Joined Up Care
Derbyshire

Derby and Derbyshire

Integrated Care Strategy 2023

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Foreword

Integrated care systems provide a positive opportunity for Derby and Derbyshire residents to receive joined up care and support to meet their health and care needs.

Derby City Council and Derbyshire County Council have responsibility for a range of social care and public health functions that support our residents to live well. Our two local authorities are working alongside NHS colleagues, Healthwatch, district and borough councils and the voluntary and community sector to deliver integrated care for our residents.

The health of our population in recent times has been negatively impacted owing to many factors, including the Covid pandemic and the cost of living. Our budgets have been impacted by funding pressures, and by increased demand for services. Our workforce is going the extra mile every day.

Integrated care is not a solution in itself; however it does allow us to develop new ways of working, utilise new technology, maximise the skills of our precious workforce to create new opportunities to collaborate and work together. It will not be easy but there is a shared local commitment to do all we can within the resources available to do our best for Derby and Derbyshire.

Our Integrated Care Strategy summarises the first steps on the journey and describes how we will further grow and develop our shared approaches. There is huge ambition and commitment across the City and County to get this right for our communities. Delivering against the proposals in this strategy has the potential to help us provide a more preventative approach to health, tackle inequality and improve outcomes for local residents.

As Joint Chairs and Vice Chair of the Derby and Derbyshire Integrated Care Partnership we hope that you find the information useful, engaging and that it provides a clear understanding of the journey we are on and what we want to achieve by doing more together for our local populations.

Cllr Carol Hart
Cabinet Member for Health and Communities – Derbyshire County Council. Chair of the Derbyshire Health and Wellbeing Board

Cllr Alison Martin
Cabinet Member for Integrated Adult Care and Health – Derby City Council. Chair of Derby Health and Wellbeing Board

John MacDonald
Chair of Derbyshire Integrated Care Board

1. Introduction

1.1 Purpose of this document

The purpose of the Derby and Derbyshire Integrated Care Strategy 2023 is to set out how Local Authority, NHS, Healthwatch, and voluntary, community and social enterprise (VCSE) sector organisations will work together to improve the health of Derby and Derbyshire citizens, and further the transformative change needed to tackle system-level health and care challenges.

This document will be published in line with national guidance, with a copy provided to each partner Local Authority and the Joined Up Care Derbyshire (JUCD) Integrated Care Board.

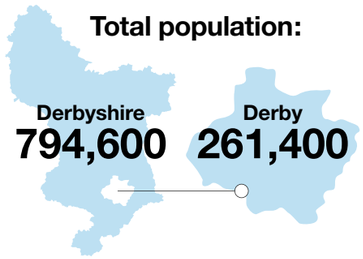
There is a summary version of the Strategy to accompany this document, which communicates the key elements in a more accessible manner.

The Derby and Derbyshire Integrated Care Strategy will not be static. National guidance requires that Integrated Care Partnerships must consider revising the integrated care strategy whenever they receive a joint strategic needs assessment. Therefore, further versions of the Strategy will be produced and published in line with this requirement meaning the Strategy should be regarded as a starting point for assessing and improving the integration of care.

Our Derby and Derbyshire System

Population size

Total population:



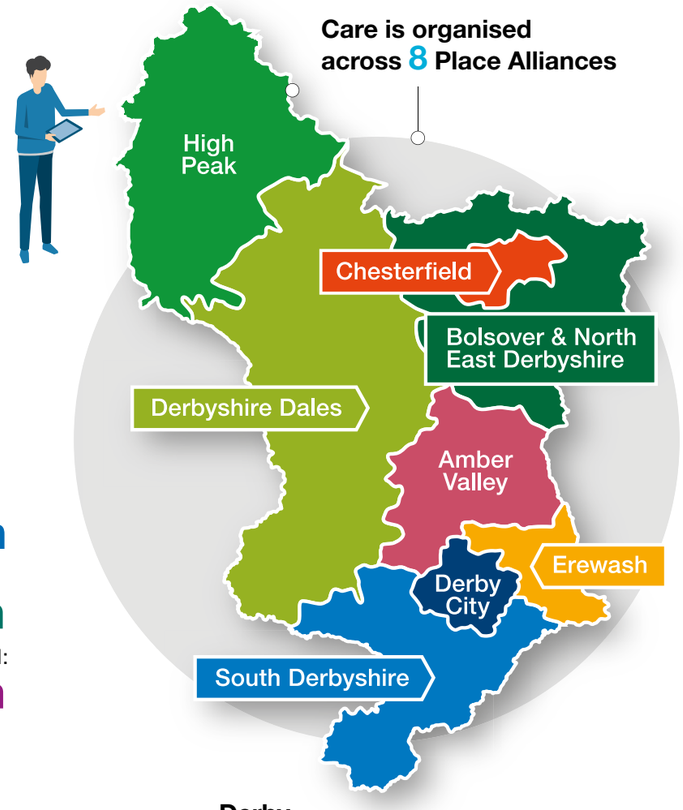
We serve a population of **1.06** million people

...across **114** GP practices

...in **15** Primary Care Networks

- 90,900 High Peak
- 71,500 Derbyshire Dales
- 182,300 Bolsover & North East Derbyshire
- 103,600 Chesterfield
- 126,200 Amber Valley
- 112,900 Erewash
- 261,400 Derby City
- 107,200 South Derbyshire

Care is organised across 8 Place Alliances



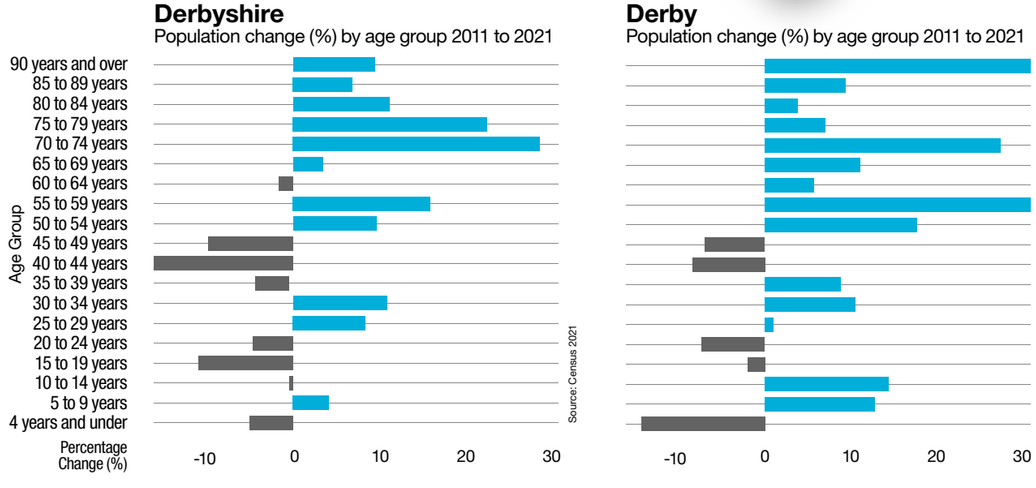
Financial position

NHS funded services:
£2.9bn

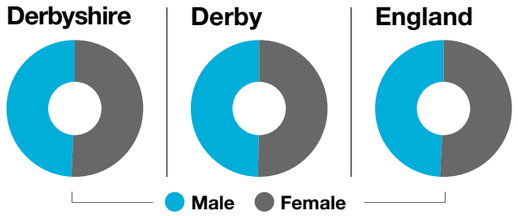
City Council:
£284m

County Council:
£668m

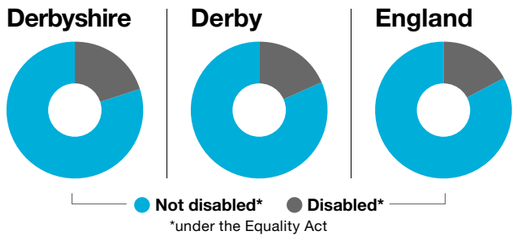
Population change



Sex



Disability



Ethnic group

Derbyshire **96.3%** **white**

Derby **76.3%** **white**

England **81.0%** **white**

The other groups are:

- Asian, Asian British or Asian Welsh
- Black, Black British, Black Welsh, Caribbean or African
- Mixed or multiple ethnic groups
- Other ethnic group

78 Languages spoken

English main language

Derbyshire **98%**

Derby City **87%**

NHS Derby and Derbyshire ICB has direct responsibility for:

- the local NHS budget - planning and commissioning of services, working closely with partners across the system
- the delivery of high quality and safe local health and care services
- producing a five-year delivery plan

Our system

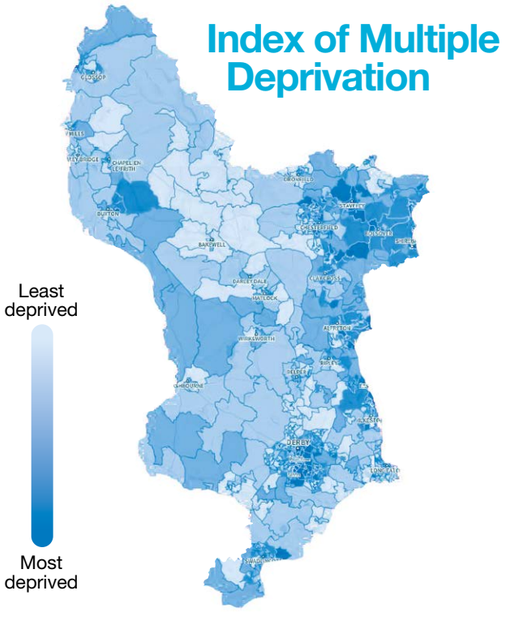
- **2** Acute Trusts
- **1** Ambulance Service Provider
- **1** Community Foundation Trust
- **2** Upper Tier Local Authorities
- **1** Mental Health Trust
- **2** Healthwatches
- **1** Out of Hours and 111 Provider
- **1** VCSE Alliance

£2.9bn for NHS funded services

1 Provider Collaborative

A health and care workforce of **53,000** people

Index of Multiple Deprivation



1.2 Impact of this Strategy

The aim is to develop a document that describes both a high-level strategic intent and the practical steps the JUCD System will take together to provide care that is more integrated, and which provides better outcomes for citizens, in response to population health and care needs.

The Integrated Care Strategy is impacting in the following ways:

- **Collaboration and collective working** - The collaborative work to develop the Strategy has helped to strengthen partnership working and engagement between local authorities, the NHS, the VCSE sector, and Healthwatch organisations. This will prove beneficial beyond the remit of the Integrated Care Strategy and act as a springboard for collective working moving forward. In short, the way in which we are developing this Strategy is just as important as the content.
- **A joined up approach to strategic enablers** - The Strategy captures for the first time the key, enabling actions that are critical to the development of high quality and sustainable integrated care, and identifies Key Areas of Focus to test these actions.

- **Agreement on Key Areas of Focus to test our strategic aims and ambitions for integrated care** - The process for developing the Strategy has resulted in system-wide agreement on three Key Areas of Focus that will help deliver prioritised population health and service delivery outcomes, they are:

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

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

- **Age/ Die Well** - To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations

- **Engagement** - It is critical that the improvements expected as a result of this Strategy are meaningful and impactful to citizens. The strategic approach to engagement developed by JUCD will be key to success. It sets out how we will listen consistently to, and collectively act on, the experience and aspirations of local people and communities. The Integrated Care Strategy provides an ideal opportunity to test and further develop this approach.

The strategic approach to engagement developed by JUCD, which includes key principles and frameworks will be key to success. It sets out how we will listen consistently to, and collectively act on, the experience and aspirations of local people and communities. The Integrated Care Strategy provides an ideal opportunity to test and further develop this approach.

1.3 Draft ‘I/We’ statements

A key hallmark (see **Section 1.6**) for the Strategy is stated as:

> **We will develop content that can be converted into statements which mean the public can easily understand how this Strategy will make a difference to them.**

Please see below for draft ‘I’ statements that have been developed in relation to this Strategy. The ‘We’ statements will follow and demonstrate how the JUCD System will respond to the ‘I’ statements once they have been tested with the public.

- I know how, and who I need to talk to if I need to ask questions about my care
- I know what to expect and that I am safe when I have treatment and care
- I have appointments and referrals efficiently made for me by health and social care staff
- I am always kept informed: - about what the next steps are, or while I wait for treatment and care
- I am supported to understand risks and uncertainties, and to take preventative behaviour change actions to avoid ill health later in my life, supported and informed by other services that are available to me.
- I am known and seen as a unique person, I am understood by health and social care workers when I first meet them
- I am given consistent and corresponding information that is relevant to me, in a way I understand
- I have treatment, care or support that is coordinated, and everyone works well together with me to achieve my personal goals
- I am given choice and control over the planning of my care, and I feel listened to. What I, my family or my carer say is acted on, my decisions are respected and have rights that are protected
- I have all my needs met that enable me to live as I want to, and I am not forgotten

The draft ‘I’ statements are intended to relate to integrated care and what matters to citizens. They have been produced using insights from local and national work already undertaken using the following sources;

- **‘National Voices – What we need now’** - What matters to people for health and care, during COVID-19 and beyond - new ‘I’ Statements 2020
- **‘JUCD – Team Up integration feasibility study’** – questions to ask patients – converted in to ‘I’ statements
- **‘Think Local, Act Personal’** – ‘I/ We’ statements for Flexible and Integrated Care and Support

The following next steps will support the testing and further development of the statements:

- Sense check the statements with the population and refine the wording based on feedback
- The JUCD System to respond with ‘We’ statements on how we will meet the ‘I’ statements, and for the Integrated Place Executive (IPE) to oversee response progress, as the delegated JUCD body for strategy mobilisation.
- To develop a process for how progress against the statements will be measured as part of our evaluation for the Integrated Care Strategy

1.4 National Guidance on the preparation of Integrated Care Strategies

The published guidance can be found on the GOV.UK website.

Legal requirements

The legal requirements stated in the guidance are included below alongside a statement on the compliance of the Strategy against these requirements.

Legal requirements stated in July 2022 Guidance	Current status for Draft Strategy
The integrated care strategy must set out how the **'assessed needs' from the joint strategic needs assessments** (JSNAs) in relation to its area are to be met by the functions of integrated care boards for its area, NHS England, or partner local authorities.	Three Key Areas of Focus emanating from 'assessed needs' have been selected as a focus for the Strategy and to test the strategic aims and ambitions for the development of integrated care, with implementation to be overseen by the Integrated Care Partnership (ICP). The Joint Forward Plan will describe how other 'assessed needs' will be met.
In preparing the strategy, the ICP must, in particular, consider whether the needs could be more effectively met with an arrangement under **S75** of the NHS Act 2006.	The governance and mobilisation arrangements for the three Key Areas of Focus will consider S75 arrangements.
The ICP **may include a statement on better integration of health or social care services with 'health-related' services in the strategy.**	It is proposed that the wording included in this Strategy document meets the requirement stated.
The ICP must have regard to the **NHS mandate** in preparing the strategy.	The NHS Mandate is referenced in this Strategy, however at the time of writing the 2023/24 Mandate has not been published. The three Key Areas of Focus will incorporate relevant requirements of the Mandate and the Joint Forward Plan is likely to play a more substantive role in responding to the Mandate, given its broader remit and its focus on delivery.

Legal requirements stated in July 2022 Guidance	Current status for Draft Strategy
The ICP **must involve in the preparation of the strategy: local Healthwatch organisations** whose areas coincide with or fall wholly or partly within the ICP's area; and people who live and work in the area.	Derby and Derbyshire Healthwatch organisations have been involved through a number of routes including the Communications and Engagement Group for the Strategy (see **Section 6**), membership of the ICP Board, discussions on the Strategy at Healthwatch Board meetings, and through conversations with the team leading the development of the Strategy. Moving forward Healthwatch will play a key role in the delivery of the Strategy, for example by: • Ensuring authentic conversations with citizens help shape and drive work programmes for the Key Areas of Focus and enabling plans • Feeding into evaluation work, ensuring the many different 'voices' of citizens are listened to when assessing progress and the impact of changes made to services.
The **ICP must publish the strategy** and give a copy to each partner local authority and each ICB that is a partner to one of those local authorities.	This version of the Strategy (April 2023) will be published in line with the guidance.
ICPs must **consider revising the integrated care strategy whenever they receive a joint strategic needs assessment.**	This will be done when new JSNAs are received and when new health and wellbeing strategies are agreed.

1.5 Aligning the Integrated Care Strategy

The Derby and Derbyshire Integrated Care Strategy and Joint Local Health And Wellbeing Strategies are designed to complement each other and will pay regard and respond to Derby and Derbyshire Joint Strategic Needs Assessments. The Health and Wellbeing Boards remain responsible for producing the Health And Wellbeing Strategies, and these will continue to have a vital role at Place.

The Integrated Care Partnership (ICP) will need to ensure that the Strategy facilitates subsidiarity in decision making, ensuring that it only addresses priorities that are best managed at system-level, and not replace or supersede the priorities that are best done locally through the Derby and Derbyshire Joint Local Health And Wellbeing Strategies.

References are included in this document to illustrate how the development of the Integrated Care Strategy is being aligned with other JUCD System strategies and plans and where further work may be required. Please see Appendix 1 for a visualisation of how health strategies link together. This includes a reference to the JUCD Joint Forward Plan (JFP) and plans are currently underway to produce a JFP by the end of June 2023, which will include content on the mobilisation and alignment of the Integrated Care Strategy.

1.6 Hallmarks for the Strategy

The hallmarks agreed through the Framework Document have been used to help guide the development of this Draft Strategy:

- There is an inclusive approach to developing the content
- The development of the Strategy and its recommended actions is based upon a strong culture of collaboration between JUCD organisations and alliances.
- We will develop a broad and deep engagement approach to inform the further development of the Strategy and relevant implementation plans
- This is a strategy for JUCD, not for regulators, and the process of developing it, should be as important as the content of the Strategy itself
- We will develop content that can be converted into statements which mean the public can easily understand how this Strategy will make a difference to them (to be done following agreement of the Draft Strategy).

1.7 Involvement and engagement in the development of this framework document

A range of senior colleagues from the NHS, local authorities, Healthwatch and the VCSE sector have been part of working groups to develop the brief, framework, and approach for the Strategy. This broad involvement has been crucial in testing the content and whether it is framed in a way that aligns with other system strategies and plans.

The Draft Strategy was endorsed by the ICP in February 2023 and has subsequently been shared and discussed with a broad range of JUCD organisational committees and management forums (see **Appendix 2**), and there has been high-level initial engagement with the public through the mechanisms outlined in **Section 6**.

Key points arising from these interactions are captured in Section 7.5 and these have been reflected in the content of this document and/ or will be fed into the mobilisation plans for the Strategy.

2. Strategic Context

2.1 National context

The Health and Care Act 2022

The Health and Care Act 2022 put new requirements on NHS and Local Authorities, including the requirements to produce an Integrated Care Strategy, set up an Integrated Care Partnership and establish an Integrated Care Board.

NHS Mandate

The ICP must have regard to the NHS Mandate, alongside guidance from the Secretary of State, when preparing the Integrated Care Strategy. The 2023-24 Mandate and accompanying objectives are awaited.

The NHS Mandate will help inform this Strategy; however it is by its nature NHS centric and some of its content is quite operational, and therefore the primary response to the Mandate will be through the Joint Forward Plan.

NHS Long Term Plan and national focus on prevention and early intervention

The 2019 NHS Long Term Plan sets out ways to overcome the challenges that the NHS faces, including by:

- “Preventing illness and tackling health inequalities: the NHS will increase its contribution to tackling some of the most significant causes of ill health” (The NHS Long Term Plan – a summary, 2019)

This echoes one of the strategic aims for this Strategy - Prioritise prevention and early intervention to avoid ill health and improve outcomes.

More recently there have been calls from key, national organisations for an increased focus on prevention and early intervention, A paper published in January 2023, named 'Joint vision for a high quality and sustainable health and care system', provides the views of the Local Government Association, the Association of Directors of Adult Social Services, and the NHS Confederation and endorses the approach outlined in this Strategy.

There are other key, national strategies and plans that will need to be reflected in the mobilisation plans for this Strategy, and the plans for improvement for the Key Areas of Focus; these include the Fuller Stocktake Report (2022) on primary care (further referenced in Section 2.2.8) and the Women's Health Strategy (2022) that seeks to address the poor experiences and worse health outcomes that women endure.

2.2 JUCD Strategic context

2.2.1 Introduction

It is recognised that the current and immediately foreseeable environment for health and care is challenging on a number of fronts, including workforce capacity and wellbeing, Covid related backlogs, and financial constraints. Whilst it is not the intention to downplay or disregard these challenges in developing this Strategy, it is important for the JUCD System, through the further development of integrated care, to identify what can be done more effectively and efficiently by integrating resources and by working differently.

It is also important to build on examples of where we do things really well in Derby and Derbyshire and to understand how actions, partnerships and behaviours that have led to successful outcomes, can accelerate plans for integrated care. A number of examples of good practice are included throughout this document to illustrate how innovative service developments can be delivered despite the challenging environment.

The sub-sections below include references to local strategies and plans that are key to the development of integrated care in Derby and Derbyshire. It is not a simple landscape, and there are multiple, relevant strategies or plans that are relevant. **Appendix 1** provides an infographic that describes the relationship between some of the key, high-level documents.

2.2.2. JUCD Integrated Care System

The purpose of the JUCD Integrated Care System is to bring partner organisations together to;

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

The strategic aims and the content included in this Strategy build out from and reflect this purpose.

2.2.3 Derby and Derbyshire Joint Health and Wellbeing Strategies

Please see **Section 3** for content on the alignment between this Strategy and the Derby City and Derbyshire Joint Health and Wellbeing Strategies.

2.2.4 JUCD Joint Forward Plan

Section 1.4 references the requirement for the production of a JFP by the end of June 2023, and that this will include content that reflects the mobilisation and alignment of the Integrated Care Strategy.

2.2.5 Local Authority Plans 2022-2025

Please see **Section 3** for an outline of how the outcomes, 'must do's' and 'headline initiatives' from the Derby City and Derbyshire Local Authority plans align with the population health and care needs and ambitions for improved population health included within this Strategy.

2.2.6 Adult social care and children's strategies

The Key Areas of Focus for this Strategy will reflect (as relevant) the stated priorities in Derby City and Derbyshire strategies covering adult social care and children's services.

2.2.7 JUCD Operational Plan 2023-2024

Prevention, access and productivity are key themes/ requirements that have driven and shaped the JUCD 2023-24 Operational Plan, which responds to guidance released by NHS England. It will be important to align the mobilisation work for the Key Areas of Focus included in this Strategy, with relevant outputs from the 2023-24 Operational Plan, and for the Key Areas of Focus and enabling actions to deliver outcomes that support improvements in prevention, access and productivity.

2.2.8 Primary Care Strategy

Primary care plays a key role at the heart of communities. GPs, health visitors, dentists, pharmacists, opticians, community nurses are among the most recognisable and visible staff delivering care around the clock.

Every day, more than a million people nationally benefit from the advice and support of general practice with up to 90% of healthcare delivered by primary care teams, making it a highly valued and crucial component of the ICS.

However, in Derbyshire, as in many parts of the county, there are real signs of genuine and growing discontent with primary care – both from the public who use it and the professionals who work within it. This is apparent in all elements of primary care and but has been particularly visible for general practice.

In the period March 2022 to February 2023 general practice in Derbyshire provided over 6.7 million appointments an increase of 5% over the same period the previous year. Despite record numbers of appointments demand has exceeded capacity and patient satisfaction with access to general practice has dropped. This is a result of a range of factors including, reducing number of GPs, increasing demands driven by the pandemic and an increasingly complexity of cases caused by an ageing population.

A number of national reports in the last 12 months have acknowledged challenges faced by primary care including and the need for coordinated action. The Next Steps for Integrating Primary Care: Fuller Stocktake (released May 2022) sets out a new vision for integrating primary care, improving the access, experience and outcomes for communities, which centres around three essential offers:

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

Implementation of the Fuller Stocktake requires significant shifts cultural shifts: towards a more a more holistic approach to supporting the health and wellbeing of a community; and realignment of the wider health and care system to a population-based approach – for example, aligning secondary care specialists to neighbourhood teams. Key to delivering this way of working is local leadership and engagement which avoids a 'top-down' approach achieving transformation through the workforce and communities.

2.2.9 Carers Strategy

The Derbyshire Carers Strategy has recently been refreshed ('2022 Refresh') and the System wide adoption of the priorities and pledges set out within the 'Strategy Refresh' will ensure its greatest impact in effectively supporting unpaid family carers. Leads for the Key Areas of Focus and relevant enablers will be asked to commit to supporting the priorities within the Carers Strategy through their mobilisation plans:

- Improving carer health and wellbeing
- Information and advice
- Carer employment and financial wellbeing
- Early identification and support
- Young carers
- Services and systems that work for carers
- Involving carers as experts
- Recognising and supporting carer in the wider community

2.2.10 Anchor Partnership

The work of the Derby/ Derbyshire Anchor Partnership needs to be incorporated into the delivery plans for this Strategy.

The two local authorities, local NHS organisations and JUCD, Derby County Community Trust and the University of Derby are signatories to an Anchor Charter, and together with Rolls Royce, are members of Derbyshire's founding Anchor Partnership. Together they aim to use their collective influence to help address socio-economic and environmental determinants and enable and facilitate community wealth building, working together through the Derby and Derbyshire Health and Wellbeing Boards and the Integrated Care Board.

The Anchor Partnership has agreed to initially focus its combined influence and actions on the following two impact areas – workforce and access to work, and social value in procurement. Anchor workshops have commenced in recent months with relationships established through communications colleagues in each organisation.

It will be important to consider how best to align Anchor Partnership actions with the work emanating from this Strategy on key enabling functions and across the Start Well, Stay Well, and Age/ Die Well areas of focus.

2.3 Strategic aims for integrated care

The strategic aims for integrated care in Derby and Derbyshire seek to reflect the strategic context outlined within this section. They were approved by the ICP in December 2022 and have helped shape the development of this Strategy and will steer the content of mobilisation plans moving forward.

Derby and Derbyshire strategic aims for integrated care

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

3. Population Health and Care Needs

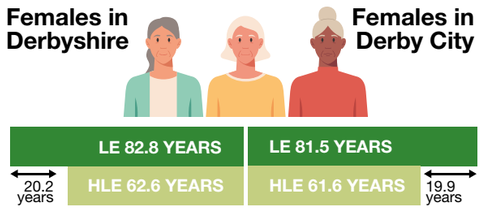
3.1 Introduction

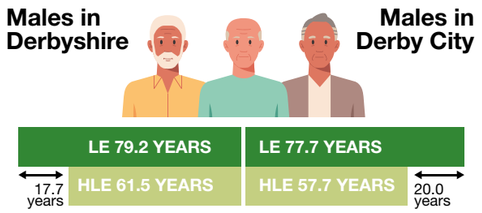
Many people in Derby and Derbyshire live for a long time with long-term and often multiple conditions and there are stark differences in rates of healthy life expectancy between populations. There are similarly striking differences in life expectancy rates when comparing the least and most deprived populations.

Through this Strategy we will therefore aim to increase life expectancy and healthy life expectancy and reduce the inequalities experienced. This will be achieved by tackling the conditions and the drivers of the conditions that, combined, are the leading causes of early death and time spent in ill-health.

The Derbyshire and Derby Joint Health and Wellbeing Strategies are to be updated during 2023. The content for this document and the needs outlined in this Section are therefore based upon the existing strategies.

Life expectancy





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

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

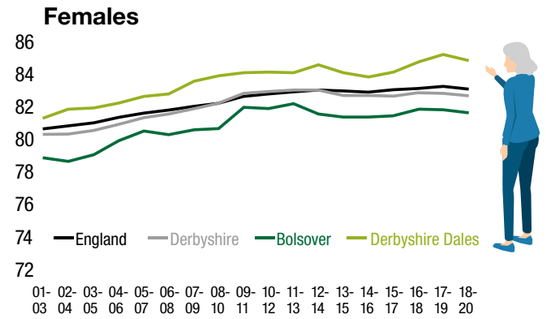
LE = Life expectancy **HLE** = Healthy life expectancy

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

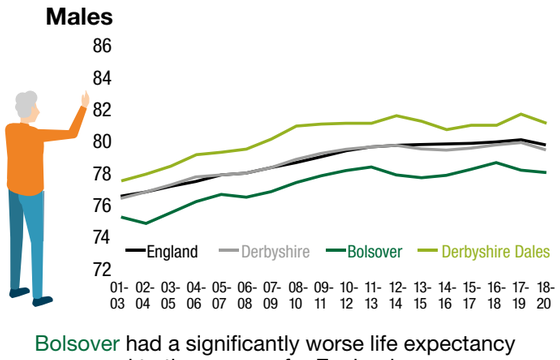
Cost of Living Vulnerability Index

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

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

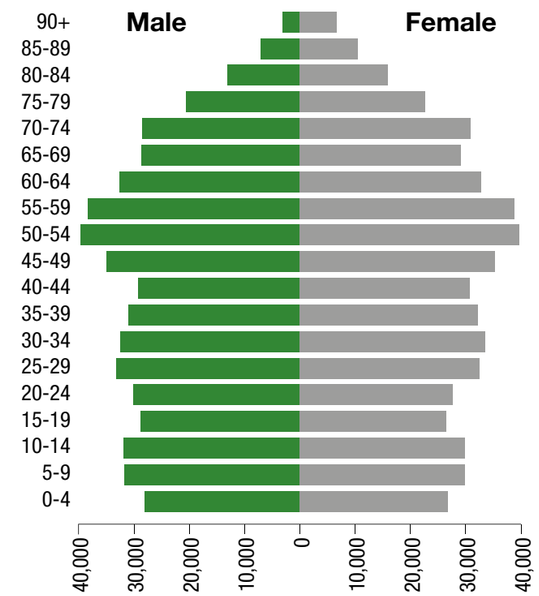


Bolsover had a significantly worse life expectancy compared to the average for England.



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

Population Pyramid



Source: SHAPE atlas accessed 31/03/2023

3.2 Life expectancy and healthy life expectancy

The health of a population can be described using healthy life expectancy and life expectancy statistics, and health inequalities can be starkly demonstrated by illustrating the difference in length of life, and how many of those years are spent in good health. Please see Table 1 below for a summary of the differences in Derby and Derbyshire.

Table 1:

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

	Derby	Derbyshire
Life expectancy at Birth (2018-20) [Inequality gap, 2018-20 describes the difference in years between the least deprived and most deprived populations*]		
Male	**77.7** (11.1)	**79.2** (8.1)
Female	**81.5** (10.9)	**82.8** (7.8)
Healthy life Expectancy (2018 – 20) [Inequality gap, 2018-20 describes the difference in years between the least deprived and most deprived populations*]		
Male	**57.7** (18.7)	**61.5** (13.7)
Female	**61.6** (19.2)	**62.6** (13.5)

*Life Expectancy at Birth statistical measures estimate the average number of years a new-born baby would survive if they experienced the age-specific mortality rates in this area throughout life. Healthy life expectancy measures reported years in good health.

The inequalities illustrated in Table 1 are distributed differently across the area. Poorer outcomes are linked to areas of socio-economic deprivation and certain groups including, but not limited to, those from Black, Asian, and minority ethnic backgrounds, those with serious mental illness, people living with disabilities, LGBTQ+ people and people currently homeless.

Going forward, we will build on existing and develop new approaches for prevention, reducing health inequalities and enabling population health management. These approaches will incorporate a review of the drivers of ill-health, early death, and the inequalities that exist between and within communities. They will set out desired population outcomes which will lead to effective action to improve health.

3.3 Population outcomes

3.3.1 JUCD approach

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

3.3.2 Population health

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

- **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.

- **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.

- **Age well and die 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.

3.3.3 Population health indicators

The latest iteration of our 'Turning the Curve' indicators have been agreed as important 'markers' on the way to improving high-level outcomes and therefore require focused activity. They address direct risk factors for the main causes of death (biggest causes being cancer, respiratory and circulatory disease), ill-health, and inequalities, including mental health.

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

JUCD has also identified indicators to reduce specific inequalities for adults drawing on local data and NHS recommendations*. These indicators (known as “Plus 5” indicators) require accelerated improvement.

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

Guidance on ‘Plus 5’ indicators for children and young people has recently been issued nationally and is being considered. Please see **Appendix 5** for the current position within Derby and Derbyshire.

* https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/

3.3.4 Local Authority plans and priorities

Headline initiatives and outcomes included within the Derby City and Derbyshire County Local Authority Plans 2022-2025 align to and support health and wellbeing plans, and the population health indicators stated in **Section 3.3.3**. This alignment provides an excellent platform for facilitating integrated care and the delivery of plans for the Key Areas of Focus included within this Strategy.

Derby City Council Plan

The following outcomes and ‘must do’s’ are included:

- Cleaner air and lower CO2
- Decent, sufficient, and affordable housing with an emphasis on the homes of vulnerable people
- Reducing inequalities and wealthier and healthier residents
- Health and wellbeing strategy with a focus on childhood obesity and public health statutory requirements
- Provide effective strategic leadership to drive stronger integration of health, housing, community, and social care agendas, safeguarding adults that need it
- Establish a citywide Prevention Strategy, focusing on building independence using individual and community assets

Derbyshire Council Plan

Headline initiatives in the plan include:

- Work with partners to enable people to lead healthier lives by supporting people to take part in physical activity, to stop smoking and manage their weight
- Work alongside people with a learning disability, those recovering from mental ill health and/or who are autistic to develop Council services to ensure they are tailored to meet individuals needs and help people achieve their personal goals
- Work in partnership with the NHS to implement the Integrated Care Strategy to benefit the health and wellbeing of the people of Derbyshire, tackle health inequalities and demonstrate a move towards more preventative interventions and investment
- In addition the council has published its “Best Life Derbyshire” Strategy in 2023 with a focus on people with lived experience being able to define the outcomes they want from social care

3.4 Health protection

Integrated Care Partnerships are asked to consider health protection in their integrated care strategy, with system partners including UKHSA, local authorities and the NHS who, among other bodies, have health protection responsibilities to deliver improved outcomes for the population and communities served. Health protection includes:

- Infection and prevention control (IPC) arrangements within health and social care settings
- Tackling antimicrobial resistance
- Reducing vaccine-preventable diseases through immunisation
- Assurance of national screening programmes
- Prevention activities related to health protection hazards such as needle exchanges for blood-borne viruses (BBVs)
- Commissioning of services for response to health protection hazards (such as testing, vaccination and prophylaxis) and to tackle health protection priorities (such as tuberculosis or BBV services)
- Emergency preparedness, resilience and response (EPRR) across all hazards
- Other health threats determined as priorities

The Directors of Public Health (DsPH) have the duty, under the Health and Social Care Act (2012), to be assured that the local health protection system is working effectively and to ensure that the health of the population is protected. This is sought through the Derby and Derbyshire Health Protection Board, chaired by one of the DsPH and reporting to the Health and Wellbeing Boards; an arrangement that has been in place since 2013. The development of the JUCD Integrated Care System is an opportunity to ensure this arrangement is embedded within the local health and care system.

Work is underway to identify key areas of work that require system support, these include:

- Developing the infection prevention and control system
- Ensuring a successful and safe transfer of the responsibility to commission immunisation services
- Ensuring oversight of screening programmes is appropriately linked to the system
- Improved connection for existing strategies e.g. air quality
- Pathway improvements for individuals with complex health protection needs e.g. those with TB who have no recourse to public funds

The following strategic actions have been identified:

- Request a commitment from the ICP to sponsor a review of the governance and architecture for health protection in Derby and Derbyshire
- Produce a health protection strategy for Derby and Derbyshire to clarify and drive the work of the Health Protection Board and establish agreed outcome measures
- Review the three key areas of the focus for the Integrated Care Strategy and identify prioritised health protection actions. Secure commitment from the Senior Responsible Owners to include these actions as an integral element of their work plans, and to work with Public Health colleagues on their resolution
- Ensure health protection priorities are included within the appropriate workstreams, and that progress is reported to the Health Protection Board

4. Strategic Enablers

4.1 Introduction

A key thrust of this Strategy is to focus on enabling actions that are critical to the development of high quality and sustainable integrated care and our response to population health and care needs. These enabling actions have been grouped as follows:

- System architecture and governance
- System shared purpose, values, principles, and behaviours
- Enabling functions and approaches

4.2 System architecture and governance

The Integrated Care Partnership (ICP) is accountable for the Integrated Care Strategy, with oversight and delivery management arrangements delegated to the Integrated Place Executive (IPE). The role of the IPE in overseeing the mobilisation of the Strategy is referenced in **Section 7**.

There is a commitment to ensuring there is 'parity of attention' on health inequalities, population health management, and prevention within system reporting and governance arrangements, to ensure clarity and visibility on how we track our ambitions for our Start Well, Stay Well, Age/ Die Well Key Areas of Focus, and wider improvement actions.

Governance issues specific to the Key Areas of Focus are highlighted in **Section 5**, and these will need to be addressed as part of Strategy mobilisation. One of the issues for consideration is how the mobilisation work and its reporting will align with existing JUCD governance arrangements, including delivery boards.

There will be ongoing liaison between the IPE and the leads for the Key Areas of Focus with the Derby and the Derbyshire Joint Health and Wellbeing Boards, to ensure there are robust feedback loop processes in place so that mobilisation plans for this Strategy are informed by updated joint strategic needs assessments and health and wellbeing strategies, and vice versa.

4.3 System shared purpose, values, principles, and behaviours

Many of the key strategic enabling actions that are intended to support improvement through practical and transactional solutions may not succeed without significant underlying changes in behaviours to support a one-system approach, due to established processes and organisational sovereignty issues. There is a desire to develop a shared set of values and principles. It is proposed to use an Organisation Development (OD) approach to create this.

What is OD?
Organisational Development is the application of behavioural science to organisational and systems issues to align strategy and capability, especially during times of change.

How do we do it?
Using tools and techniques from a wide range of disciplines e.g. psychology, anthropology, sociology, economics, to facilitate changes in the thinking and actions of groups and organisations.

What is the Impact of OD?
It enhances people's collective capability to deliver the purpose of organisations and systems.

It is proposed to undertake a programme of work during 2023/24 as follows:

Discovery

- Understand from stakeholders what has happened already to facilitate integrated care and should be maintained and built on
- Identify shared ambitions, purpose and ways of working that would accelerate integrated care

Design

- Co create a series of interventions that are accessible, inclusive and build on what exists, which facilitate partners to agree and embed shared values and ways of working which promote integrated care

Delivery

- Identify the assets from across the system who could help deliver the programme, and determine where external help may be needed
- Ensure delivery is done in a way which maximises the impact and practical application of learning eg delivered to MDT's in their place of work, builds relationships and confidence to innovate.

This work will also need to be cognisant of other development taking place in the ICB and the Provider Collaborative around vision, purpose and ways of working which support improved health outcomes for our population. This could help us articulate the "golden thread" of the overall system purpose, which so far has not been done.

4.4 Enabling functions and approaches

The content under this Section has been co-produced with JUCD leads for the functions and services covered and seeks to summarise improvement plans and constraints relevant to our strategic aims for integrated care and for the delivery of successful outcomes in relation to the Key Areas of Focus.

4.4.1 Workforce

Our vision for the JUCD workforce is:

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

Key enablers to achieving the vision include:

- A single point of access for new recruits, with a "no wrong door" approach to seeing people as a system asset, to be deployed wherever their skills fit best
- An integrated system rather than organisational approach to assessing workforce supply requirements
- Unified approach to leadership and talent development and organisational development (OD)
- An inclusive talent approach as the driver for recruitment and development
- Consistency of People Services offers, regardless of employing organisation - "One People Service across all places"
- Use of technology to enable ease of movement between organisations and reduce non value adding processes
- Clearer sense of common purpose and agreement on priorities for where we can work together, share resources
- Prioritisation of investment in training and development in prevention, personalisation and health inequalities

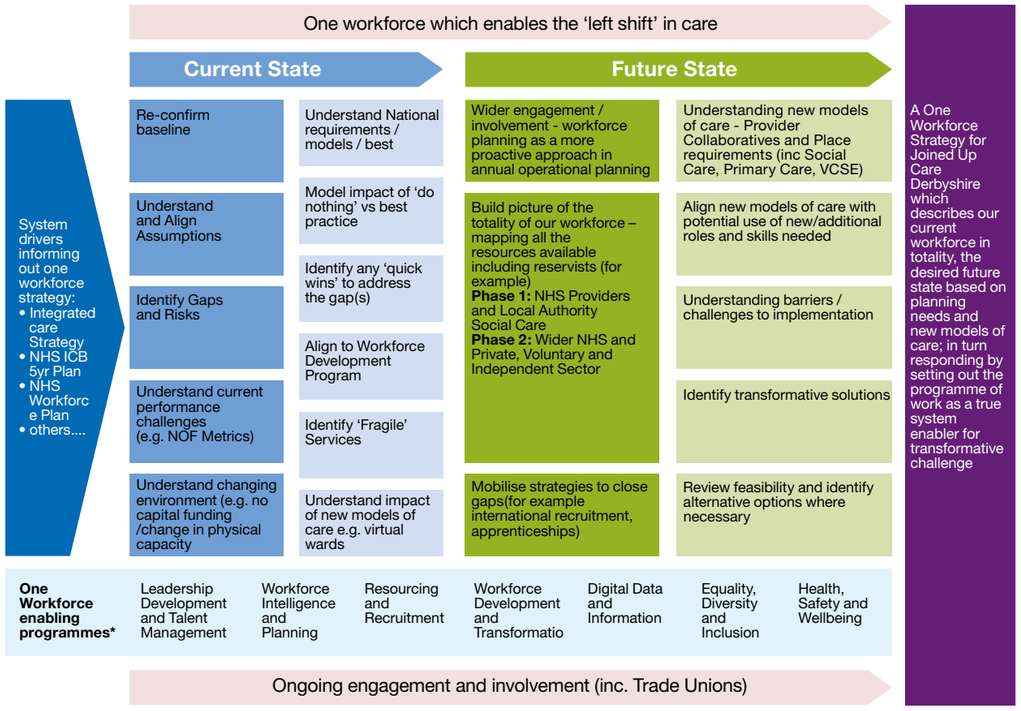
Some of the key challenges, and constraints to achieving the vision and our integrated care strategic aims include:

- Lack of dedicated workforce expertise to support integration
- Better understanding of the current workforce in the scope of this plan, what the requirement will be in light of the integrated care strategy and a joint approach between service leads and People Services to develop plans to bridge the gap using new approaches to skill mix, expanding/ introducing new roles and deploying staff closer to service users
- High percentage of social care staff who are in the private, voluntary and independent (PVI) sector and therefore harder to influence in terms of workforce planning and development
- Fragmented and short-term nature of funding streams for workforce transformation and development
- Lack of trust in processes and governance between statutory sector partners and between the statutory and Voluntary Community and Social Enterprise (VCSE) sectors.

Current areas of focus therefore include delivering the conditions that will enable a JUCD 'one workforce' spanning health and local authority organisations; leadership development at a system level; the Joined Up Careers initiative; and the 'Quality Conversations' training programme which develops a strength based, personalised care mindset for health and care staff.

The following infographic summarises our framework for developing the JUCD 'One Workforce' Strategy. We will need to align and embed this framework as part of the work programmes for the Key Areas of Focus included in **Section 5**.

Framework for Developing the Joined Up Care Derbyshire ICS 'One Workforce' Strategy



* Our current 7 areas of focus will be reviewed to ensure alignment with the key areas of the one workforce strategy which are relevant to the system as a whole

Case Study I Reservist

The Reservist Workforce Initiative is a contingent workforce model that engages people with clinical and non-clinical skills to train and prepare them to support services across the Integrated care system at times of need, supporting seasonal pressures, short term absence, surge, and vaccination programmes across Derbyshire. Facilitated by a Joined Up Care Derbyshire Workforce Sharing Agreement, the approach enables colleagues to work across different organisations without multiple employment arrangements.

Workforce flexibility and options for services to access support is essential to enable continuity of services. The reservist workforce model also enables colleagues to work differently with control of their hours, gaining experience across a range of services. People have signed up in one of four roles to work as and when needed across the Integrated Care System:

1. Reservist Essential Assistant
2. Reservist Clinical Assistant
3. Reservist Registered Healthcare Professional
4. Reservist Registered Healthcare Professional Vaccinator

Almost 100 staff have registered so far and successful pilot sites in care homes, surge wards and home visiting services are ongoing. New software to enable across system access to workforce support has been implemented, with a new legal framework to support workforce mobility. Next steps are to increase the targeted untapped recruitment pathways- including access to health students, the retired community and establish corporate social responsibility opportunities, and to increase the breadth of services signed up to the Workforce Sharing agreement and those accessing to reservist workforce support.

4.4.2 Digital and data

The Digital and Data strategic aims and delivery priorities will support and enable the System to work towards the realisation of its strategic priorities and desired population outcomes through:

- **The ability to share citizen/patient information** to support care delivery across health and social care, including;
  - **Derbyshire Shared Care Record (DSCR)**. The deployment of the DSCR will be expanded to include hospices, care homes, community pharmacies and other commissioned health and social care providers services. The DSCR provides clinicians and professionals with the most up to date patient/ citizens information to support the delivery of optimal care.
  - **Front Line Digitisation;** Electronic Patient Record (ePR). To enable collaborative working, deliver faster care, pathway redesign, reduced clinical risk and Population Health Management a new ePR will be deployed across our acute hospitals.
  - **Digitising in Social Care (DiSC)** – the implementation of digital social care record for care homes and domiciliary care providers, technology to support falls prevention and other technology evidence to enable citizens to be supported in the place they call home
- **A data architecture to enable population health management to be embedded across the system** to inform service planning and delivery. The ambition is to create a holistic view of citizens that incorporates wider determinants of health to improve physical and mental health outcomes.
- **Digitally enabled care delivery using tools and technology** to improve citizens knowledge and understanding to take greater control of their health and care

- **Digital and data innovation to support technology enabled care pathways** to augment care delivery, efficiency, and citizen/ patient/ staff experience
- **Digitisation of the wider health and social care economy** to improve care and opportunity for future interoperability and data sharing
- **Supporting and developing our citizens and workforce** in the use and adoption of digital services
- **Ensuring an inequity is not created** for those that are impacted. As we push our 'digital by default' vision we must ensure an inequity is not created for those that are impacted by the following barriers:
  - access issues
  - equipment, broadband connectivity, wifi, affordable data packages

This activity will be informed and prioritised through a systemic use of the nationally mandated and benchmarked 'Digital Maturity Assessment' and 'What Good Looks Like' tools.

Case Study | Derbyshire Shared Care Record

Health and social care organisations in Derby and Derbyshire have worked together to develop a new confidential computer record which is set to improve the care you receive. Until now, each organisation providing care has kept different sets of records, which may be duplicated or incomplete. The Derbyshire Shared Care Record joins up different records to create a more comprehensive and up-to-date record, which over time this will help improve the care received.

Joining up different records, including GP, hospital and social care records, will help improve care and avoid situations where individuals have to repeat the same details about their care to each professional they see. It will only be used for direct care and means that health and social care professionals working across Derby and Derbyshire's NHS and local authority organisations will be able to access the same, appropriate information to support the care of individuals. The record is completely confidential and secure. It's designed to help doctors, nurses and other health and social care professionals directly involved in an individual's care to make better, safer decisions.

4.4.3 VCSE sector

Nationally it is recognised that the VCSE sector is a vital cornerstone of a progressive health and care system and is critical in the delivery of integrated and personalised care and helping to reduce health inequalities. The National Development Programme – Embedding the Voluntary Community and Social Enterprise (VCSE) Sector within Integrated Care Systems (ICS) 2022/2023, which JUCD is part of, describes how;

"ICSs should ensure their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving and delivering services, as well as developing and delivering plans to tackle the wider determinants of health. VCSE partnership should be embedded as an essential part of how the system operates at all levels. This will include involving the sector in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans."

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

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

Engaging this contribution will improve services for local people but there are challenges to making this happen that need to be addressed through the implementation of this Strategy and wider system actions. Some of these are listed below and a commitment to tackling these challenges is a key recommendation to the Integrated Care Partnership:

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

How the VCSE sector will be embedded in the ICS and the processes and culture necessary to make this happen will be captured in a Memorandum of Understanding to be signed off and adopted by ICS partners.

Case Study | Voluntary, Community and Social Enterprise work as part of the ICS

The Voluntary, Community and Social Enterprise (VCSE) sector has been working with ICS partners to build a closer relationship that will build on the significant contribution it has to make in addressing health inequalities and the determinants of ill health.

The VCSE Alliance has built awareness, opportunities and provided a forum for discussion. It has also helped to populate VCSE sector representation on the various parts of the ICS. This includes the Integrated Care Partnership, the Integrated Place Executive, the two Place Partnerships, the Place Alliances and the Mental Health/Learning Disabilities/Neurodiversity Delivery Board, with further avenues in progress to connect with VCSE organisations of all types and sizes.

Through the VCSE Alliance the VCSE sector has significantly contributed to the development of the Integrated Care Strategy. It is also engaging in a rapidly increasing number of cross partner initiatives. These include,

- Extensive work to explore how procurement and commissioning approaches might better engage the VCSE sector and the contribution it has to make,
- Looking at how the paid and unpaid VCSE workforce might be supported as part of the combined health and social care workforce,
- Identifying and piloting new approaches to hospital discharge
- Working with partners to develop a joined-up approach to engaging and working with communities of place, interest and condition,
- Considering how VCSE infrastructure might develop to best support the contribution the VCSE sector has to make,
- Working closely with partners to design and develop innovative approaches to services for people with mental health, neurodiversity and learning difficulties,
- Starting to explore the VCSE sector contribution to helping people stay within their own homes, end of life care and dealing with musculoskeletal conditions.

This developing partnership will be captured in a new “Memorandum of Understanding”, required by national guidance that will set out what the VCSE sector brings, the cultures and behaviours we need to make this partnership work, how this will be underpinned by action and how we will measure success.

4.4.4 Strengths based approaches

Strength based approaches already feature as a facilitative method for catalysing change and improvements in JUCD services. For example, Derby City Council has implemented a strengths based approach based around 8 principles, with the aim of achieving stability and reducing risk for children and young people, and to encourage the involvement of children and young people and their families in decision-making so that they are more in control of the support they receive and thereby their everyday lives. And a strengths based approach is a key feature of the Team Up approach, and Derbyshire County Council’s “Best Life Derbyshire” strategy for social care.

What is a strengths based approach?

Taking a strengths based approach simply means helping people find their own solutions and to create change through their own strengths and the assets available to them. It works at any level, individual, team or system.

Why is it required?

Strengths based approaches build resilience, motivation and self-sufficiency. They have been proven to be significantly more effective than traditional deficit based approaches at creating lasting change and continuous quality improvement. This is especially so in complex adaptive systems such as health and care, or in getting the best out of a highly educated workforce.

At the current time when burnout is high amongst the workforce, approaches that build motivation and resilience are essential. Finding a way through this will require a relentless focus on our strengths, supporting people to find their own solutions and trusting them to make their own decisions.

How can it be applied?

There are many successful models and initiatives that use strengths based approaches. These include coaching, appreciative inquiry, human learning systems, quality conversations, local area coordination, Think Local, Act Personal, the ‘What Matters to You’ movement, personalisation, human learning systems and Team Up Derbyshire.

Champions training for a selection of acute, LA, DCHCS, VCSE staff has been arranged from December 2022, with the aim of embedding strength- based approaches in practice, improving communication / understanding across the system and exploring system risk.

It is proposed to embed strengths based approaches across Joined up Care Derbyshire working, as an integral element of a system-level organisational development approach.

Case Study | Quality Conversations

The Quality Conversations (QC) programme is a communication skills training programme, with a focus on experiential learning. Designed by Clinical Psychologists and delivered by qualified coaches, the programme is rooted in a commitment to address health inequalities and supports a personalised care approach. The objectives of QC are to enable staff to have strengths-based conversations, with compassion and curiosity, to support and promote health behaviour change whilst considering the impact of the social determinants of health. The programme is supplemented with a suite of localised support and resources such as, web-based resources, an ambassador network and team-based sessions to embed the approach and ensure sustainably of learning.

To date 1,545 participants from across the ICS have undertaken the training, with statistically significant improvement in participant self-rated knowledge and confidence. This was substantiated by a significant increase in exploratory open questions or 'pull' communications observed as opposed to advice-giving or 'push' communications. The two-month follow-up found that 91% of respondents considered QC relevant to their role, and that techniques learned had been put into practice. As an innovative approach to the implementation of 'make every contact count', the QC programme has received national and international interest, has been disseminated national conferences, and has had an abstract published in the Lancet. In the future, the aim is to expand the offering, developing specialist focus sessions on topics that the workforce and patient/clients have identified as importance, such as, Self-Management, Health Literacy, Leadership and Goal Setting.

4.4.5 Knowledge and intelligence capability including population health management

An effective JUCD System knowledge and intelligence capability with sufficient capacity is critical for enabling intelligence-led decision-making, planning and delivery of population health improvements, reducing health inequalities and integrated care.

Population health management (PHM) is a key part of the 'data-led toolbox' required to deliver this Strategy and embedding PHM as part of a wider shift to data and intelligence-led decision-making, planning and delivery is essential for the successful delivery of our population outcomes. Other elements of the 'toolbox' include the joint strategic needs assessments, topic-specific needs assessments, equity audits, evidence reviews, use of qualitative data, public and professional experience and insights as referenced in **Section 6**.

Also essential is evaluative capability and capacity to help determine the success of our actions and interventions. A vibrant and collaborative research culture and capability is also key to support the systematic and robust development of new knowledge, in terms of medical and technical advances, but also in the fields of prevention and wider determinants.

PHM uses data and information to identify and understand defined populations and the factors driving their physical and mental health. Better understanding through use of data then helps us to improve the health and wellbeing of people now and into the future through proactive and targeted care. It seeks to reduce health inequalities and addresses the wider determinants of health through collaborative partnership working.

Effective PHM requires an appropriate data architecture including data flows, data linkage and analytical and visualisation tools and information governance arrangements. In addition, it requires relevant workforce capacity and capability in terms of digital, analytical and wider development. Most importantly, it requires a cultural shift in how we work and how we use data.

A Derbyshire-wide systematic approach to PHM is being developed and pilot activity to test the different approaches has been undertaken at a local level in four different parts of Derbyshire. Learning from these pilots will inform next steps, including the need to incorporate qualitative intelligence and insights, and engage others in checking or adding to the picture provided through PHM data. The PHM pilot in Chesterfield is highlighting this need/opportunity.

The approach will draw on expertise from all relevant JUCD partners for each Key Area of Focus. It will utilise system intelligence and insights, and adopt an Analyse, Plan, Do, Review approach to working with cohorts to improve care and outcomes.

Case Study | Opioids Management

Opioids, such as morphine and codeine, are a type of pain relief. There is little evidence of significant benefit for the routine use of opioids in pain that is chronic (lasting more than three months) and is not cancer-related. There are also serious harms associated with opioids and a risk of dependency when taken longerterm. For this type of pain, there are often more effective approaches that do not involve medication.

Joined Up Care Derbyshire is working in partnership with the East Midlands Academic Health Science Network (EMAHSN), as part of the national Medicines Safety Improvement Programme to implement a systems approach to improving pain management and reducing the harm from opioids for people living with chronic non-cancer pain.

The programme is founded on developing a cross-sector collaborative community of stakeholders including healthcare professionals, patients with lived experience and the voluntary sector to create and deliver an action plan for improvement. This has included creating system wide guidelines, a resource website for patients and clinicians, and supporting the roll out of health and well-being coach led pain management courses.

Prior to the programme, there was a year-on-year increase in patients prescribed opioids from 16,659 in Nov 2017 to 20,257 by Jan 2021 – since then this increase reversed and by Oct 2022 (16 months) 1,120 fewer patients were being prescribed, equating to 18 deaths avoided.

There is still work to be done to maintain and build upon this progress, but the outcomes of the programme so far show the importance of the collaborative community and we can use this way of working as a blueprint for addressing other challenges.

Case Study | Supporting the health of refugees

Healthwatch Derby have been working with Derby Refugee Action Centre to help support and inform visitors about the healthcare options that are available in Derby City, and how to access them. Workshops have promoted discussions about how to register with a GP, who else works within a GP surgery, and assisted with general enquiries on seeking mental health support with a language barrier and confusion around access, waiting times and members of staff involved when attending A&E. The most recent session was around Urgent Care pathways and where to seek help including information about self-care and pharmacies, accessing GP services, 111 online and telephone services, Urgent Care centres and the services that PALS and Healthwatch Derby provide. Topics are driven by the refugee and asylum seeker community, and conversation are a good opportunity to gather the experiences this community have already had when accessing health and social care services.

Case Study | Partnership work to support rough sleeping wins award

Tracey Cunningham is a First Contact Rough Sleeper Paramedic and is part of the Derby City Multi-Agency Rough Sleeper Hub (MARSH) multi-disciplinary team (MDT) that provides intensive support to people who are sleeping rough in Derby. Tracey works directly with people who are sleeping rough to triage, treat and enable them to access the services they need. The interventions that Tracey has delivered have led to a reduction in the need for people to be unnecessarily conveyed by ambulance to A+E and a reduction in inappropriate presentations at A+E. She has also supported wider public health programmes including delivering Flu and Covid-19 vaccinations. Tracey won the Community Heroes award at the MJ Awards for Local Government in recognition of the work that she does with a population of the community who find it difficult to access support and treatment.

4.4.6 Commissioning

Effective integrated commissioning is a key enabler for achieving the strategic aims and the population health objectives included in this Strategy. It relies on System collaboration, underpinned by a collective clarity on risk and reward mechanisms affecting each partner organisation. There are a number of opportunities to improve the effectiveness of integrated commissioning in the JUCD System, they include:

- Commissioning interventions that reduce "front door" pressures and release resources to increase prevention activities, reduce health inequalities and improve quality
- Colleagues leading the Key Areas of Focus for this Strategy to recommend changes in commissioning and funding arrangements that will facilitate achievement of their aims and objectives, including an increased focus on prevention and early intervention
- Progressing our engagement and partnership with the VCSE sector, including a focus on procurement and contracting approaches
- Ensuring alignment with the JUCD approach to PHM
- Developing our approach for delegation of commissioning and better define the strategic commissioning role of the ICB
- Reviewing and refreshing existing collaborative commissioning and joint funding arrangements and identify opportunities to consider whether needs could be more effectively met through pooled budget arrangements under S75 of the NHS Act 2006.
- Potential new flexibilities within national guidance for collaborative use of resources and the opportunities this may present to support delivery of the Strategy.

However there are risks and barriers to capitalising on these opportunities and these include:

- Continued short term operational issues which divert our resources and attention away from our longer term ambitions for prevention and early intervention
- Organisational priorities trumping JUCD System priorities
- Sub-optimal processes and governance
- Risk averse behaviours including a lack of risk appetite in strategic decision-making
- Funding allocations in the 'wrong' places and a lack of financial/ contractual incentives to change and address the points above

To facilitate progress against our integrated commissioning priorities and to address the risks and barriers noted above, the JUCD System will face difficult decisions, especially given the current financial and Covid recovery context.

However there is now a great opportunity to use the momentum associated with mobilising this Strategy and the collaborative capability of the new Integrated Care Partnership to overcome these difficult decisions and realise the opportunities for improvement.

Case Study | The Derby and Derbyshire Sexual Health Alliance

A major new forum - the Sexual Health Alliance (SHA) - was established in summer 2022, bringing together commissioners, providers and associated organisations including the voluntary and community sector operating within the local Sexual and Reproductive Healthcare (SRH) system. The SRH system both nationally and locally has become increasingly fragmented resulting in multiple challenges including:

- Lack of stability for the provider workforce during recurrent, lengthy and costly procurement processes
- Restrictions within service specifications risking innovative, patient-centred change at pace
- System failures where a service is decommissioned, putting additional pressure on other parts of the system
- Loss of efficiency due to separate system budgets where there is opportunity to collaborate
- Challenges for patients with multiple needs.

Derbyshire County Council and Derbyshire Community Health Services NHS FT (DCHS), lead provider of the integrated sexual health service (ISHS) entered into a section 75 agreement with Derbyshire County Council in April 2022. This commissioning model, providing a collaborative approach raised the need for a new system alliance of commissioners including Derby City and Derbyshire County Councils, NHS England and the Integrated Care System alongside providers and voluntary sector organisations.

The Alliance believes the business of sexual and reproductive healthcare is about system-wide trusted relationships and collaboration underpinned by patient need.

Evolving success is seen through increased partner confidence, for example securing additional investment for the Derby ISHS from Derby City Council. Further results include:

- a Joint Strategic Needs Assessment for sexual health
- a commitment to develop a Sexual Health strategy
- exploration of service pathways to provide seamless care to the patient's often multiple needs
- HIV Prevention
- under 25s sexual health - Chlamydia prevention, teenage pregnancy prevention, Relationship and Sex Education

Next steps will see the Sexual Health Alliance explore its relationship with the ICS and further collaborative work to maximise the sexual health and wellbeing of the Derby and Derbyshire population.

4.4.7 Quality drivers

In relation to safeguarding JUCD has a demonstrably strong commitment in working together with statutory partners, voluntary agencies and our service users/ community in keeping children and adults safe and to ensuring that services commissioned will be focused on the early identification of risk & vulnerabilities, providing early intervention and care in order to keep our service users safe from abuse and neglect.

Key quality topics include:

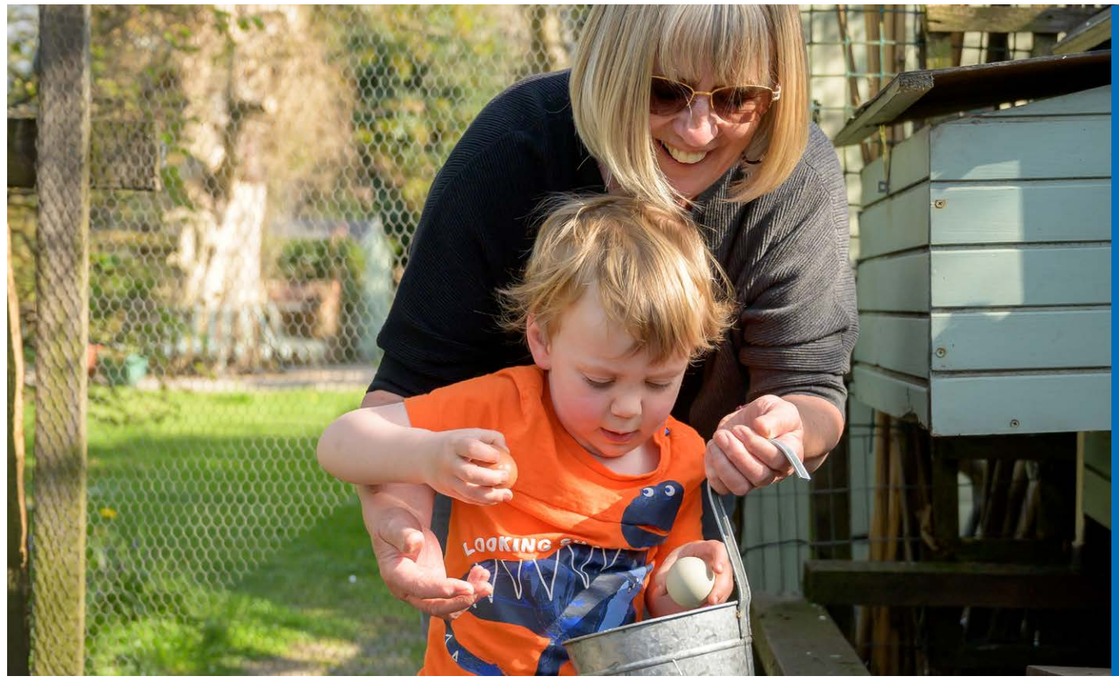
- Collaborative working between system partner patient experience and patient engagement teams to improve connectivity and alignment
- Bringing together system partners to align quality and equality impact assessments (QEIA) to develop care services that meet the needs of our population
- Bringing together health & social care partners to review and implement learning from LeDeR (Learning Disability Mortality) reviews.
- Reducing health inequalities for people with learning difficulties by bringing together system partners to increase the use of annual health checks with their local GP service
- In collaboration with system partners, NHS England, and the Kings Fund, JUCD is a pilot system in leading a project to look at experience of care across an ICS

Case Study | Nursing and midwifery forums

Joined Up Care Derbyshire has led on the creation of networks at the system and regional level to promote excellence in nursing and midwifery. The Nursing and Midwifery Excellence Forum comprises senior nurses and midwives from the Integrated Care Board, all NHS provider organisations within JUCD system, hospices, primary care, commissioning support unit and Derbyshire Health United, with plans to expand to include nurses in the care home and home care sector.

JUCD has also led on the development of a regional network to support the 11 Integrated Care Systems across the Midlands to share and learn from the successes of ward/unit and other accreditation programmes. This is consistent with the objectives identified in the NHS long-term plan and will involve staff in key decision-making and enable them to lead change which results in positive outcomes in areas of quality improvement, as well as in staff satisfaction, recruitment and retention.

These two initiatives stem from the Shared Governance: Collective Leadership (SG:CL) programme, which was launched in 2019 by England's Chief Nursing Officer (CNO). The programme aims to deliver the CNO's vision of collective leadership and one professional voice, and core components of the SG:CL are the development of local accreditation approaches and the commitment to support the sharing of best practice and learning across healthcare. JUCD has taken responsibility in delivering these two initiatives, thereby playing a key role in the CNO's project to help nursing, midwifery and care staff to identify opportunities for transformational change that will support delivery of better outcomes and experiences of those who use our services.



4.4.8 Estate

NHS, local authority services and organisations that deliver NHS contracted services in Derby and Derbyshire are provided in multiple settings and in multiple buildings. These services and buildings need to be fit for purpose in terms of being safe and appropriate environments for everyone who uses them. This takes a great deal of forward planning to ensure we are providing the right kind of accommodation to meet the evolving requirements of health and care services. By having the right kind of environments we can help to tackle health inequalities, promote a sense of wellbeing from being in well-designed spaces, reduce the carbon footprint involved in constructing, running and maintaining buildings, and ensure we are meeting our targets on sustainability.

The estate is a key enabler in delivery of the NHS Long-Term Plan; helping the System to transform by optimising the use of the estate, which can adapt to changing service models, and promote co-location and multiple occupancy of buildings with patient, people, places and partnerships as key drivers.

The main priorities for the Estates Strategy are:

- Transform places and services - prioritise & maximise the use of the best quality estate, which is modern, agile and fit for purpose to support patient care
- A smaller better, greener public estate - Create an estate which is more efficient, effective and sustainable through optimisation
- Partnership approach - Work with our partners to strengthen collaboration and benefit from multi agency working

5. Key Areas of Focus

5.1 Introduction

Three Key Areas of Focus have been selected by the Integrated Care Partnership to test in detail our strategic aims and ambitions for integrated care, in response to population health and care needs. The Key Areas of Focus align with the population health life-course approach described in **Section 3.3** and their scope incorporates improvement in prevention, early intervention and service delivery outcomes.

It is important to note that the Key Areas of Focus are not framed as priorities. They are not necessarily regarded as being more important than other topics, but they have been selected because;

- They offer broad scope to contribute to the achievement of the stated strategic aims for integrated care and have strong correlation to the strategies and plans referenced in **Section 2.2**
- The expected outcomes are critical to improving population health and care, as described in **Section 3**
- Success will rely on the planned improvements described under the strategic enablers in **Section 4**

The Key Areas of Focus are:

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

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

- **Age/ Die Well** - To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations

5.2 Start Well

Key Area of Focus

Aim

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

Rationale for inclusion as a key area of focus

It is important that children and young people can 'Start Well'. This aim links directly to the JUCD ambition to ensure 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 develop positive and healthy relationships. The overall approach will be preventative.

The Children and Young People's Delivery Board will undertake a pathway approach, incorporating prevention and early intervention that ensures connectivity across the system, and supports the Board's vision to *provide a seamless health, education and social care pathway for children and young people in Derby and Derbyshire - one that enables all children and young people to be healthy and resilient and, if support is needed, enables them to plan their care with people who work together, allowing them to achieve the outcomes that are important to them.*

The work will include a focus on the 20% most deprived population. The emerging 'plus' groups for this priority are teenage parents, homeless families, looked after children, children born at a low birthweight (due to factors during pregnancy), and children with special educational needs.

Derby, Derbyshire Child Health Profiles and benchmarking nationally indicates the need for this priority, and we are engaged with Healthwatch to ensure support for this priority from children, young people and their families. And a recent community consultation undertaken by Derby Health Inequalities Partnership exploring perceptions of health and inequalities, highlighted a key theme of respondents wanting to 'break the cycle 'of poor health in their communities with a focus on children and young people's health.

This priority is supported nationally via the requirements in the NHS Long term plan, 'Core 20 PLUS 5 for CYP' to reduce health inequalities and SEND (special educational needs and disabilities) statutory requirements. It is also aligned locally to the ICS strategy (overarching, in development), Health and Wellbeing Boards priorities (City and County), 'Turning the Curve' Priorities, Children and Family Learners Board priorities (Derby), Childrens Partnerships Priorities (County), Safeguarding Partnership, Healthwatch and local insight.

Key issues that will need to be addressed

- Improving staff retention and development is critical to success
- Service commissioning and provision is currently fragmented, and this priority will provide the momentum for better connectivity across the system and more effective and efficient working
- Existing governance is fragmented by organisation. Giving the CYP Delivery board greater authority and responsibility would ensure decision making is reflective of whole system impact and focus on the long-term vision of both JUCD and the Delivery Board
- Importance of setting behaviours in young children and setting foundations for good health
- A seamless pathway approach to support and care with empowerment given to children, young people and their families from an early age will ensure efficiency is achieved, and the effectiveness of service delivery will be improved
- A review of the current workforce position (including the VCSE sector), the need to map future staffing, describe the shift required, and ensure plans are developed to achieve the shift needed
- Digital and data, particularly the sharing of data across the system will be critical to success, with access to timely and sub-system level data to inform planning. Information governance processes are key to enable effective information sharing across agencies
- Maximising the beneficial impact of communication and engagement

Suggested measures for improvement

- School readiness: the % of children achieving a good level of development at the end of reception.

This is published nationally and annually in the Public Health Child Health Profile data that is measured at the end of Reception year. It includes several dimensions and is impacted by a range of sub-indicators: those related to the family (maternal mental health, homelessness, family income and parental education), the child (low birth weight, health status and immunisation rates) and services (quality and availability of funded early education) among many others.

Case Study | Medical Consumables at home

To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness. Many children are born with or develop lifelong health conditions. Around 90 children across Derby and Derbyshire are cared for at home with continuing care packages where care support is provided at home to support parents and ensure the child can live at home with their family.

Some conditions are so complex that they require medical consumables which range in size from swabs or bandages through to the water bottles needed for ventilators. This is known as the Kids in Their Environment programme, and is led by University Hospitals of Derby and Burton NHS Foundation Trust.

Some families in Derby City do not speak or write in English, but the new service required families to complete order forms requesting what consumables they were running low on at home. To tackle this challenge, the ICB worked with the provider of the service, Medequip, to develop picture forms so families could indicate by the picture on their 'prescription' to complete their order. This ensured they could get the consumables they needed as easily as English-speaking and writing families.

5.3 Stay Well

Key Area of Focus

Aim

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

Rationale for inclusion as a Key Area of Focus

Evidence shows these three clinical conditions are the leading cause of early death and time spent in ill health for the population of Derby and Derbyshire. This is the fundamental rationale for prioritising the prevention and early identification of these conditions to collectively contribute to ill-health avoidance and improve outcomes for the local population.

Reducing morbidity from the three clinical conditions through a prevention approach will reduce and manage the demand on resources required for treatment of later stage disease, thus improving the sustainability of the JUCD System.

JUCD has expressed a clear intention to reduce inequalities in outcomes, experience, and access. For example, identifying groups experiencing inequity of access to preventative services, and using this insight to inform subsequent targeted action to redress this.

Preventing ill health is beneficial for population wellbeing and reduces demand for NHS services. Prevention has been identified in both The Marmot Review (updated 2020) and the NHS Long Term Plan (2019) as a key objective to reducing health inequalities and its associated social and economic costs. Preventative interventions such as cardiac rehabilitation have been shown to reduce non-elective admissions (NHS England, 2019). Early cancer diagnosis leads to increased survival, which can reduce financial impact, both on healthcare resources but also on an individual's ability to work and support their family (World Health Organisation, accessed 03/2023).

Local insights identify prevention as a priority, for example:

> **"People welcome the move to focusing on the wider determinants of health but feel that priorities still reflect improvements in services, rather than wealth, education, and prevention."**

Key issues that will need to be addressed

1. Ensure population health management drives our work in the areas of prevention, early identification, and reducing health inequalities
2. Embed prevention and early intervention into our thinking for the prevention and management of key long-term conditions
3. Existing governance and delivery arrangements are currently organisation-centred which can inhibit system collaboration and added value of working across organisations to a single, shared aim. A move to JUCD objective focussed governance arrangements, incorporating all key partners (such as the VCSE, the Police and Criminal Justice System, housing services, transport services, local employers etc.) will be key to delivering the prevention approach
4. Ensure all partners understand their role and contribution to prevention and early intervention
5. Ensure resources including workforce and finance are increasingly focused over time towards prevention, acknowledging the short-term challenge but long-term benefit
6. Ensure all staff have the required capability and capacity to be able to deliver against the identified Key Area of Focus. For example, expand the use of a health coaching and strengths-based approach within service models
7. Ensure the JUCD partner organisational infrastructure (e.g. IT networks, estates etc.) enables cross-organisation / System working
8. Ensure service and System developments adopt a community-focussed approach by default (e.g. engaging with population groups identified as experiencing inequity in access, experience, and / or outcomes, to understand how to best meet their needs)
9. Ensure access into services is tailored to meet the needs of the population. In particular in our more deprived areas and for population groups who are identified as currently under-served
10. Ensure coordinated, consistent and joined up communications support using appropriate media channels, tailored to meet the needs of the target population to improve health

Suggested measures for improvement

Long term outcomes:

- Contribute to reducing the life expectancy and healthy life expectancy gaps between the most and least deprived people in Derby and Derbyshire
- Reduce preventable premature mortality caused by CVD, cancer and respiratory disease

Short-medium term outcomes:

- Identify and subsequently reduce identified inequalities in access to associated services, experience and outcomes from each service, for each condition
- Adopt a joined-up population health management approach and undertake targeted primary, secondary, and tertiary prevention activity to positively affect the drivers (risk behaviours and risk factors) that contribute to the three identified conditions

Progress will be monitored against a set of metrics by demographic profile. It is anticipated this will be agreed by System partners, including identifying those directly aligned to a specific partner (e.g. smoking cessation rates), along with those that some/ all partners can contribute to (e.g. referrals to smoking cessation services).

Case Study | Hypertension

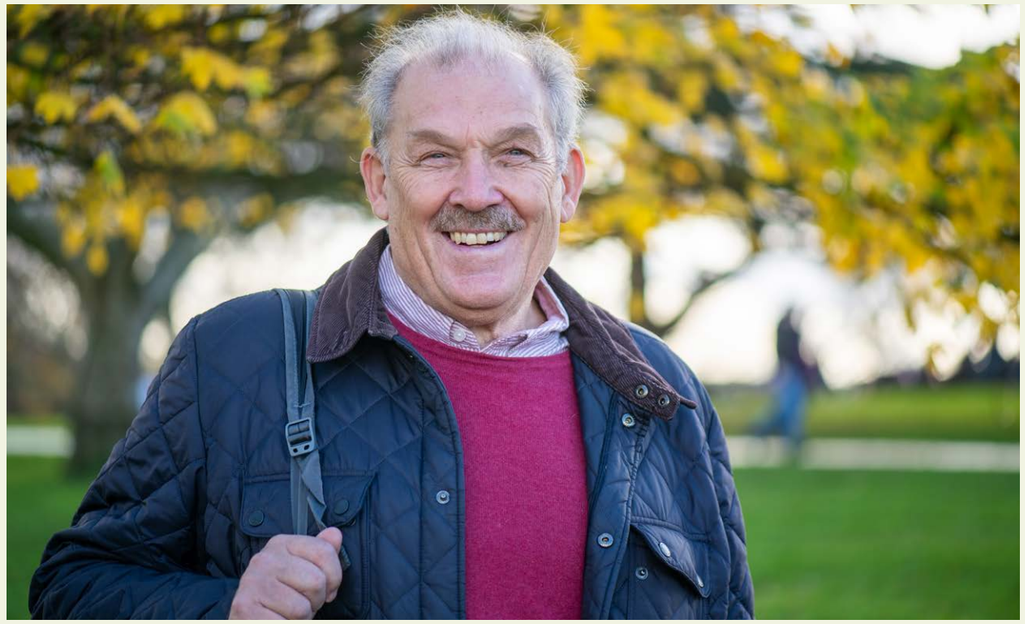
Hypertension (high blood pressure) significantly increases the risk of heart attack, stroke and other cardiovascular-related issues, diagnosing hypertension early means it can be treated, reducing the risk of potentially life-threatening situations.

In Derbyshire, there is an estimated 22,068 people who are undiagnosed with hypertension and within Derby City this estimate is 9,656. Joined Up Care Derbyshire is working hard to identify people with hypertension and therefore reduce the number of heart attacks, strokes and cardiovascular issues.

As part of the work, relationships have been developed with NHS Derby and Derbyshire, Community Action Derby, Derby Health Inequality Partnership (DHIP), LiveWell Derby, Live Life Better Derbyshire and local community pharmacies. We are keen to develop this work in partnership with those who already have trusting relationships with the communities we are trying to reach.

Together with Community Action Derby and DHIP, we have developed a bespoke engagement and communication plan which will gain insight into the knowledge and understanding of hypertension, barriers to blood pressure checks, preferred methods of communication, and where people would like pop-up clinics to be delivered. Pop-up clinics are being delivered by LiveWell Derby, Live Life Better Derbyshire and local community pharmacy teams. Community pharmacies will be working to increase blood pressure checks by addressing barriers such as access and also offering advice to patients. NHS Derby and Derbyshire has funded training to community leads who can offer blood pressure checks in the community and signpost patients to the relevant service if the patient has high blood pressure.

Through this partnership working, we hope to improve education around high blood pressure, inform people of the risks and how they can be reduced, and actively increase the number of patients diagnosed with hypertension so steps can be taken to treat them.



5.4 Age/Die Well

Key Area of Focus

Aim

To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations.

Rationale for inclusion as a key area of focus

A key ambition is a 'left shift' of care so that focus is increased on maintaining functioning and independence. Prevention and proactive identification of patients, combined with risk stratification, and effective care planning provides the best approach to supporting those patients and carers who have the most complex needs; this enables them to take an active part in decisions concerning their health and wellbeing and subsequently reducing the demand for health and social care services. When more critical episodes of care occur it is necessary to have responsive integrated community provision available so that acute admissions happen when it is the best option, not because it is the only option.

A fundamental principle of the proposed programme of work (and the leadership and delivery through place based working) to respond to this priority is a strength based approach in terms of the individual, the teams that are supporting and the communities they are part of.

The main vehicle for improving outcomes in this priority area is building integrated local planning, service responses and support in the community (including statutory services, VCSE, independent care providers, individuals and communities). Whilst the value of more integrated, locally delivered care will benefit many (if not all) groups it is particularly evident for those living with frailty and at the end of life.

The selection of this priority builds on engagement with the population over a number of years which has identified themes in terms of what is important to them, to keep them well, and their expectations from services. Derbyshire people have identified being able to stay in their own home for as long as it is safe to do as the most important thing to help them keep their independence and stay healthy as they get older (Healthwatch Report – 2019).

The approach to implementation will draw upon guidance in national publications, for example, "Next Steps for Integrating Primary Care: Fuller Stocktake Report (2022), NHS England Proactive Care Framework (2022/23), and the British Geriatrics Society report – "Joining the Dots (2023): A blueprint for preventing and managing frailty in older people" and from national sources of support including the Social Care Institute for Excellence (SCIE).

Key issues that will need to be addressed

- Support when navigating health and care – 'no wrong door' - Any point of access to the health and care system should be able to direct the user or carer to the right place
- Joined-up communication – tackle conflicting information, the need to repeat information and inconsistencies, helping staff understand the wider needs of the service user and carer, beyond the condition they are seeking help for
- Working together to reduce the potential tension regarding organisational sovereignty as demonstrated through individual policies, procedures, cultures etc. alongside the need for teams of people to work together with shared processes
- Trust – between groups of staff, and also service users' confidence in staff as advocates. Addressing the impact that existing cultures across organisations and teams have on the ability to make this shift will be an important factor to consider
- Governance mechanisms established through Place and a number of connected programmes of work needs greater ownership, visibility and system backing, if we are to affect the longer term necessary shift to improved population health and slow growth in demand. Our current governance structures don't always effectively support 'distributed responsibility' and working across teams
- The form and pace at which new financial models and mechanisms for collaborative commissioning can be developed and which may need differential allocation. Ensuring commissioning processes are aligned and reward the right things
- Further developments in workforce planning to better meet the needs of the population who are ageing or at the end of their lives
- The ability to access and update a single record to support the care of an individual, and to prevent individuals and their carers having to repeat information to many agencies and staff having to waste time updating multiple systems
- An embedded model for using Population Health Management data to plan and target provision
- The VCSE sector is vital in understanding and meeting the needs of this population
- Co-location of teams that are working together / serving the same cohort
- Ongoing and increasing commitment to ensuring subsidiarity and local determination of delivery

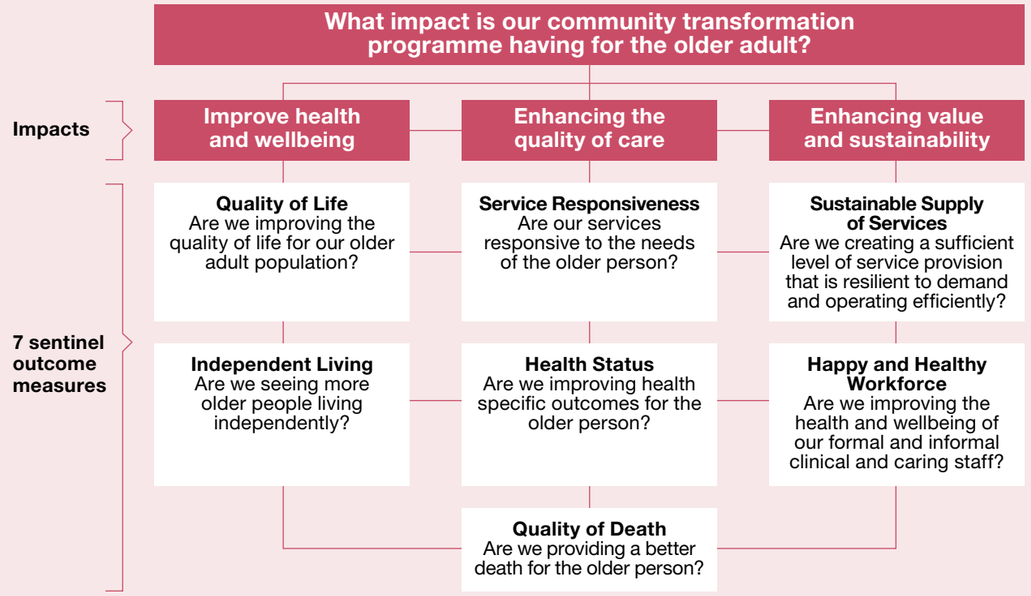
Next steps

Work is already underway to develop a strategic operating framework for organising the System's response to the issues stated above, building on the success of existing local services, including Team Up, with the further development of integrated community teams. External support has been commissioned to help identify and codify the improvement opportunities.

Suggested measures for improvement

It is proposed that 'measurement activities' for this priority are organised under 7 sentinel outcome measures – please see figure below.

There is also a National Integration Index planned to be rolled out in 2023 that will help us understand the level of integration and the impact / benefits experienced by citizens.



Case Study | Teaming Up our Urgent Community Response

Sometimes when people are unwell at home, they don't need a hospital admission to get the right diagnosis or treatment, but keeping them safe at home needs input from many services, for example a GP, a district nurse, physiotherapist, and social care. Traditionally these services have been separate and often too slow to get everything in place in time to keep people out of hospital.

Team Up Derbyshire integrates these services to act as one Urgent Community Response. This response can rapidly get everything in place to support people at their time of need, help them back to their previous (or better) level of health, and then put plans in place to minimise the risk of future crisis.

For example, a 68 year old man who suffers with a lung condition, panic attacks and weakness from a previous stroke rang for help because he was short of breath. He was bedbound and anxious, but his breathlessness was not severe enough to need hospital treatment.

The 'Teamed Up' Urgent Community Response treated his chest infection with antibiotics and physiotherapy, and they arranged carers and equipment into his home which allowed him to stay there safely.

In the following days as he recovered, they spent time to make sure he was better supported in his home and put plans in place to catch things earlier the next time. He is no longer bed-bound, feels in control of his health and is therefore much less anxious. He has not called emergency services since.

6. Engagement

6.1 JUCD approach to engagement

A key hallmark for this Strategy is;

We will develop a broad and deep engagement approach to inform the further development of the Strategy and relevant implementation plans

Gathering insight from our diverse population about their experiences of care, their views and suggestions for improvement of services, and their wider needs in order to ensure equality of access and quality of life is a key component of an effective and high performing Integrated Care System (ICS). These insights, and the diverse thinking of people and communities will be essential to enabling us to tackle health inequalities and the other challenges faced by the JUCD System.

As a result, JUCD has developed a strategic approach to engagement, which includes key principles and frameworks that will underpin our ways of working. It sets out how we will listen consistently to, and collectively act on, the experience and aspirations of local people and communities within JUCD. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

Our Ambition is:

- To embed our work with people and communities at the heart of planning, priority setting and decision-making to drive system transformation work, ensuring the voices of patients, service users, communities and staff are sought out, listened to, and utilised resulting in better health and care outcomes for our population
- To recognise that relationship building is important to increase trust, improve involvement, and needs to be considered on a planned, systematic, and continuous basis, with the required investment of time
- To ensure continuous engagement that reflects this new relationship with the public, capitalises on those emotional connections and brings people and communities into the discussion rather than talks to them about the decision

In order to ensure we have a systematic approach, our engagement with people and communities is supported by several frameworks. These frameworks are in different stages of development and co-production with system partners, including people and communities, and are described in Appendix 3.

6.2 Engagement approach undertaken to underpin the development of the Integrated Care Strategy

An engagement workstream for the ICS Strategy including representation from health, local authorities, Healthwatch and the VCSE Alliance, has overseen the development of an 'Insights Document' that pulls together insights into one place from our Patient and Public Insight Library. It highlights high-level themes under the following headings - Integration, Health Inequalities, Quality/Improvement, Strengths Based/ Personalised Care and Health Protection, and Understanding Public Behaviours, Choices, and Attitudes.

The Insights Document was considered by as part of the evidence base for the selection of Key Areas of Focus, to ensure the selected areas align with already captured views of citizens and relevant system groups.

6.3 Engagement approach to underpin the mobilisation of the Integrated Care Strategy

6.3.1 Initial engagement activities – February to May 2023

JUCD engagement platform

Each area of focus has its own space on a digital platform developed by the JUCD System (Derbyshire's Integrated Care System Strategy (derbyshireinvolvement.co.uk). The platform provides a variety of interaction options for members of the public including a question and answer facility, links to surveys, polls, provision of updated information, uploading of videos, and links to other websites. It is recognised that this approach may disadvantage digitally excluded individuals and so other methods are necessary to ensure inclusivity.

Derbyshire Dialogue

Launched in September 2020, the ‘Derbyshire Dialogue’ was set up to start a conversation between our residents, and those commissioning and providing services to update them on the response to the Covid-19 pandemic but has now broadened its remit to include all manner of different topics.

Through this forum, our residents can discuss their experience of services, what’s been helpful, what could be improved, and what matters most to them in their design and delivery.

A Derbyshire Dialogue session was held on 15 February 2023 to outline the purpose and content of the Draft Integrated Care Strategy and gather comments on the content and the proposed engagement process. Further sessions will be arranged to help assess progress and effectiveness of the engagement process.

Key Area of Focus briefing and discussion events

Two initial briefing and discussion events are being held in May (one day time and one evening) for each Key Area of Focus to introduce them in more detail, and to initiate discussions with VCSE and patient representative groups, and the wider public.

6.3.2 Addressing digital exclusion in our engagement approach

We need to ensure that an inequity is not created for people that are impacted by IT access issues and equipment, including broadband connectivity, wifi, affordable data packages.

Stage one of the engagement approach for this Strategy has involved reviewing what we already know, using the insights gathered nationally, regionally, and locally over the past 2 years to see what matters to people and what people have been telling us. The reports and insights that fed into the JUCD 'Insights Document' were from System organisations and groups and many of the reports discussed digital exclusion or resulted from engagement with digitally excluded groups.

The next stage of involvement – the initial live briefing and discussion events for the Key Areas of Focus are all on-line and are open to all the public. We have developed bespoke stakeholder mapping to target groups or organisations that represent or engage with people who experience digital exclusion to attend these sessions.

However we are clear that these sessions are just the start of the conversation, and each Key Area of Focus engagement plan will need to be individually tailored to meet the needs of the target population. Digitally excluded groups along with other seldom heard groups will be considered and involved throughout this process and development.

6.3.3 Subsequent engagement activities – May 2023 onwards

Engagement after these events will naturally develop to follow up on feedback from the initial engagement activities and gaps/ issues identified by attendees. More in-depth and bespoke methods of engagement will be developed in line with the needs of each Key Area of Focus and to help address gaps/ issues flagged.

7. Strategy Mobilisation

7.1 Context

The mobilisation of this Strategy will align with the development of relevant JUCD and local authority planning documents, as described in **Section 2.2**.

As stated in **Section 4** the Integrated Place Executive (IPE) will oversee delivery of the Strategy on behalf of the Integrated Care Partnership (ICP). In support of the IPE a multidisciplinary and multiorganizational working group that has overseen the collaborative development of the Strategy to date, will continue to operate to ensure mobilisation is organised and delivered in a similarly collaborative manner. The group includes senior leadership representatives from Derby City and Derbyshire Local Authorities, NHS providers, the JUCD Integrated Care Board, and the VCSE Alliance.

7.2 Change management

The achievement of our strategic aims and Start Well, Stay Well, and Age Well/ Die Well ambitions will require large-scale change within the context of a complex adaptive system environment. Leaders will therefore need to consider the right balance between the use of ‘planned’ and ‘emergent’ change management approaches and focus on how partners work together, linked to culture and behaviours. This means a ‘one-size fits all’ change management approach will not work, and the IPE will have a key role to play in supporting and facilitating the right conditions for emergent change to flourish.

The availability of suitably skilled and experienced programme and change managers will be a key factor in determining the pace at which improvements take place. A capacity assessment is currently taking place.

7.3 Mobilisation plans and timescales

'Route Maps' for each Key Area of Focus are being developed to demonstrate scope, objectives, planned actions, timescales, expected outcomes and governance arrangements, against which the relevant JUCD System forum (e.g. CYP Board for Start Well) will monitor progress. Please see **Appendix 4** for the minimum Route Map content. The leads for the Key Areas of Focus will work collaboratively with enabler leads to test and implement the enabling solutions (see **Section 4**) that are pivotal to delivering our ambitions.

The Route Maps will be agreed by 31 May 2023. This provides time to review and agree a prioritisation of actions that reflects national and JUCD System level drivers, and citizen insights, including the outputs from the initial public engagement sessions being held in May.

7.4 Role of the Integrated Place Executive (IPE)

The key role for the IPE will be to oversee progress and help address challenges in relation to the strategic enablers described in **Section 4**. This ensures there is a single point in the JUCD System where key enabling opportunities and constraints for integrated care are collated, managed, and where necessary escalated to other System Boards.

There are multiple, difficult challenges that will need to be overcome to achieve the strategic aims for integrated care, many of which will require system-level resolutions. The IPE will have the primary responsibility for developing resolutions to challenges that are beyond the governance and decision-making scope of the forums that oversee the Key Areas of Focus and strategic enablers.

7.5 Feedback from engagement to date

A wide variety of information sharing, and initial engagement sessions are taking place through local authority, NHS, Healthwatch and VCSE forums (see **Appendix 3**), and with the public (see **Section 6**). These reflect the start of the engagement process for the Integrated Care Strategy.

As referenced in **Section 6** the JUCD digital platform includes an area dedicated to the Integrated Care Strategy and incorporates a question and answer facility, the content for which can be accessed via the following link - Derbyshire's Integrated Care System Strategy (derbyshireinvolvement.co.uk)

The updated content in this document reflects feedback received through the engagement activities referenced above, and mobilisation plans will need to assess and act upon feedback received to date and moving forward. Some of the key points made to date are included below along with a summary of how the points have been responded to in this version of the Strategy and/ or will be addressed during mobilisation:

- **The need for simple, easy to understand summaries of the Key Areas of Focus plans, so members of the public can understand the scope, intended actions and impact**

  See **Appendix 4** for inclusion of this requirement in the Route Map submissions required for the Key Area of Focus.

- **The need for a clear articulation of the 'so what' – how things will change, when, how, etc.**

  Some information is included in **Sections 4 and 5** of this document, however the mobilisation plans will provide more granular information – see Appendix 4 for the initial requirements being asked of each Key Area of Focus.

- **Question as to why there is not a separate Key Area of Focus for improvements in mental health given prevalence and impact, and what actions to improve the health, and increase the life expectancy of people with a learning disability will be prioritised**

  Mental health and the health and care for people with a learning disability will be a key theme running through each selected Key Areas of Focus, and the Route Maps (**Appendix 4**) and subsequent mobilisation work will demonstrate expected contributions. There are some initial references included in the Strategy e.g. a focus on children with special educational needs (**Section 5.2**), however the mobilisation plans will provide the detailed information.

- **Access to suitable, affordable, and safe housing needs to be prioritised as a key determinant of health**

  This is one of the Turning the Curve population health indicators included in **Section 3** and will therefore be addressed in improvement plans for the three Key Areas of Focus.

- **General practice is fundamental to integrated care and resource distribution should reflect this**

  Please see **Section 2.2.8** in relation to primary care challenges and opportunities.

- **Healthwatch organisations need to be integral to engagement and to support evaluation of the Strategy**

  This has been discussed with both Healthwatch organisations and current activities and commitments are included in the document (see **Sections 1.4, 6 and 8**), whilst recognising the capacity constraints which will affect the scale of input available from both organisations. Opportunities are currently being explored for further collaboration.

- **A focus on wider benefits including contributions to employment, through the Key Areas of Focus**

  Section 2.2.10 describes how the work of the Derby/ Derbyshire Anchor Partnership needs to be incorporated into the mobilisation plans for this Strategy, including one of the Partnership's two impact areas – workforce and access to work. The point flagged also relates to one of the Core Purposes of the JUCD Integrated Care System – *Help the NHS support broader social and economic development*, and the contribution of this Strategy to this broader development will need to be picked up under the 'System' section of the developing Evaluation Framework (**Section 8.1**).

- **Emphasising the need for high quality end of life care in a person's place of choice**

  Quality of death is one of the 7 sentinel outcome metrics included in the measurement framework for the community transformation programme under the Age Well/ Die Well Key Area of Focus – see **Section 5.4**. End of life improvement work, under the stewardship of the Integrated Place Executive, will oversee actions for providing a better death for the older person.

- **If there are commitments on cost or time for any participant within the care system this may result in some resistance to change. How would the JUCD manage this?**

  The mechanisms for how funding is allocated and how these mechanisms may need to change is a key challenge referenced under Commissioning (**Section 4.4.6**) in the Strategic Enablers section of the Strategy.

- **Need to elevate the need for high quality population health management techniques and data to support the targeting of resources to the relatively small % of the population that consumes a very significant % of resources" and to ensure interventions are co-ordinated across all relevant bodies and organisations that can support people who are most dis-advantaged e.g. education, police, housing.**

  Please see **Section 4.4.5** Knowledge and intelligence capability including population health management.

- **A key challenge for the successful implementation of the Strategy will be the agreement of changes in commissioning and funding arrangements to facilitate a systematic 'left-shift' to prevention and early intervention.**

  Please see **Section 4.4.6** Commissioning

- **There needs to be more insight from communities so 'community voice' is frequently and regularly heard through the ICS Strategy development and ongoing implementation.**

  The content of the 'JUCD Insight Document' has been taken from reports and insights from across the City, County and nationally, many of which emanated from local communities. These reports have been collated through multiple sources, including City and County Healthwatch, Derby Health Inequalities Partnership and the Integrated Care Board Patient Experiences team, and have influenced the direction of this Strategy and the selection of the Key Areas of Focus.

  There will be stakeholder mapping for each Key Area of Focus to identify gaps in knowledge, and to facilitate targeted engagement within communities to help develop the work programmes. This will be a layered and continuous approach, looking at different methods that can be tailored to the communities being engaged. We are starting with briefing and discussion events that are open to the public and targeted to involve relevant community groups and organisations. These sessions are an introduction and a space for people to ask questions and to start exploring the next stages.

- **Consideration needs to be given to better aligning strategies, plans and care delivery with Integrated Care Systems that are neighbours to Derby and Derbyshire, given the flow in and out of the System of patients and citizens.**

  This point will be incorporated into the Route Map requirements for the Key Areas of Focus and where applicable the change plans for the enabling functions and services, noting this is an issue that has been raised through engagement with Derbyshire Dialogue and the Derbyshire Health and Wellbeing Board.

8. Evaluation

8.1 Introduction

It is key to have an evaluation framework in place prior to full mobilisation of the Strategy. A Task and Finish Group is currently developing the Framework (to be ready by start of June 2023), with VCSE sector, NHS, Healthwatch, and local authority representation, supported by links into academic institutions.

It is currently proposed that the Framework will incorporate three categories of outcomes to shape the evaluation which align to the outcome categories used in the Social Care Institute for Excellence (SCIE) Logic Model for Integrated Care:

- Experience (covering citizens, users, staff experience) – including monitoring progress against the integrated care 'I/ We' statements referenced in **Section 1.3**
- Service e.g. metrics covering inequalities, Turning the Curve population health indicators, and service performance metrics
- System e.g. streamlined decision-making, implementing strength based approaches, increased collaboration & sharing of resources, left shift of funding, improved efficiency. Some of these changes will be more felt than recorded, and therefore will be more challenging to measure

Leads for the Key Areas of Focus and for the strategic enablers will be asked to review and build on previous/ existing evaluations relating to their areas, and establish new measures, under the Framework headings.

Support will be provided to Leads under each of the outcome categories, and reporting arrangements will feed into the JUCD "E-PMO", the system level programme management office, which will include domains for the three Key Areas of Focus.

Turning the curve indicators

Reduce smoking prevalence
Increase the proportion of children and adults who are a healthy weight
Reduce harmful alcohol consumption
Improve participation in physical activity
Reduce the number of children living in low-income households
Improve air quality
Improve self-reported wellbeing
Increase access to suitable, affordable, and safe housing

Plus 5 indicators

- Maternity in minority ethnic and deprived groups
- Severe mental illness (SMI) and Learning Disabilities: annual health checks
- Improving Vaccination uptake and reducing inequalities
- Early cancer diagnosis
- Hypertension case-finding

Enablers

Workforce
Digital and data
VCSE sector
Carers
Strengths-based approaches
Population health management
Commissioning
Quality drivers
Estate

Area of Focus 1 – Start Well

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

Area of Focus 2 – Stay Well

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

Area of Focus 3 – Age Well/Die Well

To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations

Appendix 1

How our health strategies and the Joint Forward Plan link together

Shaping Our Health

How all our Health Strategies link together

Joint Strategic Needs Assessment

This identifies the health needs of Derby and Derbyshire People.

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

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

Integrated Care Strategy

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

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

Joint Forward Plan

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

It is written by our Integrated Care Board*

Joint Local Health and Wellbeing Strategy

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

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

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

Individual Organisational Strategies

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

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

Key

- Local Authority
- NHS
- Voluntary Sector

Definitions

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

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

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council

Appendix 2

Summary of engagement with the JUCD System on the Draft Strategy

Forum	Date
Voluntary Community and Social Enterprise Sector Alliance	2/2/23
Integrated Care Partnership	8/2/23
Integrated Care Board Senior Leadership Team	13/2/23
Integrated Care Board – Board development	16/2/23
Integrated Place Executive	23/2/23
Derbyshire County Council Corporate Management Team	28/2/23
East Midlands Ambulance Service NHS Trust Executive Team	TBC
Derbyshire County Adults Health Scrutiny Committee	6/3/23
Derbyshire Healthcare NHS Foundation Trust Board	7/3/23
Healthwatch Derbyshire Board	13/3/23
University Hospital of Derby and Burton NHS Foundation Trust Board	14/3/23
Integrated Care Board – Public Board	16/3/23
GP Provider Board	16/3/23
Clinical and Professional Leadership Group	21/3/23
Healthwatch Derby Board	22/3/23
Integrated Care Board Public Partnership Committee	28/3/23
Derbyshire Health and Wellbeing Board	29/3/23
DHUHealthcare Partner Board	5/4/23
Derbyshire Community Health Services NHS Foundation Trust Board	6/4/23
Derby City Council – Adults and Health Scrutiny Review Board	18/4/23
Integrated Care Partnership	19/4/23
Voluntary Community and Social Enterprise Sector Alliance	TBC
Derby City Health and Wellbeing Board	TBC May
Derby City Council – Children and Young People Scrutiny Review Board	TBC

Appendix 3 Engagement Model

Governance Framework - This examines the structures that provide the interface between people and communities at all levels of the ICS, allowing insight to feed into the system, to influence decision making. This is also about making sure appropriate assurance frameworks are in place for ensuring we implement the principles outlined in our Engagement Strategy across the system. It includes our Patient and Public Partner Programme, our Guide to Patient and Public Involvement in the ICS, and the development of our Public Partnership Committee.

1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS	**2.** Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions	**3.** Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect	**4.** Build relationships with excluded groups, especially those affected by inequalities	**5.** Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners
6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust	**7.** Use community development approaches that empower people and communities, making connections to social action	**8.** Use co-production, insight, and engagement to achieve accountable health and care services	**9.** Co-produce and redesign services and tackle system priorities in partnership with people and communities	**10.** Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places

Engagement Framework – This includes the methods and tools available to all our system partners to support 'continuous conversations' with people and communities in transformational work to improve health and care services. This includes our Citizens' Panel, Online Engagement Platform, PPG network, Readers Panel, Public and Patient Insight Library and Derbyshire Dialogue. The model we use for our Patient and Public Insight Library, has been promoted by NHS England as good practice, and a template has been created to allow other systems to duplicate it.

Co-production Framework - This is our work to embed, support and champion co-production in the culture, behaviour, and relationships of the ICS, including senior leadership level. Drawing together good practice from around the system we plan to co-produce a co-production framework and are in the process of setting up a task group, which will include patient and public partners.

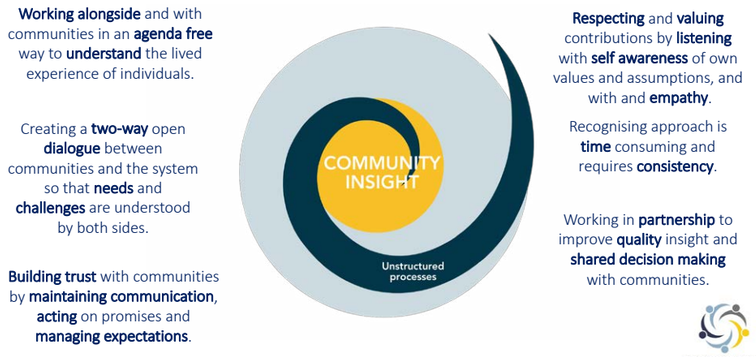
Evaluation Framework – This is being created to allow us to reflect on and examine our public involvement practice and the impact this has both on our work, but on our people and communities. The Evaluation Framework will outline how we will measure and appraise our range of methods, and how this will support ongoing continuous improvement.

Insight Framework - The Insight Framework is the most exciting development so far and looks at how we identify and make better use of insight that is already available in local communities to inform the work of the ICS.

Many communities already have established mechanisms of finding out what's important to people, with regards to their wants, needs and aspirations. We will be seeking to harness and examine that insight and present it in a way that will enable the ICS to listen to and take action, to truly put the voice of people and communities at the heart of decision making.

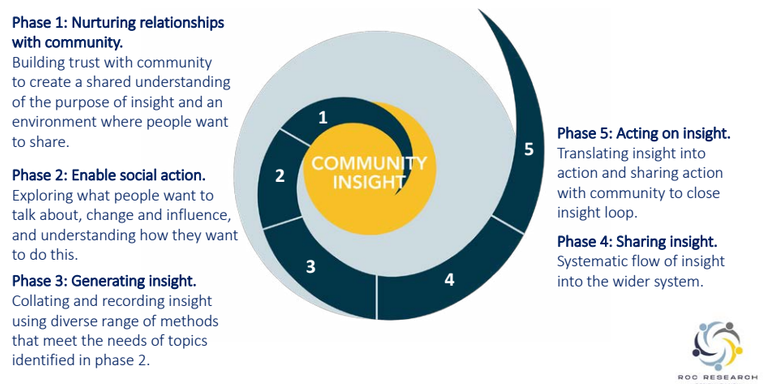
This approach is about authentic collaboration with communities without a pre-set agenda and will require that we are brave and believe that people know what they need to be well and happy. It will also require us to align our governance structures to support community led action.

Community Insight: What is understood about good unstructured insight



A key part of the Insight Framework is our process map outline which outlines 5 phases, please **see figure below**. We plan to co-produce what good looks like in all 5 phases of our model, and then build on strengths-based approaches that are already out there in communities to support them to overcome the barriers that we know they currently encounter. This work will be centred around Place and support the ambition to be a social model that is outcome driven and strength based; focussing on the assets of individuals and communities and developed with them through local leadership.

Community Insight: Exploring a potential process map for unstructured insight



Appendix 4

Route Map requirements for Key Area of Focus mobilisation

Key Area of Focus (KAOF) leads are being asked to capture some minimum requirements in the form of a Route Map, to provide clarity on the 'what' and the 'how' for each KAOF. The aim is to not stifle innovation or drown leads in programme management requirements, however some consistency and visibility of progress will be required for the IPE and ICP to undertake oversight, so minimum requirements are proposed as a starting point;

1. Simple, easy to understand summary so members of the public, voluntary sector can understand the scope, intended actions and impact
2. Scope – including the population cohort / inequalities 'plus' groups that will be the focus of improvement work
3. Clarity on how mental health and people with a learning disability will be supported through this work. To be included given concerns aired that a KAOF solely focused on mental health has not been selected
4. Reports, strategies and sources of intelligence – identify the relevant national and system strategies, reports, data and insights that will inform the development of the improvement opportunities
5. Key improvement opportunities – that are available to develop, manage and deliver services to achieve better outcomes
6. Key enabling actions – agree approaches with enabler leads for taking forward key actions
7. Portfolio of improvement projects that respond to the improvement opportunities
8. Expected outputs – noting specificity will vary, depending on the complexity of change.
9. Outcomes
10. Reporting – agree with E-PMO how reporting will be captured
11. SRO, lead forum, decision-making and course correction arrangements (managing risks, issues, and difficult decisions, including those that require escalation to the IPE)
12. Capacity & capability – confirm what is available and identify the gaps e.g. programme management, service improvement & change management, analytics
13. Alignment - The 'offer to' and 'ask of' JUCD organisations, and need to align with other forums, strategies, JUCD planning documents
14. Learning approach – identify good practice examples to learn from, and ensure there is a process in place to capture learning real time

Appendix 5

Our Position: 5 Clinical Priorities At A Glance within LTP

Compared to England: Better 95% Similar Worse 95% No data

Location	Hospital admissions asthma (<19 yrs)	Hospital admissions diabetes (<19 yrs)	Hospital admissions epilepsy (<19 yrs)	% 5 year olds with dental decay	% school pupils with SEMH needs
Derby City					
Derbyshire					

Locally we are:

1. Benchmarking: local prevalence of asthma and areas of poor air quality with links to higher rates of hospital attendances.

2. Action plan which is system side, with clearly defined deliverables for each organisation including housing and air quality.

3. Piloting the asthma friendly school approach in two identified inner city schools where asthma prevalence is 5x higher than local average.

4. Implementation of the CYP asthma bundle steered by the Derby and Derbyshire CYP asthma network.

1. Benchmarking: local prevalence of diabetes in children and young people.

2. Linking work around diabetes to that of obesity and community engagement pilot on encouraging moving more in some of our least active communities.

3. Part of the editorial group on best practice for children diagnosed with diabetes.

4. Ensuring that areas of deprivation that under-utilise CGMs are understood and clear system wide actions for improvement.

5. Participating in a nationwide CYP pilot at UHDB to improve paediatric transition to adult services.

1. Benchmarking local Audit 12 data and development of action plans.

2. Supported national work in the development of the CYP Epilepsy Bundle.

3. Creation of CYP system network for Epilepsy.

4. Reviewing service specifications to ensure smooth clinical pathways which meet quality standards outlined in NICE refreshed guidance.

5. Understanding where inequalities in health impact children locally and acting on how we can reduce any barriers to care.

6. Reducing local variation in access to care, particularly around accessing mental health support and interventions.

7. Targeted interventions and clear pathways of care for children who also have co-morbidity such as SEND and/or ND.

In Transition from NHSE - led through primary care.

1. We continue to roll out Mental Health in schools teams as Wave 10 mobilises, we are also planning for Glossop.

2. Our MH2K young people are helping us with focus groups on digital pathways and recommendations for the emotional health and wellbeing website, guidelines for professionals for messaging and to better reach CYP.

3. MH2K focus groups and survey continue to better understand inequalities in out pathways, plans to follow.

4. We are rolling out our ND community support hubs and community facing assessment pathways.

5. As we plan for the new financial year we are developing plans to tackle CAMHS waiting lists with a focus on early support and help and community facing alongside Primary Care mental health roles planning.

Our proposed +5 Locally:

SEND, LGBTQ+, Children who are looked after, Ethnicity, Speech, Language and Com-munication Needs

Our Start Well priority is now a key priority in the ICS strategy and the CYP Delivery Board (system wide representation) is operationalising delivery of the ambition to improve school readiness in children

System working is crucial for success

The Derbyshire
VCSE sector
Alliance

Derby City Council