Assurance	**The report demonstrates that:**	***Please select***
Full	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required by the Board.	☐

Adequate	• Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required by the Board.	☒
Partial	• Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or • Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required by the Board.	☐
Limited	• Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required by the Board.	☐

Items to escalate to the ICB Board

Please see the report at Appendix 1 for information.

Purpose

This report provides the Board with a brief summary of the items transacted at the meeting of the Finance, Estates and Digital Committee on the 24th September and 22nd October 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 Report (Appendix 1) highlights to the ICB Board any:

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

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the	☒

	development of services, leading to inequitable access to care and poorer health outcomes.			ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

Any risks highlighted and assigned to the 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	**Has this been signed off by a finance team member?**
Underlying deficit prevents the ICB from investing in out of hospital serves with the aim of reducing health inequalities and improving population health.	Keith Griffiths, Chief Finance Officer

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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.

Derby and Derbyshire Integrated Care Board

Board Assurance Report

System Finance, Estates and Digital Committee on 24th September and 22nd October 2024

Overall Board Assurance Level			
Full	**Adequate**	**Partial**	**Limited**
☐	☒	☐	☐

Matters of concern or key risks to escalate	Decisions made
Financial position 2024/5- As of 30th September 2024, with a deficit of £22.6m the JUCD position is £2.8m away from its planned position of a £19.8m deficit. The position now includes the £50m revenue support, which NHSE is giving to all systems, which means the Derbyshire system now has a plan to breakeven. (this revenue support will need to be repaid in full from 26/7 onwards). The System remains committed to delivering this plan but the risks are escalating. There was considerable discussion regarding current run rate driven by ongoing UEC pressure, prescribing, CHC/LA pressures and efficiency delivery. There remains an underlying £45m risk to breakeven based on current run rates. Specifically, though, the recent H1 stocktake has highlighted a number or areas where management time needs to be focussed that will improve our forecast. These include: ERF income – we are using too much insourcing and outsourcing capacity to deliver performance targets, and as a consequence we are losing significant 'margin' on ERF income Sickness absence levels are higher in all DD ICB organisations relative to the Midlands generally. Bank expenditure is unexplainably high and needs a detailed investigation.	**Month 6 System financial report –** the committee accepted the report as presented. **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 for 24/25 and reviewed the same in the light of the final 24/25 agreed system plan and the current predictions for the remainder of the year.

Surge capacity has been opened despite non elective admissions not increasing. There will be whole system drivers behind this including access to community services and Acute mental health access- / flow. Similarly there is undoubtably growing UEC pressure from Staffordshire into UHDB which the two ICB's are discussing with NHSE **System Efficiency 2024/5** - With the 5% CIP target totalling £169.7m for the whole system, we are currently largely on plan YTD having delivered 36%. Though overall this looks like a good position, an examination of rag rated schemes highlighted the level of risks in future plans and the recurrent /non recurrent proportions are a concern for 25/26. Currently schemes totalling £37m are RAG rated red, meaning CIP delivery remains the largest underlying risk for the system. **Other 24/25 Risks** –Previous commentary regarding the risks of funding shortfall for pay award has now abated. However, the impact of winter is a growing concern and the winter plan will need to be affordable as well as safe. **Final 23/24 Outturn** – The Committee received the long awaited letter from NHSE Midlands re 23/24 out turn and agreed to a formal escalation with the national NHSE team, subject to agreement by the full board. **Other significant items discussed** There were formal presentations on 25/6 Financial planning, Digital including approving a revised set of D3B Terms of reference and raising awareness of the EPR replacement risks.	
Major actions commissioned or work underway	**Positive assurances received**
DE risking the 24/25 plan - the priority for the November meeting is the deep dive by organisation on mitigations to derisk the predicted £32m overspend - including examining areas where organisations can exceed breakeven plans and deliver a surplus in order to ensure delivery of our collective 24/25 system plan.	**<u>September</u>** • Formal presentations were received from each organisation on risks and mitigations to ensure delivery of agreed 24/25 plans. • A report on the System transformation programmes and efficiency delivery during Month 5 2024-25 was noted.

	• The Committee received an update to understand resource distribution at a Programme and Place Level. **<u>October</u>** **Financial position 2024/5 of DDICB Regional and National comparisons** –The commitment demonstrated by all organisations to deliver on plan was not in question, recognising the significant operational and workforce pressures the NHS and LA's are currently under. However, there is a growing level of anxiety across partners given the operational and workforce pressure in the system and the implications this has on finances. However, it was also recognised that there was limited evidence of real transformation taking place across pathways and organisations which is a concern for 24/25 and future years. The Provider Collaborative Board and programme delivery Boards will be supported by the ePMO team in this but the system's ability to drive and lead this critical agenda is growing concern

Comments on the effectiveness of the meeting
There was excellent representation across the System at the meeting. The Committee noted the work required and being done within the system to deliver the revised 2024-25 plan and the triangulation required across committees re finance, operations (inc. transformation) and workforce. Committee members contributed to the confirm and challenge discussions.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 091

Report Title	Population Health Strategic Commissioning Committee Assurance Report – 24th October 2024							
Author	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Presenter	Maragaret Gildea, Non-Executive Member							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Maragaret Gildea, Non-Executive Member							
Which committee has the subject matter been through?	Audit & Governance Committee, 24th October 2024							

Recommendations		
The ICB Board are recommended to **NOTE** the Population Health & Strategic Commissioning Committee Assurance Report.		
Board Assurance		
Level of Assurance	**The report demonstrates that:**	***Please select***
Full	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required by the Board.	☐
Adequate	• Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required by the Board.	☒

Partial	• Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or • Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required by the Board.	☐
Limited	• Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required by the Board.	☐

Items to escalate to the ICB Board

None to report.

Purpose

This report provides the Board with a brief summary of the items transacted at the meeting of the Population Health & Strategic Commissioning Committee on the 24th October 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's Assurance Report (Appendix 1) highlights to the ICB Board any:

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

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒

SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

Any risks highlighted and assigned to the 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 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?

No interests were declared at the meeting.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

Not applicable to this report.

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable to this report.

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Population Health & Strategic Commissioning Committee – 24th October 2024

Overall Board Assurance Level			
Full	**Adequate**	**Partial**	**Limited**
☐	☒	☐	☐

Matters of concern or key risks to escalate	Decisions made
None to report.	**Commissioning Decisions** No decisions in regarding to commissioning of specific services were made at this meeting. **Board Assurance Framework (BAF)** As below. **Risk Register** The Committee did not review any specific risks at this meeting.
Major actions commissioned or work underway	**Positive assurances received**
The committee received an overview on the position with the 24/25 Operational plan and of the H1 stocktake against the plan looking at finance, activity and workforce across the system. There are a number of actions that have arisen through the Stocktake which will be taken forward through the relevant Delivery Boards. The committee received a presentation on a stocktake that has been undertaken to understand the projects and activities being delivered in Place & Partnerships arena with a focus on health inequalities and prevention. The next phases of this project would be looking at having a detailed interactive map of the geographical area, where you can click on an area to drill down into what is happening and to continue to develop this by mapping to any relevant strategies - including	**Commissioning Decisions** The Commissioning and Procurement subgroup report provided assurance on the accreditation of Community Health & Eye Care (CHEC) to provide elective ophthalmic services. The committee received the winter plan and were provided assurances on the plan that has been developed across system partners. Noting the risks and continued dynamic work to manage risks across the system during the winter period. The committee noted in most areas we have received good or high level of assurance following NHSE review of our plan. The Population Health and Strategic Commissioning Committee noted the IVF service "case for change" proposal which has been

outcomes where applicable- and impact measures linked to performance and/or national targets.	agreed by the East Midlands Review Group in preparation for the commencement of the pre-engagement phase. A number of confidential items were discussed at the meeting. **Risk Register** The Committee did not review any specific risks 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 the final quarter 2 2024/25 position and reviewed the current risk scores and assurance levels for the Strategic Risks 7, 8 and 9 **The following items were received for information:** • CPAG updates • Derbyshire Prescribing Group report/minutes • JAPC Bulletin • CPLG minutes • GP Strategy Update
Comments on the effectiveness of the meeting	
Nothing of note in terms of concerns. It was noted to be a productive meeting with good items received and good input and participation from committee members.	

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 092

Report Title	Public Partnership Committee Assurance Report – 24th September 2024							
Author	Sean Thornton, Director of Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Sue Sunderland, Vice Chair – Public Partnership Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Richard Wright, Chair – Public Partnership Committee							
Which committee has the subject matter been through?	Public Partnership Committee, 24th September 2024							

Recommendations		
The ICB Board are recommended to **NOTE** the Public Partnership Committee Assurance Report.		
Board Assurance		
Level of Assurance	**The report demonstrates that:**	***Please select***
Full	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required by the Board.	☐
Adequate	• Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required by the Board.	☒

Partial	• Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or • Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required by the Board.	☐
Limited	• Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required by the Board.	☐

Items to escalate to the ICB Board

No matters of concern or key risks to escalate.

Purpose

This report provides the ICB Board with highlights from the development meeting of the Public Partnership Committee on the 24th September 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	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☒
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line	☐	**SR6**	*Risk merged with SR5*	☐

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

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

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

Yes ☐	No☐	N/A☒

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

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

No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

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 24th September 2024

Overall Board Assurance Level			
Full	**Adequate**	**Partial**	**Limited**
☐	☒	☐	☐

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	Board Assurance Framework (BAF) The risk relating to population engagement in the design and development of services was reviewed, with the risk score remaining at 12. The Committee felt more assured through the actions being undertaken and asked when the score would decrease. They were informed that the score remained at 12 due to the complexity of the work underway and the high workload capacity which was being monitored. Corporate Risks The ratings for the Committee's corporate risks relating to communications and engagement team capacity (risk score of 6), stakeholder engagement (risk score of 12) remained the same due to ongoing work. The recently-adopted risk relating to the introduction of the new provider selection regime, ensuring that processes to connect PPI governance into change programmes are retained, had its rating reduced from a 3x4=12 to a 3x3=9 due to the establish of strengthened procurement processes within the ICB.
Major actions commissioned or work underway	**Positive assurances received**

• Board Assurance Framework action plan – ongoing delivery of mitigating actions
• East Midlands Fertility Policy Review
• Review of approach to committee/sub-group diversity.
• Establishment of Lay Reference Group.
• Ongoing development of engagement frameworks
  ○ Insight Framework
  ○ Governance Framework
  ○ Evaluation Framework
	Patient and Public Involvement Log
	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. Items noted by the Committee included:
	• The withdrawal of dermatology services in the Glossop area by c commissioners in Greater Manchester. This was being pursued in collaboration with the ICBN's contracting team.

○ Co-production Framework ○ Engagement Framework	• The proposed permanent closure of the Brailsford and Hulland GP branch surgery, whereby the ICB's engagement team was supporting the practice with their engagement approach. <u>Insight Strategy Update</u> The Committee received an update on this pioneering work. The committee ehad attention drawn to aspects of the pilot work where good progress was being made, including the discharge pathway programme and tobacco cessation programme. The committee agreed that it was a very positive report showing how the framework was working and the need to encourage ongoing use and development going forward. <u>Lay Reference Group</u> The group is being established to broaden inclusion of citizens, communities, and infrastructure organisations in engagement activity. Early stages of development are to develop a shared understanding of and a shared purpose of what we wish this to be and then to develop that into some co leadership. Real inroads are being made working across all communities and with all communities and there is an opportunity to get it right and need to give them skills and support to interact, recognising there has not been that interaction with these communities in the past. The committee wished to see the Group up and running with continued adjustment and reviewing pointing out that it was very difficult to get that inclusivity and could be waiting forever to set something up. <u>Brailsford and Hulland – proposal to close branch surgery</u> Hulland Ward branch had been effectively closed for several years certainly in a semi-formal way since June 2021. It is unsustainable to open in a business sense and although it had not been a consultant space for some time it had acted as a conduit for patients that were difficult to reach. The proposal is to close Hulland Ward branch and redistribute the resources and move to one location. The Committee was assured that different groups had been considered and mitigations in place, and that the engagement was inclusive and thorough, with PPG involvement. <u>Stroke Rehabilitation</u> The Committee reviewed the case for change and the engagement plan associated with the public and patient pre-engagement for the review of the Derby

	and Derbyshire Stroke Rehabilitation Services. The report was well-received by the Committee who liked the fact that the general public had been involved.
Comments on the effectiveness of the meeting	
The committee reviewed a series of assurance questions and agreed that the meeting had been effective.	

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

PUBLIC SESSION

21st November 2024

Item: 093

Report Title	Quality and Performance Committee Assurance Report – 31st October 2024							
Author	Philip Sugden, Assistant Director of Quality – Community							
Sponsor (Executive Director)	Prof Dean Howells, Chief Nurse Officer							
Presenter	Adedeji Okubadejo, Clinical Lead Member							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report Signed off by Chair	Adedeji Okubadejo, Clinical Lead Member							
Which committee has the subject matter been through?	Quality and Performance Committee –31/10/2024							

Recommendations		
The ICB Board are recommended to **NOTE** the Quality and Performance Committee Assurance Report.		
Board Assurance		
Level of Assurance	**The report demonstrates that:**	***Please select***
Full	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required by the Board.	☐
Adequate	• Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required by the Board.	☒
Partial	• Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or	☐

	• Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required by the Board.	
Limited	• Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required by the Board.	☐

Items to escalate to the ICB Board

There were no items for escalation.

Purpose

This report provides the Board with a brief summary of the items transacted at the Quality and Performance Committee on the 31st October 2024. As reported in previous reports the ICB is currently not compliant with any statutory operational targets relating to the urgent care and planned care and cancer programme. The 2024/25 NHS Operational Plan developed by the Derby and Derbyshire System addresses these issues of underperformance.

Background

This report provides the Board with a brief summary of the items transacted at the meeting of the Quality and Performance Committee on 31st October 2024.

Report Summary

The System Quality and Performance Committee Assurance Reports (Appendices) highlight to the ICB Board any:

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

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☒
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to	☒	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital	☐

	achieve long term strategic objectives including reducing health inequalities and improve outcomes.			transformation in order to improve outcomes and enhance efficiency.	

Any risks highlighted and assigned to the 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?

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.

Derby and Derbyshire Integrated Care Board

ICB Board Assurance Report

Quality and Performance Committee – 31st October 2024

Overall Board Assurance Level			
Full ☐	**Adequate** ☒	**Partial** ☐	**Limited** ☐

Matters of concern or key risks to escalate	Decisions made
There were no items for escalation.	The following papers were discussed and approved: • **Deep NHS Derby and Derbyshire Integrated Care Board Integrated Care System Quality Risk Escalation Policy 2024-2026** • **Board Assurance Framework and Q2 Updates -** final position for quarter 2 2024/25 Strategic Risks 1 and 2
Major actions commissioned or work underway	**Positive assurances received**
• **Personalisation -** Since April 2024 the expectation from NHSE is that personalised approaches should be business as usual and remain a key driver in supporting service delivery. The membership were asked to discuss how we ensure that personalisation remains a priority and business as usual across the system. • **Deep Dive - Right Care Right Person –** Outline the approach taken in developing the Multi Agency Agreement (MAA) for Right Care Right Person (RCRP) and to ratify the RCRP MAA. • **Primary Care Early Warning System -** to provide an update on development and usage of Early Warning System Dashboard as a tool which supports identifying and intervening with practices using key quality & performance indicators.	The following papers were presented for assurance: • **Safeguarding Children and Adults Quarterly Update** – The Committee were assured and noted the increase in the number of referrals and the work around Prevention. • **Fragile Service Approach- Hyper Acute and Acute Stroke Services Rehabilitation, Governance & Provider update/HASU review Updates –** The Committee received Limited Assurance and noted that whilst this is a national issue there is a requirement for more integrated local/Regional services and the ongoing service design work. • **Integrated Performance Report –** It was noted that the Maternity report would come to the November meeting for assurance. • **System Quality Group Assurance Report -** summary of the items transacted at the October meeting. • **Q&P Biannual attendance report –** review attendance of Quality & Performance Committee members from April to September 2024 **Ratified Minutes from:** • **System Quality Group 03.09.2024**

Comments on the effectiveness of the meeting
Those present agreed that the meeting had been effective, with sufficient opportunity for discussion and that the papers presented were appropriate.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 094

Report Title	Primary Care Access Improvement Plan							
Author	Emma Prokopiuk, Assistant Director of Primary Care							
Sponsor (Executive Director)	Michelle Arrowsmith, Chief Strategy and Delivery Officer							
Presenter	Craig Cook, Director of Strategy and Planning							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1 – Primary Care Access Recovery Plan update slides							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Population Health and Strategic Commissioning Committee – November 2024							

Recommendations

The ICB Board is asked to **NOTE** that the ICB has continued to make good progress against the Primary Care Access Recovery plan in year 2 and has robust plans to deliver to target by the end date of 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 2024 with a further update at the end of year 2 (March 2025).

The ICB Board received and approved the full plan in November 2023 with subsequent updates in. 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 9 May23. 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 and their practices to deliver the initiatives contained within the plan.

Primary Care Networks developed Capacity & Access plans (CAP) which were a national requirement as part of the PCN 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 focused on 3 areas:

- Patient experience of contact
- Ease of access and demand management
- Accuracy of recording in appointment books

The ICB met with and assessed the PCNs against delivery of their plans during June/July 2024. Following these reviews 86% of the total funding available was paid to PCNs.

Significant progress has continued to be made into 2024/25 and the slides (appendix 1) demonstrate against each indicator the progress made. This is a two-year plan and further work will be continued to the end of 2024/25.

A summary of the progress so far includes:

- 100% of practices have enabled patients to order repeat medications, book/cancel appointments and receive secure messaging through the NHS App;
- 97.3% of practices are utilising the automatic GP registration service;
- Supported and funding (over £1m) our practices to move to digital phone systems;
- In August 24 practices delivered 46403 online consultations which is a 12% increase in the number which was delivered in April 2023 when PCARP was published;
- 83 practices have taken part/taking part in the National General Practice Improvement Programme;
- 196 (99%) pharmacies have signed up to deliver Pharmacy First;
- 85% of appointments seen within 2 weeks.

The 2024/25 Capacity and Access plan requirements look different to last year for PCNs. To obtain the full 30% remaining funding for this the PCNs will need to be able to sign off the following statements for all their practices in the PCN:

Domain	Number of PCNs Signed up
Better Digital Telephony • Digital telephony solution implemented, including call back functionality and each practice is complying with the Data Provision Notice. • Digital telephony data is routinely used to support and capacity/demand service planning and quality improvement discussions.	2 (PCCO and Swadlincote)
Simpler Online Requests • Online consultation (OC) is available for patients to make administrative and clinical requests at least during core hours. • Practices have agreed to the relevant data provision notice (DPN) so that data can be provided by the supplier to NHS England as part of the 'submissions via online consultation systems in general practice' publication.	3 (Erewash, PCCO, Swadlincote)
Faster Care Navigation, assessment and response • Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests. • Approach includes asking patients their preference to wait for a preferred clinician if appropriate (for continuity).	2 (Erewash and PCCO)

The table above indicates which practices so far have been able to sign the declaration for each section.

In summary PCNs and GP practices are progressing well to deliver the Primary Care Access Recovery Plan by the end of 2024/25. 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	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☒	**SR6**	*Risk merged with SR5*	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☒

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☒	No☒	N/A☐

Details/Findings	**Has this been signed off by a finance team member?**
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 the ICB.	Section 7 of the full plan relating to funding was produced by Rebecca

	Monck, Assistant Chief Finance Officer.

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

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

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

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None identified.
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings Not applicable.

Derby and Derbyshire Integrated Care Board

Derby & Derbyshire ICB Primary Care Access Recovery Plan

November 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 was made during 23/24 and this has continued into 24/25. The following slides provide an update on the initiatives contained within the plan.

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 – November 2024
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 • 74.8% of Derbyshire practices have enabled patients access to their prospective medical records. The ICB are 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	See slide 7
Registering with a GP service	97.3% of practices are utilising the automatic GP registration service.

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
Better digital telephony	We have supported and funded (over £1m) our practices to move to digital phone systems. • 31 Practices are now live • 12 practices are waiting for installations to take place (including upgrades) • 10 further practices are still in discussion with procurement.
Simpler online requests	In August 24 practices delivered 46403 online consultations which is a 12% increase in the number which was delivered in April 23 when PCARP was published.
Faster navigation, assessment and response	93 practices have participated in the national Care Navigation Training.
Digital Framework	The national digital framework was disbanded following a legal challenge. Since then PCN managers in D&D have been leading a market engagement exercise with a view to procuring a new front end digital triage tool for practices. This will support practices to provide faster and consistent care navigation for patients contacting the practice.
GPIP (Oct 24 Position)	83 practices in total have signed up/or completed a national or local GPIP, breakdown: • 34 Practices have signed up/or completed the national intensive GPIP 23/24 (19 Intermediate/15 intensive) • 18 practices participated through the national PCN GPIP (3 PCNS) • 8 practices participated in the national Practice Level Support Programme (previously GPIP) 23/24 • 17 practices are signed up to take part in the national Practice Level Support Programme 24/25 • 6 practices have taken part in the local GPIP run by Hub Plus (local training hub)
GPAD (appointment data)	• Total appointments in August24 was 519,000 which is an increase of 11% (minus Glossop appts to compare to August 2019) • 85% of appointments in the national categories in scope for the national target are within 2 weeks. This is an improved position for D&D and we are now reaching the lower threshold of 85% (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	Progress
Larger Multi-Disciplinary Teams	PCNs are projected to spend 90% of their ARRS allocation in 2024/25. As of September 2024, spend to date is approx. £12.09m leaving an underspend of £2.76m. Only four PCNs are showing a significant underspend (greater than £100k). These figures do not include the 5.5% uplift that can be applied from October onwards, which will increase PCN spend. The March 2024 target has been met. There are currently 595 WTE in post (as of September 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 August 2024 is 3,932 working a Full Time Equivalent (FTE) of 2,900.33. This is an increase of 43.44 FTEs since March 2024. 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 data available via the National Workforce Reporting System). We've gained 64 GPs (including trainees) over the last five years. However, the partnership model is changing, and we have seen a 27.9% reduction in partners since 2019. Many of these positions have been filled by salaried GPs. GPs are now also available under ARRS until March 2025, and we are working with PCNs to recruit into these roles.
Retention and return of experienced GPs	Derbyshire is on track to utilise its full allocation of £1.6m on retention in 2024/25. The allocation has decreased from 2023/24, which is largely due to two national schemes being closed to new entrants (Fellowships and Mentoring) as funding is matched to activity. We are currently supporting 173 members of general practice. However, this doesn't include the number of people accessing local schemes, training etc. • **Fellowships:** 74 GP Fellows, 28 Nurse Fellows – Newly qualified and new to practice • **Supporting Mentors**: 15 Mentors, 40 Mentees • **Local Retention Schemes:** 5 schemes in place • **GP Retainer scheme:** 25 GPs
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 undertake assurance on the delivery of the Interface work. • ToR and Governance agreed. • Group meet monthly to oversee programme progression. • Agreed initial priority is establishment a single point of contact (SPOC) within each provider for general practice to contact for speedy answers to patients' enquiries. SPOCs will save general practice workforce significant time currently spent chasing up enquiries on behalf of their patients, in the main linked to diagnosis results, follow up appointments and waiting times. • Supported by the NHS funded Peer Coaching Programme, an Operational Group has been established across all providers led by Provider Collaborative. Improvement Plans for Single Point of Contact have been developed by each provider lead in this group. • Recent NHS Interface Assessment Tool submitted for Derby & Derbyshire showing improved levels of performance for both acute hospitals across two areas; Fit Notes and Clear Points of Contact following the previous submitted Assessment Tool in April 2024. • ICB representation at NHSE Interface Community of Practice meetings.

Pharmacy First

Across Derbyshire 196 (99%) pharmacies have signed up to deliver Pharmacy First. From 1st April 2024- end August 2024 Derbyshire community pharmacies have delivered:

- In total between February – September 2024 in Derby and Derbyshire 69302 consultations have been completed for Pharmacy First, Blood Pressure and Oral Contraception. These would otherwise would have taken up appointments in general practices and other healthcare settings.
- Assuming for each consultation the patients would have needed a GP appointment and each GP appointment is 10mins. Also, assuming 9 in 10 Pharmacy first consultations are not referred into another setting. This is a saving of 10,395 GP practices hours since Jan 2024.
- Over 6840 (10%) of consultations (PF,OC and BP from Feb – June 2024) delivered by pharmacies in the areas of greatest deprivation (Pharmacy IMD decile score 1=10% most deprived) = 10% most deprived)

- We have PCN sent out an expressions of interest to PCN's and community pharmacy contractors for a Community Pharmacy engagement leads using the national funding sent to systems in June 2024.. Subject to the interest received a moderation panel will review the applications and proposal. Aim to have these posts in place mid November 2024. There is more data available now for pharmacy first activity. The community pharmacy clinical lead will support these engagement roles with the data and overarching support.
- We are working to increase the number of referrals from General Practice to Pharmacy First and have been increasing awareness in forums such as GP Leadership Group, PCARP working group, PCN meetings and other stakeholder meeting. In the initial stages the lack of data meant that the scrum meetings help could not have a focused approach. However, we have seen good examples of collaborative working and a whole PCN approach . We have been able to share these on webinars and training events. All the regional, local and national resources are hosted on the intranet for ease of access.

How many PCNs have claimed their 30% CAIP payments in 24/25

Domain	Number of PCNs Signed up
Better Digital Telephony • Digital telephony solution implemented, including call back functionality and each practice is complying with the Data Provision Notice. • Digital telephony data is routinely used to support and capacity/demand service planning and quality improvement discussions.	2 (PCCO and Swadlincote)
Simpler Online Requests • Online consultation (OC) is available for patients to make administrative and clinical requests at least during core hours. • Practices have agreed to the relevant data provision notice (DPN) so that data can be provided by the supplier to NHS England as part of the 'submissions via online consultation systems in general practice' publication.	3 (Erewash, PCCO, Swadlincote)
Faster Care Navigation, assessment and response • Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests. • Approach includes asking patients their preference to wait for a preferred clinician if appropriate (for continuity).	2 (Erewash and PCCO)

Next steps

- Continue to work with our practices to make progress against the plan.
- 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 2024/25.
- 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

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)

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st November 2024

Item: 095

Report Title	Delegation of additional specified Specialised Acute Services and Mental Health, Learning Disability and Autism specialised services and associated workforce							
Author	Chrissy Tucker, Director of Corporate Governance & Assurance							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1 – Briefing Paper, December 2024							
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 contents of this report.
Purpose
This paper provides a summary of the process for the delegation of additional specialised acute services, and Mental Health, Learning Disability and Autism (MHLDA) services and the corresponding staff resources in ICBs in 2025/26, with a forward look at the board approvals that will be required.
Background
The attached report has been provided by NHSE to update boards on the delegation of specialised services and to give prior notification of documentation that will need to be signed off by ICBs to support the transition.
Report Summary
ICB Boards approved the delegation of 59 Acute Specialised Services on 1 April 2024, with staffing resource to transfer to the host ICB (Birmingham & Solihull) on 1 July 2025. The next phase of delegation includes: i. An additional number of acute specialised services ii. Mental health Learning Disability and Autism (MHLDA) specialised services

and Boards will be requested to approve the supporting formal documentation at future meetings as follows:

Item	Action	Date
Delegation Agreement	Approval	Feb/March Boards
Hosting Agreement	Approval	June Boards
Joint Working Agreement	Approval	Feb/March Boards

This programme of work is managed internally by the ICB Delegated Functions Programme Board, chaired by the Chief of Staff.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.4bn available funding.	☐
SR5	There is a risk that the system is not able to maintain a sustainable workforce and positive staff experience in line with the people promise due to the impact of the financial challenge.	☐	**SR6**	*Risk merged with SR5*	
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	☐
SR9	There is a risk that the gap in health and care widens due to a range of factors including resources used to meet immediate priorities which limits the ability of the system to achieve long term strategic objectives including reducing health inequalities and improve outcomes.	☐	**SR10**	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	☐

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

[To be completed by Finance Team ONLY]

Yes ☐	No☐	N/A☒
Details/Findings Not applicable.		**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.

Item 095 – Appendix 1

BRIEFING PAPER

DATE: December 2024

PAPER TITLE: Delegation of additional specified Specialised Acute Services and Mental Health, Learning Disability and Autism specialised services and associated workforce.

PURPOSE: INFORMATION ☒ DECISION ☐

EXECUTIVE SUMMARY: This paper provides a summary of the process for the delegation of additional specialised acute services, and Mental Health, Learning Disability and Autism (MHLDA) services and the corresponding staff resources in ICB's in 2025/26.

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1. INTRODUCTION AND PURPOSE OF THE PAPER

1.1 The purpose of this paper is to update Boards on the next phase of specialised service delegation to ICBs to be undertaken by April 25, and the aligned transfer of staffing resource.

1.2 ICB Boards approved the delegation of 59 Acute Specialised Services on 1 April 2024. The next phase of delegation includes the following:

i. An additional number of acute specialised services

ii. Mental health Learning Disability and Autism (MHLDA) specialised services

1.3 In line with nationally agreed processes, the staffing resource to support the on-going commissioning responsibilities for these services will transfer on 1 July 2025. The team is currently hosted by NHS England (NHSE) and working on behalf of the ICBs supported by the arrangements of the current delegation agreement.

1.4 A small number of acute and MHLDA specialised services will remain commissioned through NHSE.

1.5 ICB Boards will need to be assured and approve the final elements of the specialised services delegation prior to April 25.

2. BACKGROUND AND CONTEXT

2.1 ICBs were set up to work with all partners to create a system where decisions are taken as locally as possible, with frontline clinicians and professionals at the centre of driving change and supporting patients and communities having a say on how the changes are being proposed.

2.2 However, at the inception of ICBs a significant proportion of the population's care was managed outside of the ICS through NHSE as specialised services

2.3 In December 2023, the NHSE Board approved the 11 Midlands ICBs' applications for the delegation of an initial 59 specialised acute services to the Midlands ICBs. In Spring 2024, the Board reviewed the remaining services and determined the final list of specialised services to be either retained by NHSE or delegated to ICBs across all parts of the country on 1st April 2025.

2.4 Although NHSE remains accountable to the Secretary of State for the services, under delegation the responsibility for all decision relating to the planning, design, quality, finance, and delivery, transfer to ICBs this includes:

i. Decisions in relation to the commissioning and management of the delegated services

ii. Planning delegated services for the population, including carrying out needs assessments

iii. Undertaking reviews of delegated services in respect of the population

iv. Supporting the management of the specialised commissioning budget for delegated services

v. Co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate

vi. Such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.5 Whilst national specifications and standards remain for Specialised Services, delegation provides the opportunity to ensure that planning is based on the needs of local populations, and that value is realised across pathways.

2.6 The responsibility for delivery of Specialised Services sits collectively with the Muli-ICB partnership (East and West Joint Committees) and this multi-ICB arrangement is a formal requirement of delegation. Therefore, if a service in one ICB is having issues then is it the multi-ICB partnership who will have oversight and the responsibility through the hosted Specialised Commissioning team to resolve.

2.7 The multi-ICB commissioning footprints for the Midlands are:

- East Midlands (Notts and Nottinghamshire ICB, Derby and Derbyshire ICB, Lincolnshire ICB, Leicester, Leicestershire and Rutland ICB, and Northamptonshire ICB)

- West Midlands (Birmingham & Solihull ICB, the Black Country ICB, Shropshire, Telford and Wrekin ICB, Staffordshire & Stoke-on-Trent ICB, Herefordshire and Worcestershire ICB, Coventry and Warwickshire ICB).

3. THE DELEGATION PROCESS

3.1 A Delegation Agreement currently exist between individual ICBs and NHS England. This arrangement was agreed in relation to the 59 services delegated in April 2024. Therefore, a new delegation agreement will be required to reflect the additional service responsibilities and any agreed developmental arrangements from April 2025. The agreement will be presented to the ICB Board for approval in early 2025.

3.2 In addition to the new Delegation Agreement, a hosting agreement and new ICB Joint Working Agreement will be required to support the staff transition and management of services through the host ICB on behalf of the 11 ICB's and the retained functions of NHS England. As previously agreed, the host ICB will be BSOL ICB.

3.3 The current programme infrastructure to oversee the delegation process has relevant representation from the 11 ICB's and is managed through 6 key workstreams: - Governance, BI, Workforce and People, Finance & Contracting, Quality and Comms & Engagement.

3.4 An executive leadership function has been agreed to provide strategic direction to the delegation programme. The Executive Leadership Group (ELG) is co-chaired by David Melbourne, CEO lead from the West Midlands Joint Committee and Caroline Trevithick, CEO lead from the East Midlands with Roz Lindridge as Executive lead from NHSE.

3.5 The work programme and associated governance has been reviewed considering lessons learnt from earlier delegations. This includes clearer accountability, focus on communications and engagement and a jointly owned work plan.

4. BENEFITS OF MHLDA DELEGATION

4.1 The delegation of MHLDA specialised provision will include the majority of CAMHS inpatient services, Adult Low and Medium secure provision, Adult ED inpatient beds and Perinatal (Mother and Baby) Units. Some services, including high secure services, will remain commissioned by NHSE.

4.2 Currently these services are commissioned through formal Provider Collaborative arrangements. NHSE will novate contracts with 8 lead providers who are supported by provider collaborative agreements.

4.3 The provider collaborative model in MHLDA has already impacting on how ICB populations access care, ensuring a reduction in OOA placements, reduced LOS and improved quality frameworks for example. The delegation of the services to ICBs will ensure further opportunity to drive pathway improvements to ensure that population needs are met in the least restrictive environment and realising value through early intervention and/or safe and responsive discharge.

4.4 Expected benefits are summarised below:

5. FINANCE

5.1 The budget for all delegated services will be transferred to ICBs upon delegation. ICB Directors of Finance and NHSE, through the finance and contracting specialised services subgroup, are developing mechanisms for financial governance, building on those developed for the delegation of acute specialised services in April 2024.

5.2 Although there is already a financial risk framework within the provider collaboratives, consideration needs to be given to a process for managing financial risk exposure between ICBs. These will be developed through the finance and contracting subgroup as part of the 2025/26 planning process.

6. THE WORKFORCE

6.1 There is a dedicated specialised services workforce currently employed and hosted within NHSE which will be transferred to BSOL ICB. The hosted team will work on behalf

of all 11 ICBs to commission delegated specialised services, working with the retained team in NHSE.

6.2 A national process for transfer has been agreed with a single date for transfer on 1st of July 2025.

6.3 The TUPE consultation on transfer will take place between April – June 2025.

6.4 To continue to develop our joint working and approach to integrated commissioning, there will still be functions that the ICB hosted team and the NHSE retained teams work on together and functions that each team will undertake on behalf of the other; these functions will be described in the agreements between the ICBs and NHSE.

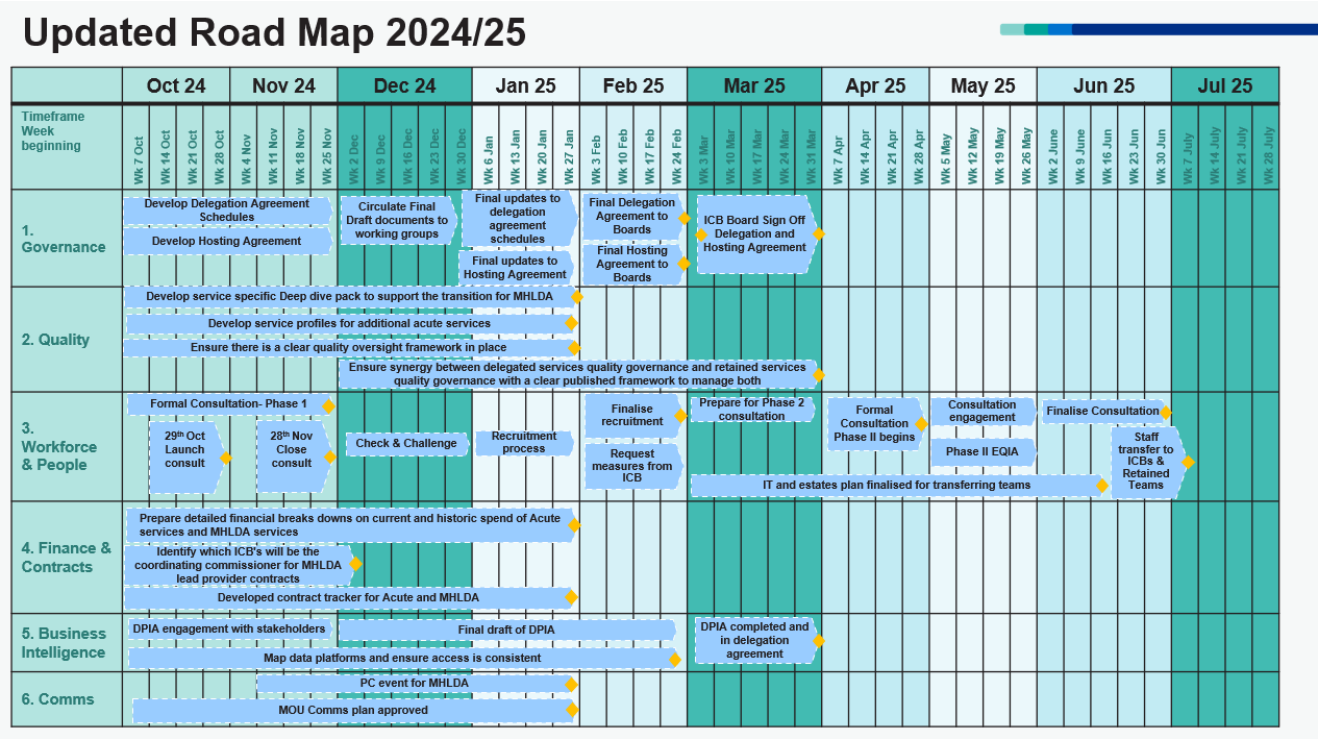
7. REQUIREMENTS OF ICB BOARDS

7.1 In summary ICB boards will receive the following document for approval:

Item	Action	Date
Delegation Agreement	Approval	Feb/March Boards
Hosting Agreement	Approval	June Boards
Joint Working Agreement	Approval	Feb/March Boards

1 APPENDICES

1. HIGH LEVEL TIMELINE FOR DELEGATION PROGRAMME



2. LIST OF SERVICES FOR DELEGATION

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
		29V	**Complex home ventilation (adults)**
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
6	Adult secure mental health services	**22S(a)**	**Secure and specialised mental health services (adult) (medium and low) – excluding LD/ASD/WEMS/ABI/DEAF**
		22S(c)	**Secure and specialised mental health services (adult) (Medium and low) – ASD MHLDA PC**
		22S(d)	**Secure and specialised mental health services (adult) (Medium and low) – LD MHLDA PC**

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology
		13Z	Cardiac surgery (outpatient)
8	Adult specialist eating disorder services	**22E**	**Adult specialist eating disorder services MHLDA PC**
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass (complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	Adult specialist neurosciences services (continued)	58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
		58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
		11T	**Renal Transplantation**
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
29	Haematopoietic stem cell transplantation services (adults and children)	**02Z**	**Haematopoietic stem cell transplantation services (adults and children)**
		ECP	**Extracorporeal photopheresis service (adults and children)**

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
32	Children and young people's inpatient mental health service	**23K**	**Tier 4 CAMHS (general adolescent inc eating disorders) MHLDA PC**
		23L	**Tier 4 CAMHS (low secure) MHLDA PC**
		23O	**Tier 4 CAMHS (PICU) MHLDA PC**
		23U	**Tier 4 CAMHS (LD) MHLDA PC**
		23V	**Tier 4 CAMHS (ASD) MHLDA PC**
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
45	Cystic fibrosis services (adults and children)	**10Z**	**Cystic fibrosis services (adults and children)**
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
98	Specialist secure forensic mental health services for young people	**24C**	**FCAMHS MHLDA PC**
103A	Specialist adult haematology services	**03C**	**Castleman disease**
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01X	**Penile cancer (adults)**
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		24Y	Skin cancer (adults)
		29E	**Management of central airway obstruction (adults)**
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
114	Specialist haemoglobinopathy services (adults and children)	**38S**	**Sickle cell anaemia (adults and children)**
		38T	**Thalassemia (adults and children)**
115	Specialist immunology services for adults with deficient immune systems	**16X**	**Specialist immunology services for adults with deficient immune systems**
115A	Specialist immunology services for children with deficient immune systems	**16Y**	**Specialist immunology services for children with deficient immune systems**
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
124	Specialist perinatal mental health services (adults and adolescents)	**22P**	**Specialist perinatal mental health services (adults and adolescents) MHLDA PC**
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	**05C**	**Specialist augmentative and alternative communication aids (adults and children)**
		05E	**Specialist environmental controls (adults and children)**
		05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

END

Derby and Derbyshire Integrated Care Board

Derby and Derbyshire ICB

Meeting in Public Forward Planner 2024/25 - Summary

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

ICB Key Areas	16 May	18 Jul	19 Sept	21 Nov	16 Jan	20 Mar
Leadership						
Chair's Report	X	X	X	X	X	X
Chief Executive Officer's Report	X	X	X	X	X	X
Citizen's Story		X	X	X	X	X
Annual Report and Accounts (AGM to follow Sept Board)			X			
Strategy, Commissioning and Partnerships						
Joint Forward Plan		X		X		
Strategic Update from Place			X			
Strategic Update from Provider Collaborative				X		
Estates Plan/ Infrastructure Strategy			X			
Opportunities for Delegated Services			X	X		
Research Strategy		X				
Primary Care GP Strategy	X					
Digital Development Update					X	
Green NHS Strategy and Progress						X
Final delegation papers for the Delegation of Specialised Commissioning				X		X
Delivery and Performance						
Performance Report • Quality • Performance • Workforce • Finance		X	X	X	X	X
Primary Care Access Recovery Plan	X			X		

ICB Key Areas	16 May	18 Jul	19 Sept	21 Nov	16 Jan	20 Mar
NHS Impact	X					
Operational Plan and Financial Plans 24/25 and 25/26		X				X
H1 & H2 Review and Reset				X		
Seasonal Plan			X	X		
Review on Intensive & Assertive Community Mental Health Care				X		
People and Culture						
ICB Staff Survey		X				
NHS Long Term Workforce Plan						X
NHS Workforce Strategy and Plan Update					X	
Governance and Risk						
Board Assurance Framework		X		X		X
ICB Risk Register	X	X	X	X	X	X
Assurance Reports from Committees	X	X	X	X	X	X
ICB Committee Review Proposal					X	
Committee Terms of Reference					X	