NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC AGENDA – ICB SYSTEM FOCUSED

Thursday 15th June 2023 at 9am to 10.45am

Via MST

Questions from members of the public should be emailed to ddicb.enquiries@nhs.net and a response will be provided within 20 working days

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

Time	Reference	Item	Presenter	Delivery
09:00	**Introductory Items**			
	ICBS/2324/022	Welcome, introductions and apologies: Andy Smith	John MacDonald	Verbal
	ICBS/2324/023	Confirmation of quoracy	John MacDonald	Verbal
	ICBS/2324/024	Declarations of Interest • Register of Interests • Summary register for recording interests during the meeting • Glossary	John MacDonald	Paper
09:05	**Minutes / Action Log**			
	ICBS/2324/025	Minutes of the meeting in public held on 20th April 2023	John MacDonald	Verbal
	ICBS/2324/026	Action Log – April 2023	John MacDonald	Verbal
09.10	**Strategy and Leadership**			
	ICBS/2324/027	Chair's Report – May 2023	John MacDonald	Verbal
	ICBS/2324/028	Chief Executive Officer's Report – May 2023	Dr Chris Clayton	Verbal
09:25	**For Decision**			
	ICBS/2324/029	ICB 2023/24 Financial Plan and Delegated Budgets	Keith Griffiths	Paper

Time	Reference	Item	Presenter	Delivery
	ICBS/2324/030	Memorandum of Understanding - Voluntary, Community and Social Enterprise Sector and the ICB	Dr Chris Clayton Kate Brown Wynne Garnett	Paper
	ICBS/2324/031	Operational Plan for 2023/24 - Activity - Finance - Workforce	Dr Chris Clayton Zara Jones Keith Griffiths Linda Garnett	Paper
	ICBS/2324/032	Organisational Development and People - ICB Staff Survey - ICB Strategic Framework	Linda Garnett Helen Dillistone	Papers
10:15	**For Discussion**			
	ICBS/2324/033	Draft Joined Up Care Derbyshire Joint Forward Plan	Zara Jones	Paper
	ICBS/2324/034	Digital Development	Jim Austin	Paper
10:25	**Corporate Assurance**			
	ICBS/2324/035	Board Assurance Framework Quarter 1 2023/24	Helen Dillistone	Paper
10:35	**Items for Information**			
	The following items are for information and will not be individually presented			
	ICBS/2324/036	Ratified minutes of Health and Wellbeing Board Meetings: • Derby City Council - 19.1.2023 • Derbyshire County Council - 25.1.2023 / 29.3.2023	John MacDonald	Papers
10:40	**Closing Items**			
	ICBS/2324/037	Forward Planner	John MacDonald	Paper
	ICBS/2324/038	Any Other Business	John MacDonald	Verbal
	ICBS/2324/039	Questions received from members of the public	John MacDonald	Verbal
Date and time of next Public ICB Business focused meeting: **Date:** Thursday, 20th July 2023 **Time:** 9am to 10.45am **Venue:** via MS Teams **Date and time of next Public ICB System focused meeting:** **Date:** Thursday, 21st September 2023 **Time:** 9am to 10.45am **Venue:** via MS Teams			John MacDonald	Verbal

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Allen	Tracy	Partner Member - DCHS	Primary & Community Care Delivery Board Chair of Digital and Data Delivery Board Integrated Place Executive Meeting	CEO of Derbyshire Community Health Services NHS Foundation Trust	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Partner is a Director (not Board Member) for NHS Derby and Derbyshire ICB				✓	01/07/22	Ongoing	
				Trustee for NHS Providers Board		✓			01/07/22	Ongoing	
				Sister-in-law is Business Development Director of Race Cottam Associates (who bid for, and undertake projects for the Derbyshire system estates teams)				✓	01/07/22	Ongoing	
Austin	Jim	Chief Digital Information Officer	Finance & Estates Committee	Employed jointly between NHS Derby and Derbyshire Integrated Care Board and Derbyshire Community Health Services NHS Foundation Trust	✓				01/11/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Spouse is a locum GP and the Local Place Alliance lead for High Peak (8 hours per week)				✓	01/11/22	Ongoing	
Bhatia	Avi	Partner Member - Clinical and Professional Leadership Group	Chair - Clinical and Professional Leadership Group, Derbyshire ICS Population Health & Strategic Commissioning Committee	GP partner at Moir Medical Centre	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				GP partner at Erewash Health Partnership	✓				01/07/22	Ongoing	
				Part landlord / owner of premises at College Street Medical Practice, Long Eaton, Nottingham	✓				01/07/22	Ongoing	
				Spouse works for Nottingham University Hospitals in Gynaecology				✓	01/07/22	Ongoing	
Clayton	Chris	Chief Executive Officer	N/A	Spouse is a partner in PWC				✓	01/07/22	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Corner	Julian	Non-Executive Member	Public Partnership Committee Population Health & Strategic Commissioning Committee Remuneration Committee	As the CEO of Lankelly Chase Foundation, I may have an interest in organisations being commissioned by the JUCD if that would support a grant funding relationship that Lankelly Chase has with them.		✓			01/03/22	30/06/25	Not aware of any grant relationships between Lankelly Chase and Derbyshire based organisations, or organisations that might stand to benefit from JUCD commissioning decisions. If that were to happen I would alert the JUCD chair and excuse myself from decisions both at Lankelly Chase and JUCD.
Dhadda*	Bukhtawar	Non-Executive Member (Population Health & Strategic Commissioning)	Audit & Governance Committee People & Culture Committee Quality & Performance Committee Population Health & Strategic Commissioning Committee Remuneration Committee CPAG	GP Partner at Swadlincote Surgery	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Private GP work for Medical Solutions Online (Health Hero)	✓				01/07/22	Ongoing	
Dillistone	Helen	Executive Director of Corporate Affairs	Audit & Governance Committee Public Partnership Committee	Nil							No action required
Gildea	Margaret	Non-Executive Member	People and Culture Committee Population Health & Strategic Commissioning Committee Quality and Performance Committee Remuneration Committee	Director of Organisation Change Solutions Limited	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Coaching and organisation development with First Steps Eating Disorders	✓				01/07/22	Ongoing	
				Director, Melbourne Assembly Rooms		✓			01/07/22	Ongoing	
Green*	Carolyn	Interim Chief Executive, DHcFT	People & Culture Committee Population Health & Strategic Commissioning Committee	Board Member - National Mental Health Nurse Directors Forum		✓			06/12/22	31/03/23	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Griffiths	Keith	Executive Director of Finance	Finance & Estates Committee Population Health & Strategic Commissioning Committee	Nil							No action required
Houlston	Ellie	Partner Member - Derbyshire Local Authority	System Quality Group Integrated Care Partnership Health and Wellbeing Board - Derbyshire County Council	Director of Public Health, Derbyshire County Council	✓				01/09/22	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair. Sheffield based - unlikely to bid in work in Derbyshire
				Director and Trustee of SOAR Community			✓		01/09/22	Ongoing	
Jones	Zara	Executive Director of Strategy & Planning	Finance & Estates Committee Population Health & Strategic Commissioning Committee Quality & Performance Committee	Nil							No action required
MacDonald	John	ICB Chair	Derby and Derbyshire Integrated Care Partnership Board	Chair at University Hospitals of Leicester NHS Trust	✓				01/07/22	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Majid*	Ifti	Partner Member - DHcFT	People & Culture Committee Population Health & Strategic Commissioning Committee	CEO of Derbyshire Healthcare NHS Foundation Trust	✓				01/07/22	05/12/22	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Co-Chair of NHS Confederation BME leaders Network		✓			01/07/22	05/12/22	
				Chair of the NHS Confederation Mental Health Network		✓			01/07/22	05/12/22	
				Trustee of the NHS Confederation		✓			01/07/22	05/12/22	
				Spouse is Managing Director (North) Priory Healthcare				✓	01/07/22	05/12/22	
Mott	Andrew	Partner Member – Primary Medical Services	Joint Area Prescribing Committee System Quality Group	GP Partner of Jessop Medical Practice	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Clinical Director, ARCH Primary Care Network	✓				01/07/22	31/03/22	
				Practice is shareholder in Amber Valley Health Ltd (provides services to our PCN)	✓				01/07/22	Ongoing	
				Medical Director, Derbyshire GP Provider Board	✓				01/07/22	Ongoing	
				Wife is Consultant Paediatrician at UHDBFT				✓	01/07/22	Ongoing	
Okubadejo	Adedeji	Clinical (Other) Member	Audit & Goverance Committee Population Health & Strategic Commissioning Committee Quality & Performance Committee Remuneration Committee	Director, Carwis Consulting Ltd – Provision of clinical anaesthetic services as well as management consulting services to organisations in the independent healthcare sector	✓				01/04/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Consultant Anaesthetist, University Hospitals Birmingham NHS Foundation Trust	✓				01/04/23	30/04/23	
				Provision of private clinical anaesthetic services in the West Midlands area	✓				01/04/23	Ongoing	
				Director & Chairman OBIC UK – Working to improve educational attainment of BAME children in the UK			✓		01/04/23	Ongoing	
Powell	Mark	Partner Member - DHcFT	People & Culture Committee Population Health & Strategic Commissioning Committee	CEO of Derbyshire Healthcare NHS Foundation Trust	✓				01/04/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Treasurer of Derby Athletic Club			✓		01/03/22	Ongoing	
Rawlings	Amanda	Chief People Officer	People & Culture Committee Population Health & Strategic Commissioning Committee	Employed jointly between NHS Derby and Derbyshire Integrated Care Board and University Hospitals of Derby and Burton NHS Foundation Trust, as Chief People Officer	✓				01/07/22	30/04/23	This position was agreed by both the ICB and UHDB. Declare interest when relevant and withdraw from all discussion and voting if UHDB is potential provider, unless otherwise agreed by the meeting chair
Smith	Andy	Partner Member - Derby City Local Authority	N/A	Director of Adult Social Care and Director of Children's Services, Derby City Council	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Member of Regional ADASS and ADCS Groups		✓			01/07/22	Ongoing	
Stacey	Brigid	Chief Nurse Officer and Deputy Chief Executive Officer	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee	Nil							No action required
Sunderland	Sue	Non-Executive Member - Audit & Governance	Audit and Governance Committee Finance and Estates Committee Public Partnership Committee Population Health & Strategic Commissioning Committee IFR Panels CFI Panels	Audit Chair NED, Nottinghamshire Healthcare Trust		✓			01/07/22	Ongoing	The interests should be kept under review and specific actions determined as required - declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Audit Chair of Joint Audit Risk & Assurance Committee for the Office of the Police & Crime Commissioner and Chief Constable of Derbyshire		✓			01/07/22	Ongoing	
				Husband is an independent person sitting on Derby City Audit Committee				✓	01/07/22	Ongoing	Unlikely for there to be any conflicts to manage
Weiner	Chris	Executive Medical Director	Population Health & Strategic Commissioning Committee Quality & Performance Committee System Quality Group EMAS 999 Clinical Quality Review Group Local Maternity & Neonatal System Board	Nil							No action required
Wright	Richard	Non-Executive Member - Finance & Estates	Audit and Governance Committee Finance and Estates Committee Quality and Performance Committee Population Health & Strategic Commissioning Committee Remuneration Committee	Nil							No action required

SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

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

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

Abbreviations & Glossary of Terms

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

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

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

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

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

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

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

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

MINUTES OF NHS DERBY AND DERBYSHIRE ICB BOARD MEETING IN PUBLIC

Thursday, 20th April 2023

via Microsoft Teams

Unconfirmed Minutes

Present:		
John MacDonald	JM	ICB Chair (Meeting Chair)
Tracy Allen	TA	Chief Executive DCHSFT and Place Partnerships (NHS Trust & FT Partner Member)
Jim Austin	JA	ICB Chief Digital and Information Officer
Dr Avi Bhatia	AB	Clinical & Professional Leadership Group participant to the Board
Dr Chris Clayton	CC	ICB Chief Executive Officer
Helen Dillistone	HD	ICB Executive Director of Corporate Affairs
Margaret Gildea	MG	ICB Non-Executive Member
Keith Griffiths	KG	ICB Executive Director of Finance
Zara Jones	ZJ	ICB Executive Director of Strategy and Planning
Dr Andrew Mott	AM	GP Amber Valley (Partner Member for Primary Medical Services)
Dr Deji Okubadejo	DO	ICB Non-Executive Clinical Other Member
Mark Powell	MP	Chief Executive DHcFT (NHS Trust and FT Partner Member)
Amanda Rawlings	AR	ICB Chief People Officer
Andy Smith	AS	Strategic Director of People Services – Derby City Council (Local Authority Partner Member) (part meeting)
Brigid Stacey	BS	ICB Chief Nursing Officer and Deputy Chief Executive Officer
Sue Sunderland	SS	ICB Non-Executive Member
Dr Chris Weiner	CW	ICB Chief Medical Officer
Richard Wright	RW	ICB Non-Executive Member
In Attendance:		
Helen Blunden	HB	Interpreter
Linda Garnett	LG	ICB Programme Director, People Services Collaborative
Dawn Litchfield	DL	ICB Board Secretary
Suzanne Pickering	SP	ICB Head of Governance
Sean Thornton	ST	ICB Deputy Director Communications and Engagement
Samantha Waters	SW	Interpreter
Apologies:		
Julian Corner	JC	ICB Non-Executive Member
Ellie Houlston	EH	Director of Public Health – Derbyshire County Council (Partner Member for Local Authorities)

Item No.	Item	Action
ICBP/2324/001	**Welcome and apologies** John MacDonald (JM) welcomed everyone to the meeting. Introductions were made by Mark Powell and Dr Deji Okubadejo, who both attended the Board meeting for the first time as members today. Apologies were noted as above.	
ICBP/2324/002	**Confirmation of quoracy** It was confirmed that the meeting was quorate.	

Item No.	Item	Action
ICBP/2324/003	**Declarations of Interest** The Chair reminded Committee Members of their obligation to declare any interests they may have on issues arising at Committee meetings which might conflict with the business of the ICB. Declarations made by members of the Board are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the ICB Board Secretary or the ICB website at the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/integrated-care-board-meetings/ No further declarations of interest were made.	
ICBP/2324/004	**Minutes of the meeting held on 16th March 2023** **The Board APPROVED the minutes of the above meeting as a true and accurate record of the discussions held**	
ICBP/2324/005	**Action Log from the meeting held on 16th March 2023** There were no outstanding items on the action log. **The Board NOTED the Action Log**	
ICBP/2324/006	**Chair's Report** JM presented his report, a copy of which was circulated with the meeting papers; the report was taken as read and the following points of note were made: • There is a move towards finalising the Joint Forward Plan (JFP); however, there are still a lot of discussions to be held, mainly around the financial position and how it is balanced alongside other things to improve care in all settings. • The Hewitt Report contains important messages for the ICB; although the national response is still awaited, it reiterates important messages from the early days of defining Systems and their roles which require further consideration. • Over the past few months work has been undertaken within the ICB to agree how it wants to work, defining its values and behaviours. This is a good piece of work, which has received wide engagement across the System, setting out ways of thinking differently considering the challenges faced; it is an important foundation stone to use to move forward operating as a System, and thinking what added value the ICB could offer to the System. • JM formally noted that has been appointed to lead the work across the Northamptonshire and Leicestershire Acutes, resulting in him stepping down as the ICB Chair at the end of June. Interim arrangements are in the process of being finalised. JM will leave Derbyshire with mixed feelings; the ICB has made some important changes and JM looks forward to seeing how this journey continues. **The Board NOTED the Chair's report**	

Item No.	Item	Action
ICBP/2324/007	**Chief Executive's Report** Dr Chris Clayton (CC) presented his report, a copy of which was circulated with the meeting papers; the report was taken as read and the following points of note were made: • The report has significant congruence with the agenda, including an update on the Joint Forward Plan6, led by Zara Jones (ZJ). • Today marks the first run of the new Board meeting format; the meetings will discuss integrated performance and provide the Board with an opportunity to look at the work undertaken within the sub-committees to provide assurance on quality and performance. • The Hewitt Report will be Systematically worked through, led by Helen Dillistone (HD); this will be presented to the Board in due course to understand any local implications. • The wider determinants of health, and the ICBs role to influence and be a partner in them, is discussed in section 3 under Devolution. Local Authority partners are working with Nottingham and Nottinghamshire Councils on socio-economic development. Although the NHS is not driving this, it is an important partner in these discussions to help ensure socio economic regeneration and growth. • Derbyshire Voluntary Action was congratulated on being shortlisted for an award; the NHS is not driving this agenda but is a partner and is supportive of the other partners in the Integrated Care System. • Engagement work is being undertaken by partners in South Yorkshire on oncology work; CC highlighted the importance of this for Derbyshire from a Chesterfield perspective. • The care System is always changing; although always challenging, there is a need to reflect on the change and move forward. It is a bitter blow for Derbyshire that JM is moving on. CC will work with the Board and NHSE to think about the future Chair arrangements. • CC thanked Amanda Rawlings (AR) publicly for the work she has done on the ICB's behalf as its Chief People Officer. This arrangement is coming to an end this month, and CC will be working with the Remuneration Committee on the interim and substantive arrangements as to how the ICB will discharge its people functions and duties. The System has tested the model of an integrated Chief People Officer role, taken on by AR, which has helped with the thinking. Consideration will be given to what the different functions need to be: oversight, assurance, and development in the workforce approach, and the important work that provider collaboratives must do on workforce transformation, efficiency, and productivity; the ICB's role will be to support providers to take this on. AR will remain part of the Derbyshire Integrated Care System. **The Board NOTED the Chief Executive's report**	
ICBP/2324/008	**Joint Forward Plan – ICB 5 Year Plan** Zara Jones (ZJ) highlighted the key messages from the Joint Forward Plan (JFP), a copy of which was included in the meeting papers. <u>Questions / comments</u> • A lot of work had gone into this; an opportunity to see the detail behind it would be appreciated in order to provide input before it is	

Item No.	Item	Action
	submitted. It is fundamental to what the ICB wants to deliver over the next five years and there is a need to ensure that it is picking up on the ICB's ambitions (SS). ZJ responded that work is being undertaken with the Director of Communications around an Engagement Plan which will include input from the Board. The detail behind the JFP is also being mapped out to provide clarity; between now and early June, when it is anticipated the Plan will be published, regular conversations will be held to further inform it. ZJ asked members, should they want to feed anything into the JFP, to contact her directly. • Clarification was requested on the alignment of the JFP in respect of duplication and in terms of what it will look like from a delivery point of view; it was asked whether there would be a Delivery Plan as part of the JFP or whether it would refer to existing plans. Any early feedback from interactions with the Health and Wellbeing Boards would be useful (MP). ZJ agreed that this is a real risk. Whereas the Integrated Care Strategy set out some high-level ambitions which the Delivery Boards are working through, the JFP will be the ICB's Delivery Plan for a 5-year period. There may be some overlaps with individual organisations' plans however the JFP will set out a collective Delivery Plan with tangible principles. • This is a plan whereby the big objective is to meet the physical and mental health needs of the population; it was enquired at which point the impact of the JFP will be measured post implementation (DO). ZJ outlined the process by which the mechanisms in place, through the System architecture, will be monitored on a regular basis. As part of the ongoing engagement, a framework will be set out to demonstrate the measurables and the process by which they will be monitored and evaluated. This will be a live process to be adapted as necessary. • What the development of the JFP means was supported as a key System document. It will help System partners to work in this complex, busy space and understand their contribution to the JFP. It was enquired what the take of this is for respective spaces in the System to be able to target and focus its activities on the delivery. It makes sense for everyone to think about it from their own perspectives. The first slide on how all the strategies fit together was commended (AS). • Public engagement is important; the JFP needs to be translated into something that the general population can use and link in to. It is important that the public know what the System wants to do differently and what their role is in their own health and development (SS). • Building on the conversations around measuring success, relating to the enablers, and organising ourselves to deliver the ambitions in the JFP, there is a need to incorporate the work NHSE published yesterday around quality improvement processes. Consideration is required as to how all System organisations could work together to embed the continuous quality improvement approach to achieve the ambitions. This builds on the work of the Strategic Framework on improvement and innovation. It is not just about what to achieve but how to achieve it (TA). ZJ thanked members for their helpful comments, all of which will be taken on board. JM summarised that a Board workshop needs to be held by the end of May / early June to better understand the JFP and allow observations to be reflected in the final document. Measures on impact would like to be	

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	seen. Clarity is required on the role of partners and the expectations of them regarding joint working. The messages for the public will not just be about health services but about lifestyles. There is an expectation that Systems will be adopting a common approach to service improvement. **The Board NOTED the progress on developing the Joint Forward Plan**	
ICBP/2324/009	**2023/24 Financial Planning** Keith Griffiths (KG) highlighted the key points of the report, a copy of which was provided with the meeting papers: KG summarised the key areas to be achieved in 2023/24 including seeing more patients in the community setting, investing more in out of hospital treatment and population health, spending less money within the challenge set in the context of performance and getting back to pre-COVID levels of activity. There is a significant journey in 2023/24 to achieve the agreed deficit of £22m. There is a commitment from all System CEO's and provider Directors of Finance (DoFs) that this is the result to aim for; the pathway to finalise specific components to deliver the £22m deficit is currently being formalised. The 2023/24 financial plan will be resubmitted in accordance with the national planning requirements on 4th May. There is still work to be done with DoFs to reach a final position for the System to achieve no more than a £22m deficit. There are many risks around this trajectory; a 4% delivery and efficiency target has been set in 2024/25 to help the return to pre-COVID productivity levels. A lot of energy, effort and collegiate working will be required to commit to achieving this as a System. RW added that there are some significant productivity challenges included in the plan that need to be addressed in order to reach a long-term sustainable position; this can only be addressed by working together as a System and there are many good things being done to help achieve this. <u>Questions / Comments</u> • AR has done a lot of work with the Providers' Chief People Officers to understand where the manpower is now and how the extra 2.5% WTE will be deployed to ensure productivity improvements are met. A coordinated financial activity and people plan is required to deploy staff to the places where they will make the most difference in terms of productivity and continuous improvement (MG). CC thanked KG and the System DoFs for their leadership on the financial aspects of the plan, and operational colleagues, including ZJ and her team, for pulling the plan together, particularly the work being done to triangulate the principal resources. Regarding the strategic approach to the 2023/24 finances, a three-pronged approach is being worked upon, including the difference between allocation and turnover in the System, and understanding what this means technically. The ICB is an important part of the System, with an vital commissioning role to play in the efficiency conversation, looking at commissioning policies, approaches and how it compares with other	

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	Systems. It is important to come together around the provider productivity efficiency concept to achieve the 4% efficiency. The answer to this sits within the importance of Place, Provider Collaboratives, Primary Care Networks (PCNs) and General Practice Provider Boards (GPPBs) to allow each area to contribute using their respective skillsets. The Board will require a better understanding of the critical risks, and how they will be overseen throughout the System, prior to final sign off. **The Board NOTED the update to the 2023/24 Financial Plan**	
ICBP/2324/010	**Integrated Assurance and Performance Report** An integrated report was provided on quality, performance, workforce, and finance, a copy of which was circulated with the meeting papers. CC requested feedback on the format and content of the report. The key work of the ICB's sub-committees were highlighted within the report, drawing out key matters of business being worked upon for the Boards attention, challenge, and support. <u>Quality – Brigid Stacey</u> The key messages were highlighted around the current position against plan, any key risks and proposed mitigating actions, and infection, prevention, and control. <u>Questions / Comments</u> • Of the MRSA bacteraemia numbers, 7 of the cases are attributed to Derbyshire's Acute Trusts; it was enquired what the other 15 are attributable to and whether further work is needed (AM). BS responded that the other 15 cases are attributable to Trusts outside of the Derbyshire boundary relating to Derbyshire residents. • Further detail was requested on the Elmwood Medical Centre risk, and whether it is linked to the Elmwood Care Home (MP). BS advised that there is some confusion around this connection, as the Elmwood Care Home has recently decided to undertake voluntary closure due to CQC concerns; this is not related to the issues at Elmwood Medical Centre. Gold Command was in place around this care home; however, this has now reduced to weekly Silver Command. The difficulty with Elmwood Care Home is that it caters for people with complex needs on the Transforming Care Programme. Closure of the home is planned for the end of June in conjunction with the home itself, the CHC and residents' families. • It was enquired whether there were strong actions in place to address the maternity, and infection, prevention, and control issues, or whether there are other things needing to be done to progress matters. It was also asked whether the actions being undertaken elsewhere in the country to resolve these issues are also being learnt from (JM). BS advised that significant work has been done by the LMNS and reported to the System Quality Group, which also includes members from other Systems. Learning and benchmarking is taken through this group to ensure everything possible is being done to resolve the issues. The System Quality and Performance Committee is undertaking a series of deep dives to provide assurance to the	

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	Board on these key areas. CW added that there is significant learning from the Ockenden Report from across the country. The HSIB review has drawn attention to reviewing the governance process for the quality improvement of maternity services. Areas of good practice are being highlighted in terms of how to maintain oversight and delivering the required improvements. • One of the main quality and performance mechanisms implemented is the concept that more assurance will be provided by undertaking deep dives and concentrating on the actual issues, risks, and mitigating factors to ascertain what may be learnt from elsewhere. <u>Quality – Maternity – Dr Chris Weiner</u> Oversight arrangements for maternity care across Derbyshire were highlighted, particularly the key risks, mitigations, and quality metrics in place. Common themes across UHDBFT and CRHFT were identified, as was compliance against national targets. <u>Performance – Zara Jones</u> The key messages across a broad range of performance priorities were highlighted, together with the current position against the plans, key risks identified and mitigations in place to deal with any issues being faced. <u>Questions / Comments</u> • It would be good to understand how to broaden the range of things being looking at. Planned Care looks at the constitutional standards relating to consultant led care, however there are also huge waits for non-consultant led care, including children's therapy services. From a public perspective, it would be good to demonstrate why these long waits are occurring (TA). • For Urgent and Emergency Care, the importance of the discharge position was highlighted, however there is good information on improving discharge performance, including details of the urgent community response. It would be good to include information that reflects more citizens' experiences in accessing healthcare (TA). • When presenting this information, it would be good to have a time series control to understand ongoing improvement, rather than comparing one month to another (TA). • Work has been undertaken on cancer referrals work to put in steps between primary and secondary care to ensure that referrals are appropriate. Requesting tests prior to referral will ensure that only the most appropriate referrals are made, thus not wasting patient or secondary and primary care clinicians' time (AB). • There are concerns about counting appointment numbers, as this does not show what happens in these appointments; quantitative information is being collected rather than qualitative (AB). • When looking at patient pathways across the System, the diagnostic situation would be a useful set of metrics to consider, ascertaining whether these happen before, during or post referral (AM). • Rationalising the areas reported to Board, ensuring that only critical, non-compliant ones are highlighted would be more useful (JM). • It was enquired when the Primary Care Strategy will be available for discussion; this is a complex area for which, from a public perspective, there are many concerns (JM). AM confirmed that a	

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	Board Development session is scheduled for May on General Practice. Due to purdah, the final details of the Strategy on contractual matters and the Primary Care Recovery Access Plan are awaited. The Strategy continues to be discussed in more detail, with more information made available at the May Development session. • CC advised that there is currently a General Practice Strategy, which is the inherited position from the previous CCGs; this was created by the GP Alliance and owned by the General Practice Body, alongside the GP taskforce, supported by the LMC. The General Practice Provider Board is now taking ownership of the future direction of General Practice. The PCNs, the Integrated Place Executive, the Integrated Care Strategy, and the JFP are all coming together to inform the General Practice forward strategies, including broader primary care and a multi partner approach to a more community-based model of care. National oversight and development are expected to be published post purdah on improving access to General Practice. An overview on how all constituent parts will play an important role in the overall strategy is now emerging. • The report stated a 75% face to face GP appointment level; it was asked if this was always with a GP or with another member of the primary care team. It was enquired what the right percentage of face-to-face appointments would be versus virtual appointments (RW). AM responded that the data is roughly 50/50 in terms of appointments offered for GPs as opposed to other members of the wider team. Practices have a lot of freedom in how they meet the needs of the core contracts; there are many different models in place, some of which are workforce dependent or relate to the demographics of the practice population. AM's practice has moved away from a full triage model; patients are now able to choose whether they want a virtual or face to face consultation. It will be interesting to see how this plays out when the metrics are available. There is a mismatch as to how much can be dealt with over the telephone and how much patients choose to be seen face to face. AB added that there is a heterogenous group of individuals who will see patients face to face; it may be that the best person to see someone is not a GP. The concept of appointments with a GP needs to be changed towards one of seeing the most appropriate person. In AB's practice, face to face appointments is approximately 60-70%, with 30-40% being remote; the patient has a choice. Receptionists implement a triage process, with certain symptoms immediately resulting in a face-to-face appointment; offering a telephone appointment and then converting it to face to face is waste of time. However, some patients much prefer a remote appointment. There has to be a degree of fluidity for a practice to deal with this in accordance with staff availability and patient need. <u>Workforce – Amanda Rawlings</u> A summary of the key messages from the Workforce Plan was provided up to the end of February 2023 when the data was produced. <u>Finance – Keith Griffiths</u> A summary of the Months 11 and 12 positions was provided, demonstrating a £13.4m deficit position for 2022/23. The financial outlook for 2023/24 was also provided.	

Item No.	Item	Action
	The Board RECEIVED and NOTED the Integrated Assurance and Performance Report for assurance purposes	
ICBP/2324/011	**Delegation of Pharmacy, Optometry and Dental Services and Joint Commissioning Arrangements for Tier 1 and Tier 2** Helen Dillistone (HD) provided assurance on the arrangements for the delegation of the pharmacy, optometry and dental services that were formally delegated to the ICB from 1st April 2023. Nottinghamshire ICB will host the staff working on these services on behalf of the five ICBs that the services are transferring into from NHSE. HD confirmed that the complaint's function will transfer on 1st July 2023 and further specified specialised services, including Acute and Pharmacy, are due to transfer to ICBs in April 2024. An important aspect of this transfer is how these services become embedded into local population health planning, including Place and PCNs. The Board may wish to discuss these services further, as they are taken on, to gain a better understanding. **The Board NOTED the contents of the report and TOOK ASSURANCE of the legal transfer of the delegation of Pharmacy, Optometry and Dental services to the ICB**	
ICBP/2324/012	**ICB Corporate Risk Register Report – March 2023** Helen Dillistone (HD) advised that the Risk Register forms part of the agenda for each of the ICB's Corporate Committees and is amended according to the detailed discussions held within those settings. One risk rating was increased during March 2023; Risk 16 – With the pending review of the ICB structures there is risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being. The ICB staffing structures are currently in development, driven by the requirements of ICBs, recognising that accountabilities and responsibilities have now changed. This has in part been driven by the Hewitt Review and the required running cost reduction for ICBs from 2024/25. With the structures being closely looked at across the ICB, this could result in an increased risk of anxiety amongst some staff. The Executive Team is looking how best to support their respective teams to manage this process. **The Board RECEIVED and NOTED:** • **The Risk Register Report** • **Appendix 1, as a reflection of the risks facing the organisation as at 31st March 2023** • **Appendix 2, which summarised the movement of all risks during March 2023**	

Item No.	Item	Action
ICBP/2324/013	**Month 11 System Financial Position** Keith Griffiths (KG) provided a verbal update on the financial position as at Month 11. **The Board NOTED the verbal update provided on the Month 11 System Financial Position**	
ICBP/2324/014	**Audit and Governance Committee Assurance Report – March 2023** Sue Sunderland (SS) provided an update following the Audit and Governance Committee meeting held on 23rd March 2023. SS confirmed that the Committee will be following up on the areas of concern highlighted around procurement information, and whether the governance is right around picking up on contract expiry dates. JM thanked the Committee for its focus on the detail of the vast numbers of documents recently requiring consideration; this process has provided additional assurance to the Board. **The Board NOTED the Audit and Governance Committee Assurance Report**	
ICBP/2324/015	**Derbyshire Public Partnership Committee Assurance Report – March 2023** Sue Sunderland (SS) provided an update following the Derbyshire Public Partnership Committee meeting held on 28th March 2023. There are no matters of concern to be flagged up. The Committee is working well and is consulting its Terms of Reference to ensure delivery against what it was set up to do. There is good participation from all Committee Members. **The Board NOTED the Derbyshire Public Partnership Committee Assurance Report**	
ICBP/2324/016	**Quality and Performance Committee Assurance Report – March 2023** Margaret Gildea (MG) provided an update following the Quality and Performance Committee meeting held on 30th March 2023. JM thanked MG for chairing these meetings on an interim basis. An extraordinary meeting was held as it was recognised that the ICB was not compliant with all the statutory targets it needed to meet. The 2023/24 Operational Plan was considered in detail to ascertain whether it would mitigate these areas of non-compliance. **The Board NOTED the Quality and Performance Committee Assurance Report**	
ICBP/2324/017	**Serious Violence Duty** Brigid Stacey (BS) highlighted the requirements of the ICB in relation to the Serious Violence Duty Act which came into effect from January 2023. There are additional responsibilities on the ICB in relation to this Act; it is a Home Office requirement for the ICB to become one of the strategic partners. The Home Office has brought in Cresta Agency to assess all Systems on their adherence to this duty. This assessment has been	

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	undertaken as part of the Derbyshire Serious Violence Board and its outcome is awaited. **The Board NOTED the Serious Violence Duty Report for assurance purposes**	
ICBP/2324/018	**Ratified minutes of ICB Corporate Committee Meetings** • Audit & Governance Committee – 9.2.2023 • Quality & Performance Committee – 23.2.2023 **The Board RECEIVED and NOTED the above minutes for information**	
ICBP/2324/019	**Forward Planner** **The Board NOTED the forward planner for information**	
ICBP/2324/020	**Any Other Business** No items of any other business were raised.	
ICBP/2324/021	**Questions received from members of the public** No questions were received from members of the public	

Date and Time of Next Meetings

ICB Business Focused Meeting

Date: Thursday, 20th July 2023
Time: 9am to 10.45am
Venue: via MS Teams

ICB System Focused Meeting:

Date: Thursday, 15th June 2023
Time: 9am to 10.45am
Venue: via MS Teams

ICB BOARD MEETING IN PUBLIC

ACTION LOG – APRIL 2023

Item No.	Item Title	Lead	Action Required	Action Implemented	Due Date
All actions have been completed and there were no new actions arising from the April meeting					

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

15th June 2023

Item: 027

Report Title	ICB Chair's Report – May 2023							
Author	Sean Thornton, Deputy Director Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	John MacDonald, ICB Chair							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	None							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Not Applicable							

Recommendations
The ICB Board is recommended to **NOTE** the ICB Chair's Report.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
This will be my final report as the Chair of Derby and Derbyshire Integrated Care Board. I announced in April that I would be leaving the role to become Chair of University Hospitals of Northamptonshire NHS Group. It has been a privilege to work once again in Derby and Derbyshire, a patch where I operated as a Chief Executive earlier in my career. As Chair of the Joined Up Care Derbyshire Board, and more recently the Integrated Care Board, I believe our system has made great steps in collaboration and partnership, navigating through some of the most challenging periods that have ever faced our services and citizens. I am proud of everyone's achievements and very grateful for the exceptional work that has made such a difference as the ICB continues to establish itself. **Appointment of ICB Acting Chair** The appointment of Richard Wright as Acting Chair of the ICB has been approved by NHS England. Richard will already be known to many colleagues as an ICB Non-Executive Member and the Chair of our Finance and Estates Committee. Richard has been formally appointed as the Vice Chair of the ICB Board and it is in that role that he will assume the role of Acting Chair while a recruitment process takes place to make a permanent appointment.

NHS Joint Forward Plan

NHS partners have been working on the first version of the NHS Joint Forward Plan. Set out in legislation as a statutory requirement of ICBs, the Joint Forward Plan seeks to describe a medium-term plan for the delivery of Joined Up Care Derbyshire (JUCD) strategic aims and priorities. Legislation requires that the Joint Forward Plan responds directly to the Integrated Care Strategy.

A version of the plan is to be published by 30th June 2023. It will continue beyond that date as an iterative document, and progression will include patient and public engagement to help shape priorities. The plan will begin to articulate the need to address the following issues

1. Mapping current service provision against more sophisticated population health needs analyses and demographic modelling, and agreeing changes to service provision to reflect this
2. Realising our agreed aim to shift system resources from secondary care service delivery to facilitate increased investment in the delivery of our prevention and early intervention aims, as articulated in the Derby and Derbyshire Integrated Care Strategy
3. Aligning our objectives for reducing inequalities, improving prevention and early intervention, and population health management to maximise the impact across all three
4. Implementing agreed workforce improvement priorities covering workforce planning in support of the above plans, plus actions to improve recruitment, retention and staff wellbeing
5. The next steps in developing system working, including through the Provider Collaborative and Place Alliances, supported by new strategic and collaborative commissioning models, to facilitate genuine, integrated ways of working
6. Ensuring the difficult choices that have to be made, including shifts in investment, are informed by the views of the public and our staff, and genuine engagement with the public and staff is a constant from development to delivery
7. Ambitious productivity improvement, informed by benchmarking, which meets the requirements of the financial plan supported by a system benefits realisation model
8. Quality improvement, with an emphasis on personalised care
9. Primary care, working with system partners to drive a transformed and sustainable approach to preventative, proactive and accessible care at neighbourhood level
10. Collaborative and distributed leadership through strengths-based approaches, that is supported by a unified approach to leadership, talent, and organisational development, and which reflects the complex adaptive system within we operate

The Joint Forward Plan is currently undertaking analysis in the following areas to understand the current strengths, weaknesses, opportunities, and threats to NHS commissioned and provided care in the next five years:

- Improving Outcomes in Population Health
- Improving Outcomes in Healthcare
- Tackling Inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development

This plan is to be submitted to NHS England during June 2023 and will seek to meet the requirements of NHS England's Joint Forward Plan guidance.

Integrated Care Strategy

The Derby and Derbyshire Integrated Care Strategy was received in final draft at the Integrated Care Partnership meeting on 19th April and, in line with agreed partnership governance arrangements, is being formally signed off by council cabinets on 14th and 15th June. The strategy now reflects a very comprehensive approach to working through integration of care and has been discussed in its early stages of delivery with members of the public and other key stakeholders through a series of Derbyshire Dialogue sessions. These are the start of our engagement on the

strategy and further development on the three key areas of focus will follow. To reiterate, the Integrated Care Strategy 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 three 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 maximise a return to independence following escalations

Mental Health, Learning Disability and Autism Priorities
Mark Powell started in his position as Chief Executive of Derbyshire Healthcare NHS Foundation Trust on 3rd April 2023. Mark, who joins Derbyshire Healthcare from Leicestershire Partnership NHS Trust, previously served as the Trust's Chief Operating Officer. He was appointed following a national recruitment process late last year.

Mark chairs the Mental Health, Learning Disability and Autism Delivery Board for the Derby and Derbyshire system. This month's Delivery Board had a focus on performance and transformation, with a number of recovery action plans being agreed for the following services:

- Perinatal services – to increase the number of local women accessing specialist perinatal mental health support; increasing the number of referrals into the service (including self-referrals via GPs) and reducing the number of people who do not attend scheduled appointments
- Eating Disorder services for children and young people – to manage growing waiting times to access the service which have resulted from a significant growth in demand for the service
- Memory Assessment Services – to manage growth in demand for the service and increase the number of people receiving an early diagnosis of dementia, in line with national targets

The Delivery Board meeting in June will have a focus on partners' collective work to tackle health inequalities.

Guidance for delegation for joint working arrangements
NHS England has published statutory guidance that provides an overview of the new collaborative working arrangements that are possible between NHS organisations and local government, following commencement of the Health and Care Act 2022. The 2022 Act introduces new sections 65Z5 to 65Z7 to the 2006 Act. These changes will give organisations greater flexibility to collaborate in exercising their statutory functions, either through delegation or joint exercise of those functions – enabling better integration of their services to improve outcomes for patients and facilitate the best use of resources across care pathways at system and place level.

The new legislation is permissive, allowing delegation and joint arrangements to develop and evolve in ways that best suit the needs of patients and the public. The guidance therefore explains what delegation and joint working arrangements are permitted by the legislation, and when these can be used. This enables organisations to sense check that their proposed delegation or joint exercise of any statutory functions is done lawfully and in accordance with the principles of good governance and adheres to any expectations in this guidance that have been placed on their delegation or joint exercise.

Industrial Action
The British Medical Association has announced a further period of industrial action for junior doctor members from Wednesday 14th June to Saturday 17th June 2023. Government proposals to

increase NHS staff pay by 5%, with a non-consolidated payment for 2023/24, has been broadly accepted by other unions. Pay awards continue to be a matter for Government, and the NHS system has continued to make fully collaborative preparations for the periods of industrial action, including with colleagues from Local Authorities, to ensure the continued flow of patients through the urgent and emergency care system.

NHS 75th Birthday

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

Locally, NHS organisations are to be involved in a 'baton' relay across Derby and Derbyshire, with a wooden carved '75' being passed among organisations through the course of the week. There will be a wide range of other activities taking place to mark the special anniversary.

NHS@75

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

NHS@75 aims to help shape the future NHS and during a tight window of engagement, the ICB has facilitated the wide distribution of a survey across the NHS and partners asking for views on the past successes of the NHS, on what is working well today and what needs to be the focus for the future. The NHS Assembly will develop a report based on the feedback and will present this to NHS England during June.

Identification of Key Risks

Not applicable to this report.

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

Not applicable to this report.

Identification of Key Risks

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

Not applicable.

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

Have any conflicts of interest been identified throughout the decision making process?
None identified

Project Dependencies

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

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

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

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

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

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

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

15th June 2023

Item: 028

Report Title	Chief Executive Officer's Report – May 2023							
Author	Dr Chris Clayton, Chief Executive Officer							
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer							
Presenter	Dr Chris Clayton, Chief Executive Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	None							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Not Applicable							

Recommendations
The ICB Board is recommended to **NOTE** the ICB Chief Executive Officer's Report.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
We will shortly be entering the second year of the existence of the ICB, with reflections on what has been achieved in our first twelve months. It is well-documented that a fair proportion of our work has been focussed on managing the daily operational pressures faced by health and care services in our system. At the same time, we have established reviews of our care pathways and processes to seek long-term solutions to managing pressure, including the persistent challenges we face around discharge and reducing our waiting lists. These are already bearing fruit in some areas and we expect to see sustained improvement over the coming months. Further attention has been focussed on the longer-term priorities across the wider health system, with a programme founded first and foremost in the priorities highlighted within the first Derby and Derbyshire Joint Forward Plan, which is being presented at the Board for discussion today. The permissive nature of national guidance has ensured that this is truly a Derby and Derbyshire plan, setting out the areas that we need to tackle as a system to help improve the health of local people. There are some significant challenges within it, not least the continued need to engender a culture of prevention rather than treatment and see the movement in our care model from hospital-based to community-based care, based on the principle of our citizens starting well, staying well and

ageing/dying well. The delivery of sustainable health improvement rests on the progress we must now make in these areas and will be a conversation we will start with local people later this year.

There has also been change within the leadership space in Derbyshire in the least year. Our two acute trusts and our statutory mental health service provider have appointed new Chief Executives in recent months; our county council leaders in adult care and public health have changed, as have many of our leaders at executive level across our system. Within the ICB, we announced the departure of our Chair, John MacDonald, to pastures new from July, our Chief Nursing Officer Brigid Stacey will retire in July and our Executive Director of Strategy and Planning Zara Jones has secured a Deputy Chief Executive role in a trust from the autumn. We are progressing the arrangements to recruit to these posts and while it will mark a change in leadership within the ICB, we will remain focussed on the priorities set out in our operational plan for 2023/24, the Joint Forward Plan referenced above and the system's Integrated Care Strategy.

Another area of our work this year has been the delegation of services from NHS England to ICBs. We have already taken delegated responsibility for pharmacy, optometry and dentistry (POD) services from 1st April 2023, and next year we will assume responsibility for some specialised commissioning services and vaccination and immunisation programmes. ICBs across the East Midlands are working collaboratively to find the best solution to hosting these responsibilities. We have previously and continue to host commissioning arrangements for 111 and ambulance services on behalf of the East Midlands and our colleagues at NHS Nottingham and Nottinghamshire have taken the hosting role for PODs.

We will work collaboratively with midlands ICBs to find the right hosting arrangements for specialised commissioning and vaccinations, with the potential to create an East Midlands office to manage these collective responsibilities. There is an air of collaboration across ICBs in the East Midlands and whilst there is no policy appetite to change the footprint of ICBs, there are opportunities to work together across a broad commissioning landscape. Indeed, our Executive held its first meeting with the Executive of NHS Nottingham and Nottinghamshire on 5th June to seek to understand where further opportunities might lie to work more closely together, particularly aligned to the emergence of the East Midlands Combined County Authority for Derbyshire and Nottinghamshire, which will focus on the wider determinants of health linked to skills and employment.

Looking to July, we will celebrate the NHS's 75th birthday on 5th July with a range of activities across our system to celebrate such a significant milestone. On the birthday the ICB will hold its first face-to-face staff event since before the start of the pandemic, and we will be discussing the priorities of our organisation for the coming years and the support our staff will need to deliver against a significant agenda. With all things considered, and reflecting on the formative first year of ICBs, the second year of ICBs is to be one of emerging delivery against our plans and an anticipation and expectation that we will see improvements in those areas that we know are of most interest and concern to our citizens, and that we know will make the greatest impact on the health of our population.

Dr Chris Clayton
Chief Executive Officer

Chief Executive Officer calendar – examples from the regular meetings programme

Meeting and purpose	Attended by	Frequency
JUCD ICB Board meetings	ICB	Monthly
JUCD ICP Board meeting	ICB	Bi-Monthly

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

National developments, research and reports

NHS cuts longest waits and speeds-up response times

New figures show major improvements across long waits, urgent and emergency services, and cancer care.

The number of patients waiting more than 18 months fell to 10,737 by April – down by more than 90% from 124,911 in September 2021 and by more than four-fifths since the start of January when there were 54,882.

Ambulance response times improved significantly with average category two response times now at 28.5 minutes and category one at 8 mins – both the lowest in almost two years.

For the first time since the start of the pandemic, the 62-day cancer backlog fell year-on-year, with those waiting two months or more down from 21,823 at the end of the last financial year (March 2022) to 19,248 at the end of this March (2023). This is down almost 15,000 from a peak of 34,000 in July 2022.

Separate operational data shows huge progress on the NHS Elective Recovery Plan's target to virtually eliminate those waiting 18-months or more for elective treatment by April.

Patients to benefit from faster, more convenient care, under major new GP access recovery plan

Millions of patients will receive quicker, more convenient access to NHS care from their high street pharmacy, thanks to a major expansion of services under a radical plan to improve access to primary care. For the first time ever, patients who need prescription medication will be able to get it directly from a pharmacy, without a GP appointment, for seven common conditions including earache, sore throat, or urinary tract infections by next winter,

NHS response to Galleri trial results

An NHS cancer director has commented on the promising results of an early clinical trial into the Galleri blood test, which was correctly able to identify two out of every three cancers among 5,000 people who had visited their GP with symptoms. The findings are set to be presented at the American Society of Clinical Oncology conference and published in The Lancet Oncology journal.

Number of repeat prescriptions ordered via NHS App up by 92% in the last year

More than 500,000 repeat prescriptions are now booked through the NHS App every week. New figures released by NHS England show that since the NHS App's launch in December 2018, more than 42 million repeat prescriptions have been ordered through the app. Year on year, numbers have increased by 92% from 13 million repeat prescriptions ordered via the app in 2021/22 to 25 million in 2022/23.

NHS hits three million spring boosters

As of 19 May, the NHS COVID-19 Vaccination Programme has vaccinated almost half of those eligible with a spring booster.

World-first NHS test to curb transfusion side-effects for thousands with inherited blood disorders

The NHS is set to introduce a new genetic blood-matching test for thousands living with sickle-cell disease or thalassemia that could reduce painful side-effects of transfusion treatments. As it marks its 75th year, the NHS is to become the first healthcare system in the world to provide

blood group genotyping – a detailed DNA analysis of each patient's blood group – to more accurately match those in need of transfusions to donated blood.

NHS rolls out new 'lifeline' combination therapy for hundreds of women with womb cancer
Hundreds of women with advanced womb cancer in England will now be offered a new 'lifeline' option, as the NHS rolls out a life-extending new combination therapy that can halt the progression of the disease for twice as long as chemotherapy.

NHS rolls out order-to-home hepatitis C tests via NHS website for tens of thousands at risk
Tens of thousands of people at increased risk of hepatitis C are now able to confidentially order self-testing kits to their home, as the NHS steps up its bid to eliminate the deadly disease.

New Chief Midwifery Officer for England announced
Kate Brintworth has been appointed to the role of Chief Midwifery Officer for England. Kate has been a midwife for 26 years and is currently the Chief Midwife for NHS England in the London region and will join the national team in June.

Sara Hurley, the Chief Dental Officer for England, to stand down
Sara Hurley, the Chief Dental Officer for England is standing down after eight years. NHS England will shortly be undertaking the process to appoint the next Chief Dental Officer for England and will announce further details in due course.

Local developments

New Children and Young People's Assessment Unit Opens at Chesterfield Royal Hospital NHS Foundation Trust
GPs and clinicians in Chesterfield and beyond are now able to refer children and young people to a purpose-built £2m state-of-the-art Paediatric Assessment Unit. The exciting new development will ensure that children who have been referred by a healthcare professional can be assessed, investigated and reviewed much more quickly and responsively, in a setting which is far more suited to their short-term needs.

Junior doctors' industrial action: Wednesday 14 June - Saturday 17 June
Junior doctors who are members of the British Medical Association (BMA) and Hospital Consultants and Specialists Association (HCSA) have voted to take industrial action at NHS Trusts across England, including Trusts serving Derby and Derbyshire. During this time, junior doctors in Derbyshire will have the opportunity and personal choice to go on strike for all or some of the time.

E-bike loan scheme helps Derbyshire NHS staff improve their health
NHS staff in Derbyshire have been helped to improve their health and wellbeing through a bike loan scheme. A total of 157 people have used the bikes over the past year and a half. In a survey to those who took part 91% said they were considering buying an e-bike now or in the future and 70% said they would be likely to reduce their car use as a result of having an e-bike.

Weight loss scheme for people with type 2 diabetes to benefit hundreds more people in Derbyshire
Hundreds more people in Derbyshire are to be helped to lose weight and put their type 2 diabetes into remission when an innovative NHS programme is expanded from this month (June). Derbyshire was one of 10 pilot areas in England for what has now become the NHS

Type 2 Diabetes Path to Remission Programme. The programme supports participants to lose weight, control their blood sugars and live a healthier lifestyle – reducing the need for medication and helping to achieve remission of their diabetes.

Community pharmacy consultation service helps patients to be seen quickly

A service that enables community pharmacists to see patients quickly if they have minor conditions has been highlighted as one successful example of improving access to primary care. The Community Pharmacy Consultation Service has been operating in Derbyshire for over a year and has been particularly embraced by the Lister House GP practice, which has 46,500 registered patients across four sites in Derby. Their call centre advisers are trained to offer people who call to request an appointment with a GP the option of seeing their local pharmacist instead within 24 hours of the call. A total of 1,319 patients who called Lister House's Pear Tree and Chellaston sites were referred to a pharmacist between April 2022 and March 2023, with the numbers increasing over the course of the year.

Joined Up Care Derbyshire (JUCD) Public and Patient Insight Library Relaunch

The JUCD Public and Patient Insight Library, created following the outbreak of Covid-19, has been revamped. A central hub for collating and storing patient and public insight gathered across Derbyshire health, care, statutory and voluntary organisations is open to a wide variety of professionals to help inform decision-making.

Derbyshire's trailblazing role in Enhance training

The Enhance training programme enables doctors in training to undertake enhanced generalist skills and involves them taking up placements at Derbyshire Community Health Services NHS Foundation Trust (DCHS). The first Enhance internal medicine trainees arrived in August 2022 and over the course of the three-year training scheme will be rotating through placements across DCHS and with other Derbyshire system partners.

Supporting care leavers into the workplace

The health and care system in Derby and Derbyshire has become one of the first in the country to get all local organisations signed up to a scheme to support young people leaving care to access a career path in the sector. Partner organisations across Joined Up Care Derbyshire have all signed up to the programme, known as the Care Leaver Covenant, which will help care leavers aged 16-25 access employment, education and training opportunities and support their independence.

Identification of Key Risks

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

SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐			

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

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

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

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

Not applicable to this report.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

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

Not applicable to this report

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

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Not applicable to this report.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

15th June 2023

Item: 029

Report Title	ICB 2023/24 Financial Plan and Delegated Budgets							
Author	Donna Johnson, Acting Assistant CFO							
Sponsor (Executive Director)	Keith Griffiths, Executive Director of Finance							
Presenter	Keith Griffiths, Executive Director of Finance							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 - 2023/24 Financial Plan Appendix 2 – Financial Plan Delegated Budgets							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	As part of the System Plan at the Extra-ordinary ICB Board meeting on 4th May 2023							

Recommendations
The ICB Board is recommended to **DISCUSS** and **APPROVE** the ICB 2023/24 Financial Plan and Delegated Budgets.
Purpose
Formal approval of the ICB Financial Plan and Budgets as an individual statutory body
Background
The System Operational, Workforce, and Financial Plans for 2023/24 were previously brought to Finance and Estates Committee, and the Board. To ensure governance arrangements for the ICB's Plan are clear, the 2023/24 Financial Plan is returned to the Board.
Report Summary
The final plan for the ICB was submitted in May 2023 with a break-even position. This includes a challenging level of efficiencies at £44.2m. Key assumptions are outlined in the report, alongside further risks to its delivery.
Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐

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

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

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒
Details/Findings *This paper is for financial information.*		**Has this been signed off by a finance team member?** *Produced by Finance*

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

None

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?					
The paper is for financial information only, outlining the resources available.					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings *This paper is for financial information only, and does not outline projects that would have a green impact.*					

Purpose

- The Board is recommended to **DISCUSS** and **APPROVE**
  - The ICB's 2023/24 financial plan as an individual statutory body

    The plan has previously been to extraordinary Board and Finance & Estates Committee as part of the wider System 2023/24 plans.
  - The resultant delegated budgets and efficiencies

23/24 Financial Plan

- Planning to achieve a break-even position

- Significant challenge to deliver the required level of efficiencies of £44.2m

- Appendix 1 delegates the budgets and level of efficiencies (of this plan) to each Executive

- POD was outside of the planning submission, and has been delegated in year

	Plan £000's
Total Allocations	**2,240,004**
Acute Services	1,188,923
Mental Health Services	266,635
Community Health Services	183,152
Continuing Health Care	123,843
Prescribing	178,774
Primary Care Services	41,317
Other Programme	
Better Care Fund	61,359
111 Call Services	9,116
Other Programme - Support	(22,400)
Other Programme - Anticipated Allocations & Repatriations of Funding	(28,541)
Other Programme Expenditure	28,820
Primary Care Co Commissioning	189,422
Running Costs	19,583
	2,240,004
Total ICB Surplus/(Deficit)	**0**

Key Assumptions

- The ICB received allocations in line with national growth, adjusted for ‘Convergence’ (deemed over-funding) of £14.4m.

- 2023/24 expenditure derived with an initial resultant deficit of £14.2m:
  - 22/23 recurrent spend alongside full year effects
  - Inflation growth of 2.9% for Core and 5.7% for Primary Care Co-commissioning.
  - 3% efficiencies applied

- 2023/24 expenditure further reviewed with a final break-even submission
  - Uncommitted investments
  - Increase efficiencies to 4.4%
  - Use of non-recurrent support

- The impact of the additional 1% for organisations and £4m for Delivery Boards resulted in an efficiency requirement for the ICB of £44.2m.

Other Risks (1)

- Actual growth levels subsequently agreed > planning assumptions,
  - E.g. £4m s117, £5m BCF

  → requiring further efficiencies to be identified

- The plan includes actions for which the ICB is reliant on other organisations
  - E.g. £5m EMAS

- Elective Recovery Fund allocations may be clawed back by NHSE where performance does not meet the 103% system target

- In producing a balanced financial plan, Executives have agreed to remove some investment funding from the plan.
  - It is important that such decisions are considered when identifying further efficiencies in these areas for patient impact.
  - E.g. Long term conditions

Other Risks (2)

- Continued inflationary pressures
- Impact of industrial action
- No technical financial opportunities (balance sheet fully utilised in 2022/23)
- Costs transferring from other Government departments
    - E.g. School Health Review

BOARD PAPER – 15th JUNE 2023

ICB 2023/24 FINANCIAL PLAN

APPENDIX 2

Budget Holder	Service Area	Gross Expenditure Budget £'000	Efficiencies £'000	Net Budget £'000
Brigid Stacey	Continuing Health Care	130,364	(6,521)	123,843
Brigid Stacey	Other Programme - Staff Non Pay	1,325	(3)	1,322
Brigid Stacey	Other Programme Corporate Costs Derbyshire Providers	7	0	7
Brigid Stacey	Other Programme Pay Costs	3,380	(222)	3,158
Brigid Stacey	Running Costs	220	0	220
Brigid Stacey	**Subtotal**	**135,295**	**(6,746)**	**128,550**
Chris Weiner	Prescribing	190,347	(11,573)	178,774
Chris Weiner	Primary Care Services	7,062	(275)	6,787
Chris Weiner	Other Programme - Staff Non Pay	9	(0)	9
Chris Weiner	Other Programme Corporate Costs	729	(23)	706
Chris Weiner	Other Programme - Medicines Order Line	1,943	(128)	1,815
Chris Weiner	Other Programme Pay Costs	6,582	(435)	6,148
Chris Weiner	Other Programme Long Term Conditions	3	0	3
Chris Weiner	Other Programme Prevention	316	(10)	306
Chris Weiner	Running Costs	520	(34)	486
Chris Weiner	**Subtotal**	**207,512**	**(12,478)**	**195,033**
Helen Dillistone	Other Programme - Property Services	2,222	(73)	2,149
Helen Dillistone	Running Costs	9,591	(549)	9,043
Helen Dillistone	**Subtotal**	**11,813**	**(622)**	**11,192**
Keith Griffiths	Other Programme Reserves	(39,541)	0	(39,541)
Keith Griffiths	Running Costs	2,546	(168)	2,378
Keith Griffiths	**Subtotal**	**(36,994)**	**(168)**	**(37,162)**
Linda Garnett	Running Costs	721	(48)	674
Linda Garnett	**Subtotal**	**721**	**(48)**	**674**
Zara Jones	Acute Services	1,199,384	(10,461)	1,188,923
Zara Jones	Mental Health Services	270,332	(3,696)	266,635
Zara Jones	Community Health Services	185,366	(2,214)	183,152
Zara Jones	Primary Care Services	35,896	(1,366)	34,530
Zara Jones	Primary Care Co Commissioning	194,420	(4,997)	189,422
Zara Jones	Better Care Fund	62,211	(852)	61,359
Zara Jones	111 Call Services	9,398	(282)	9,116
Zara Jones	Other Programme - GP Development	1,925	(127)	1,798
Zara Jones	Running Costs	7,264	(481)	6,783
Zara Jones	**Subtotal**	**1,966,194**	**(24,476)**	**1,941,718**
Planning Adjustments		**(324)**	**324**	**0**
		2,284,218	**(44,214)**	**2,240,004**

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

15th June 2023

Item: 030

Report Title	Memorandum of Understanding - Voluntary, Community and Social Enterprise Sector and the ICB							
Author	Wynne Garnett, Programme Lead, Engaging the VCSE sector in the ICS							
Sponsor (Executive Director)	Dr Chris Clayton, Chief Operating Officer							
Presenters	Wynne Garnett, Programme Lead, Engaging the VCSE sector in the ICS Kate Brown, Director of Commissioning and Community Development							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 – Memorandum of Understanding							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Final version for recommendation agreed by VCSE Alliance on 23rd May and the Integrated Place Executive on 25th May.							

Recommendations
The ICB Board is recommended to **AGREE** and **ADOPT** the Memorandum of Understanding.
Purpose
The Memorandum of Understanding sets a framework for the principles, culture and activities that are needed to underpin the VCSE sectors contribution as a partner in the Integrated Care System.
Background
Context National Guidance on engaging the VCSE sector in Integrated Care systems was released in 2021 and included an expectation that Memorandum of Understandings (MoUs) would be developed within each system, setting out how the VCSE sector would be embedded as a partner. Initial guidance advised that these were to be signed off by the ICB and the VCSE Alliance. MoUs vary significantly from system to system. In some systems the MoU has also been signed off by the Integrated Care Partnership and it is the intention to propose this MoU to the Derby & Derbyshire ICP for adoption at its next meeting. There is growing recognition of the importance of the VCSE sector particularly around prevention, health inequalities and tackling determinants of ill health, in addition the sector plays a vital role connecting with and amplifying the voices of communities. A great deal of positive work has been undertaken in the Derby & Derbyshire system and the MoU builds on this and aims to underpin positive relationships going forward.

Whilst the national expectation has been a catalyst for this work it is likely that the system would have initiated this action now as a useful step in confirming, with clarity, the commitment to working in partnership and a checklist of outcomes against which it will be possible to review whether VCSE engagement is developing effectively.

Development & Engagement
A draft MoU was originally produced by a VCSE Alliance Task group to stimulate discussion. The drivers were to produce something short, understandable, effective and measurable. The focus was on four components; context; behaviours and culture, aspirations/actions and measurements. The draft was circulated and promoted widely throughout the VCSE sector, including VCSE networks and infrastructure organisations. It has also been to a number of relevant structures of the Integrated Care System namely the Integrated Place Executive, the City and County Place Partnerships, Local Place Alliances and the Mental Health, Learning Disabilities and Neurodiversity Alliance.

Engagement opportunities included a Teams session for statutory partners and making the draft available online. There was a lot of helpful feedback and support.
Issues included:

- using “we” statements rather than ascribing different expectations between VCSE and other partners;
- the importance of engaging the breadth of the VCSE sector at all planning cycle stages
- recognising power dynamics; and
- the need to develop sustainable relationships.

The final version takes feedback into account and was approved by the VCSE Alliance on 23rd May and the Integrated Place Executive on 25th May.

Next Steps
The agreement is intended to be a practical reference point for working with the VCSE sector in the system. The culture and behaviours are critical, and the addition of aspirations, actions and measurements make the MoU something that can be evaluated. When the MoU was supported by the Integrated Place Executive, the concept of having an annual review by a cross sector group that could report back into the IPE was proposed.

If approved by the ICB the proposal is to launch and promote the agreement at an event organised on June 26th which is called 'Moving Forward Together' and is open to VCSE and public sector colleagues to meet together and share learning and opportunities, build connections and help shape future ways of working together for the benefit of the population of Derby & Derbyshire.

Report Summary

The MoU begins by setting out the policy context and the nature/contribution of the VCSE sector. It then sets out the principles, behaviours and culture needed by all partners (including the VCSE sector) to build trust and underpin partnership working. The next section identifies aspirations and actions in the key areas of intelligence, engagement, strategy, investment, support/infrastructure, workforce development and data sharing. Finally, the MoU captures some key outcomes. The intention is that this should be an iterative document, reviewed and refreshed every 12 months and one that helps us to see what progress has been made and where the barriers might be.

Identification of Key Risks

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

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

The main risk / challenge is that truly acting in line with the aspiration in the MoU requires cultural change across the whole system and VCSE partners may feel frustrated and disengaged if they don't experience the change hoped for. However, the maturing relationship enables open conversation about the challenges, potential pace and priorities.

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

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

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

None identified

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☒	No☐	N/A☐	**Summary:** Stakeholder engagement as identified above

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

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

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?					
None identified.					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Not applicable					

Memorandum of Understanding between the VCSE Alliance and the Integrated Care Board

1. The National Context

In September 2021, national guidance on the engagement of the voluntary, community and social enterprise sector (VCSE) in Integrated Care Systems was released. It included an expectation that Integrated Care Boards (ICBs) should develop a formal agreement for engaging and embedding the VCSE sector in "system level governance and decision-making arrangements ideally by working through a VCSE Alliance to reflect the diversity of the sector". Since then, NHS England has issued guidance that Integrated Care Systems should be well on the way to signing off agreements by April 2023. Initially the expectation was that the agreement should be signed off by the Integrated Care Board as a constituted body but in some systems the agreement (now called a Memorandum of Understanding) has been signed off by the Integrated Care Partnership (ICP). In Derbyshire the Memorandum of Understanding is to be signed off by the ICB and to go to the ICP for adoption.

The national implementation guidance also underlines the VCSE sectors role as a key strategic partner "with an important contribution to make in shaping, improving and delivering services and developing and implementing plans to tackle the wider determinants of health".

In addition, the ICS Design Framework sets out some key "partnership principles" to underpin partnership working between ICS partners.

2. The Derbyshire Agreement

This agreement meets the national expectation. It builds on the partnership principles, initial feedback from VCSE organisations in the county, engagement experience in the ICS so far and examples from elsewhere in the country.

3. The VCSE sector in Derbyshire

The VCSE sector is extraordinarily diverse. There are thousands of independent organisations across the county ranging from large groups with million-pound turnovers to small groups with no paid staff. They are active in every field imaginable including Health, Social Care, Arts, Faith and Regeneration. They can be focussed on where people live; "communities of place" and on people sharing common characteristics and experiences; "communities of interest/condition". VCSE groups deliver a wide range of functions including championing/engaging communities, delivering services and providing a vehicle for people to provide mutual support, (it is not uncommon for groups to be undertaking more than one). The most recent study of the VCSE sector in Derbyshire (excluding the City), revealed 5000 VCSE groups with 5 million service users and a combined value of £340 million. 70% of organisations were composed only of volunteers but there were 10,000 FTE paid staff working in the sector, a figure similar in size to the number employed by the University Hospital of Derby and Burton NHS Foundation Trust.

4. What does the VCSE sector bring to the ICS?

Guidance from NHS England stresses the importance of the VCSE sector contribution to the ICS, particularly given the focus on tackling health inequalities and the wider determinants of ill health, engaging communities, doing things differently and looking at cost effective delivery. There is also a recognition that the gap between demand and treatment services will continue to grow, making preventative work so important. VCSE organisations already provide support that underpins statutory health and social care services and can,

- Provide hard and soft intelligence about the needs and challenges facing communities,
- Contribute a Lived Experience perspective,
- Facilitate access and engagement with communities that experience health inequalities

- Provide services that are innovative, complementary and mainstream and which could be low level (for example at a social prescribing level) or sophisticated and mainstream (eg Eating Disorders support)
- Release resources within communities to respond to challenge and generate social capital (as was seen in the pandemic)
- Access other streams of investment to provide additional value,
- Address wider determinants of ill-health (debt, homelessness, domestic violence etc)

Altogether this contribution can generate better planned/designed services, greater reach into communities and approaches that can limit the extent of costly later interventions.

The VCSE sector can therefore contribute significantly to the approach and aspirations of the ICS. To get the most from this potential contribution, we want to move towards an equal partnership This agreement sets out a framework for achieving this, outlining principles that can underpin behaviours and culture and practical areas of action.

5. Principles, Behaviours and Culture

Trust between partners is essential to making partnership work. Trust has to be built and earned and is underpinned by behaviours and culture. The following set of principles are designed for VCSE organisations and partners to make the most of this relationship.

<u>Working together</u>

- We will value everyone's experience and expertise equally,
- We will acknowledge and work to our respective strengths,
- We recognise the power dynamics that sometimes exist between partners and recognise that It is ok as partners to constructively challenge and disagree,
- We commit to collaborative working as equals, will follow commitments through and walk the talk,
- We will work to the values of co-production including co-design and co-learning,
- We will learn from each other, from what we do and from what happens elsewhere,
- We will work together to build sustainable VCSE sector services and organisations,
- We will be outcome focussed and willing to cede leadership to where it works best,
- We will take time to understand and take account of the ways different organisations and sectors work,
- We will work together to identify and remove barriers to joint working.

<u>Working within the system</u>

- We will be creative and work differently to best engage VCSE organisations of all sizes, being careful not to undermine diversity through structure.
- We will promote more integrated and joined up ways of working,
- We will ensure that the breadth of the VCSE sector has the opportunity to be involved in all stages of the planning cycle at the earliest point. We recognise that VCSE organisations don't always fit neatly into structures and systems!
- We will take a strengths-based approach building on existing assets,
- We will seek to put communities of place, shared interest and condition at the centre of our work.
- We recognise the independence of VCSE organisations including the right to campaign,
- We will commit the time and resources that are necessary to develop effective relationships,
- We will look to build sustainable relationships with approaches that are proportionate to the sizes of organisation involved,
- We will take the risks necessary to innovate and do things differently,
- We will recognise and work with VCSE Alliance and infrastructure systems, processes and structures, recognising that there are many different perspectives.

<u>A final thought</u>

- Collaborative working should generate more accessible and effective services for those who use them. Evaluation should show whether this is happening.

6. Vision

It is important that we have a clear vision. We want the VCSE sector to bring the full range of its strengths to the ICS which means proactive and collaborative working, where the VCSE sector contributes at all stages; needs assessment, prioritising, planning and design as well as delivery. Our vision is,

"A thriving, diverse and sustainable VCSE sector that contributes as an equal partner to improve the health and wellbeing of people in Derby and Derbyshire".

7. Aspirations and Actions

The VCSE sector is a critical partner in improving the health and well-being of people in Derbyshire, particularly within the context of the Integrated Care System that promotes prevention and dealing with health inequalities/determinants of ill health. Engaging the VCSE sector and working differently does present challenges to working culture and behaviours. Below is a summary of the key aspirations and actions required to generate a positive culture of partnership and make the most of the VCSE contribution.

Aspiration	**Action**
<u>Intelligence</u> Qualitative and quantitative data and information from VCSE groups shape planning and priorities	• VCSE sector embedded in ICS processes that engage communities (Insight) and use data to shape health and well-being (Population Health Management), • VCSE engages Lived Experience and the expert knowledge of organisations to shape and influence decisions. • Local intelligence from communities and through social prescribing/similar initiatives influence commissioning, • Up to date information on VCSE sector maintained.
<u>Engagement</u> • VCSE sector represented across ICS partnership structures. • VCSE sector involved at outset of all stages of the planning cycle. • Alliance and representatives able to engage with breadth and tapestry of sector	• VCSE sector to have provider and infrastructure places on ICP, Place Partnerships, Integrated Place Executive, Mental Health/Learning Disabilities/Neurodiversity Delivery Board and Local Place Alliances, • VCSE sector also has strategic connections with Integrated Care Board, other Delivery Boards and Provider Collaborative • Sector engagement approaches are creative and bring discussions outside system meetings. • System processes allow enough time for VCSE organisations to collaborate, • VCSE sector to be core partners in Local and County/City Place Alliances and be a key Insight mechanism for the engagement of local communities with support from VCSE infrastructure, • Use of forums, VCSE infrastructure and a virtual VCSE to inform, learn, cascade out information and generate discussion.
<u>Strategy</u> Ensure VCSE sector is engaged at the outset in key strategy development	Involvement as core partner in continued development of key system plans and strategies including the Integrated Care Strategy and Health and Well-Being Plans
<u>Investment</u> Funding supports VCSE sector to maximise its strengths and	• Procurement and commissioning approaches engage the VCSE sector at all stages,

contribute as a sustainable partner	• Clear guidelines support good practice approach to collaborative commissioning, • Facilitation and support for collaborative working through VCSE infrastructure • Small grants support VCSE organisations working at local level and contributing to Integrated Care system initiatives, • Investment builds on local assets and recognises full cost recovery, • Funding approaches build long term sustainable relationships, • Evaluation approaches help to capture impact and preventative value of work undertaken, • Partners work together to identify new sources of funding.
<u>Support and Infrastructure</u> VCSE organisations have the right support to enable them to make the best possible contribution as partners	VCSE infrastructure includes local VCSE infrastructure and the VCSE Alliance. Local VCSE infrastructure functions are critical to a healthy sector. Applied to the Integrated Care System this includes, • Supporting VCSE engagement across the system including Place Alliances • Building the capacity of VCSE organisations in areas such as governance and product development • Building cross sector relationships and partnerships including responding to new developments • Facilitating and brokering collaborative working within the VCSE sector • Being an information source • Advocating the VCSE sector contribution Action will include supporting local VCSE infrastructure to undertake these functions, exploring any economies of scale and looking at the development of the VCSE Alliance
<u>Workforce Development</u> Explore the nature of the paid and unpaid VCSE workforce and how the system might help to meet challenges.	• Establish a sense of the current VCSE workforce and its challenges, • Explore how as partners we can support issues of recruitment, talent management, progression and succession planning, • Look at the challenges created by differences in remuneration between sectors, • Support management and leadership development, • Develop statutory partner skills and understanding around working with the VCSE sector, • Explore how statutory partners may support the VCSE sector through volunteering,
<u>Data Sharing</u> Remove barriers to joint working created by issues of data sharing	• Identify and mainstream examples of good practice within the Integrated Care System • Adopt a Derbyshire wide data sharing protocol.
<u>Culture and behaviours</u>	• Promotion, training and guidelines to ensure that engaging the VCSE sector early and at all stages is

To create a fertile context for partnership with the VCSE sector	integral to statutory partner thinking and the design of new policies and initiatives, • Encourage proactive rather than reactive thinking within the sector, • Support approaches around co-production • Support approaches around cross sector and intra sector collaborative working • Explore Integrated Care System approaches to risk and encourage innovation and new ways of working, • Look at how evaluation can best capture VCSE impact, • Evaluate progress against the MoU in 12 months' time,

8. Outcomes

We need to be able to review whether VCSE engagement is developing effectively in line with this agreement and that requires outcome measures that we can revisit in 12 months' time. The checklist below provides a starting point.

Outcomes	✓
Strategies, plans and initiatives provide the opportunity for wide VCSE sector involvement at the earliest opportunity at all stages. This is demonstrated in initiatives such as Team Up, Social prescribing, Living Well and the roll out of Start Well, Stay Well, Age Well/Die Well activity.	
Strategies, plans and initiatives reflect this involvement through new approaches and increased VCSE activity and engagement.	
Qualitative intelligence from community engagement is shaping priority setting and design with the VCSE sector at the heart of the Insight approach.	
VCSE representation on key existing and emerging system structures	
Local VCSE infrastructure is embedded as a core partner within Local Place Alliances	
Evidence of changes to procurement and commissioning that promote more collaborative approaches, build on existing assets and generate sustainable relationships.	
Evidence of co-production approaches	
Continued development of the VCSE Alliance and its relationship with other infrastructure	
Clarity around how VCSE infrastructure functions can be focussed and delivered for the benefit of the Integrated Care System using existing investment.	
Understanding of the nature of the VCSE workforce, the challenges it faces and a cross sector system plan of action to address these.	
Cross sector data sharing protocol in place	
Small grants available at Local Place Alliance level to support small community-based groups that contribute to initiatives such as social prescribing, hospital discharge and Team Up	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

15th June 2023

Item: 031

Report Title	Operational Plan for 2023/24
Author	Sukhi Mahil, Assistant Director Workforce Strategy, Planning and Transformation Nancy Cooke, System Workforce Planning Lead Sam Kabiswa, Assistant Director, Planning and Performance Darran Green, Associate Chief Finance Officer
Sponsor (Executive Director)	Zara Jones, Executive Director of Strategy and Planning
Presenter	Performance – Zara Jones, Executive Director of Strategy and Planning Workforce – Linda Garnett, Interim ICB Chief People Officer Finance – Keith Griffiths, Chief Finance Officer
Paper purpose	Decision ☒ Discussion ☐ Assurance ☒ Information ☐
Appendices	Appendix 1 - 2023/24 Operational Plan Appendix 1.1 2023/24Operational Plan Narrative Appendix 2 - Operational Performance Progress Update Appendix 3 - 2023_24 Workforce Plan M1 Position Appendix 4 - M01 System Finance Position Final - Board
Assurance Report Signed off by Chair	Not Applicable
Which committee has the subject matter been through?	System Finance and Estates Committee ICB People and Culture Committee Quality and Performance Committee

Recommendations
The ICB Board is recommended to **AGREE** the 2023/24 Operational Plan and **NOTE** the Month 1 performance Operational Plan progress update against the plan commitments and targets.
Purpose
The purpose of this report is to present the final 2023/24 Operational Plan which was submitted to NHSE on 4th May and provide an update on progress against the performance targets and commitments, including workforce and finance, which were agreed with NHSE.
Background
The 2023/24 Operational Plan set clear, measurable objectives which are fundamental to the NHS' contribution to improving health outcomes. The Plan was submitted to NHSE on 4th May. The improvements in the Plan are planned to be achieved by using our assets more productively with minimal or no growth in workforce. The Financial Plan assumed a break-even position.

Following submission of the operational plan, work is now underway to develop a more cohesive and integrated framework for future reporting against delivery of the Plan. The ambition is to:

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

Whilst this initial report aims to present the information in a more joined up way, it is important to note that there is a significant amount of development work still required to create a truly integrated and triangulated monitoring and reporting framework and report.

Report Summary

Below is a summary of the M01

Summary of 2023/24 JUCD Operational Plan (Appendix 1)

- This plan is strategically sound and aligns well with the aims of the ICB. It sets clear, measurable objectives which are fundamental to the NHS' contribution to improving health outcomes.
- Improvement is hard-wired into this plan and for the majority of metrics within scope, we aim to perform better in 2023/24 compared to 2022/23.
- This improvement is planned to be achieved by using our assets more productivity and requires minimal growth in workforce.
- Our financial plan proposes a break-even position.
- We will face significant challenges in delivering this plan – resources, timescales, uncertainties i.e. operating environment.

Performance (Appendix 2 – please note some of the data in this report is part validated)

Urgent and Emergency Care:

- Both Trusts met their A&E 4hr plan in April 2023 and performance continues to stay at this level in May. However, there is more work to improve Type 1 performance at both trusts.
- In April 2023, EMAS' out turned performance of 33 minutes against the 30-minute category 2 response time. For Derby and Derbyshire, the target was achieved.
- Ambulance handover delay performance is relatively stable at both JUCD Acute Sites.
- Neither Trust is meeting the 92% average adult G&A bed occupancy rate – with the 6-week average standing at 96.6% and 93.0% at the Chesterfield Royal Hospital and Royal Derby Hospital sites, respectively. However, long length of stay is improving at UHDB and is operating 'within control limits' at the CRH.
- The number of patients who are remaining in hospital who no longer meet the criteria to reside this financial year is no different to what we saw at the same time last year.

Planned Acute Care

- Both Trusts are reducing their long cancer wait positions – with the Chesterfield Royal Hospital ahead of its target trajectory (47 patients waiting 63 days or more against at target of 49 as at 30/4/23) and the University Hospitals of Derby and Burton is behind (473 patients waiting 63 days or more against a target of 421 as at 30/4/23).
- Referral to Treatment – the number of patients waiting 65 weeks, or more was slightly higher at the end of April 2023 compared to the start of it (2,260 patients as at 30/4/23 vs 2,087 as at 2/4/23).

- The Chesterfield Royal Hospital is ahead of its target trajectory (369 patients as at 30/4/23 against a target of 467) and the University Hospitals of Derby and Burton is behind its target trajectory (2,260 patients as at 30/4/23 against a target of 2,156).

Diagnostics

- Early unvalidated data for April indicates that as a system we are currently achieving 70% against a 75% target of those waiting 6 weeks or less for diagnostics.

Primary Care

- During April there were 471,753 GP appointments. This was 27,695 more GP appointments than the April operational plan target of 444,058.
    - 76.1% of the appointments were held face to face
    - 40.0% of patients were seen on the same day that the GP was contacted

Community Health

- The ICB has so far achieved a performance of 78% against the national target of 70% for the 2 Hour Urgent Community Response.

Mental Health and Learning Disabilities

- Unvalidated data shows that we are on track to achieve the increase in access performance requirements for CYP and Adult Community Mental Health contacts, Talking Therapies and perinatal mental health services. We have seen an improvement in dementia diagnosis rate however are still showing slightly under the national required performance achieving 66% against a target of 67%. We are on track to achieve the LD Annual Health Check quarterly performance requirement
- In relation to inpatient services, we continue to be non-compliant with achievement of 0 out of area MH placements however this position is due to the lack of PICU services within Derbyshire. Transforming Care for people with LD&A continues to be an area of pressure; we are performing well against the agreed trajectory; however it is non-complaint against the national requirement.

Workforce (Appendix 3)

Providers are not required to submit a month one Provider Workforce Returns (PWR) and the national team are amending the PWR template to reflect the Whole Time Equivalent (WTE) workforce plan submission template, as the staffing categories were more detailed than in previous years. Therefore, it has not been possible to collate the workforce data in the usual way from the PWR. In order to provide an interim view of the workforce position an alternative method has been adapted to provide a high-level interim view of the month one position. This has been done by extracting information from the finance ledger. The details can be found in Appendix 3.

In summary, by undertaking this exercise the system level position appears to be £2.6m over plan on the year to date pay costs. This is with 1,311 fewer substantive staff in post (WTEs) against the baseline establishment figure (net vacancies). Overall, the net staffing (Substantive, Bank and Agency WTE total) is only 79 WTE above the planned figures and therefore an assumption is made that the over plan pay costs may be attributed to the over plan bank and agency position (135 WTE and 51 WTE respectively).

It is assumed that the industrial action during April impacted on the pay position, which correlates with the finance position below.

An aligned view of workforce and finance has never been undertaken in this way before and this is a very crude assessment of the data in the absence of the PWR and more detailed month one reporting. The exercise and reviews taking place have highlighted the need for greater triangulation of the data with finance and performance moving forwards. Work is underway to try to bring each of the aspects together, but it is important to note, there is more work to be done to build a cohesive view.

Finance (Appendix 4)
As of 30th April 2023, the JUCD year to date position is £7.0m deficit against a £3.6m planned deficit, which is largely driven by the industrial action by Junior Doctors. However, all JUCD organisations remain committed to a breakeven position.

Key to achieving the financial plan for 2023/24 will be the delivery of £136.1m of efficiencies, but only £102.0m of which are planned to be recurrent, which will mean there is still a recurrent underlying financial issue. The Provider Collaborative and Place will be required to make a significant contribution to delivering the in-year and recurrent underlying position.

Identification of Key Risks

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

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

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒
Details/Findings *This paper is for financial information.*		**Has this been signed off by a finance team member?** *Produced by Finance*

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

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

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

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

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

NHS
Derby and Derbyshire
Integrated Care Board

2023/24 Operational Plan

4th May 2023

Draft: v1.1

Executive Summary

Headlines:

- This plan is strategically sound and aligns well with the aims of the ICB. It sets clear, measurable objectives which are fundamental to the NHS' contribution to improving health outcomes.
- Improvement is hard-wired into this plan and for the majority of metrics within scope, we aim to perform better in 2023/24 compared to 2022/23.
- This improvement is planned to be achieved by using our assets more productivity and requires minimal growth in workforce.
- Our financial plan proposes a break-even position.
- We will face significant challenges in delivering this plan – resources, timescales, uncertainties r.e. operating environment.

Improvement to operational performance is hardwired into this plan…

Area	Objective	Compliant with NHSE target?	Improvement on 23/24?
Primary Care	Increase General Practice appointment activity	No target set at time of writing.	
	Increase referrals into Community Pharmacy Consultation Services		
	Recover dental activity to pre-pandemic levels		Mirrors 22/23 levels.
Mental Health, Autism & Learning Disabilities	Increase the dementia diagnosis rate	65.5% vs. a target of 67.6%.	
	Provide access for 28,294 people to receive IAPT in 23/24		Mirrors 22/23 levels.
	Increase the number of women accessing specialist perinatal services in 2023/24.		
	Increase the number of children and young people accessing a mental health service.		
	Increase the number of adults with a severe mental health illness receiving 2+ contacts with a community health service.		
	Ensure that 75% of individuals listed on GP registers as having a learning disability will receive annual health check.		
	Reduce the number of adults who are autistic, have a learning disability or both who are in beds commissioned by the ICB and NHSE.	23 inpatients vs a target of 16.	
	Reduce out of area placements	736 vs a target of 0.	
Cancer	Ensure that at least 75% of people receive communication of a diagnosis for cancer or ruling out of cancer, or a decision to treat if made before a communication of diagnosis, within 28-days following an urgent referral for suspected cancer.		
	Reduce the number of people waiting longer than 62 days for their first definitive treatment for cancer.		

Area	Objective	Compliant with NHSE target?	Improvement on 23/24?
Planned Acute Care	No person waiting longer than 65 weeks on an RTT pathway at the end March 2024.		
	At least 85% of people receive a diagnostic test within 6 weeks by March 2024.		
Urgent and Emergency Care	No less than 76% attending ED waiting longer than 4 hours either to be treated, admitted or discharged, by March 2024.		
	30 minutes or less for EMAS to respond to a category 2 incident, on average.		
	Both Acute Trusts to operate at an average general and acute occupancy rate of 92%.	92.6%	
	At least 70% of referrals into the Urgent Community Response Service to be responded to within 2 hours.		
	Increase virtual ward capacity.	No target set.	
	Reduce emergency admissions resulting from a frailty induced fall.	No target set.	

Area	Objective	Compliant with NHSE target?	Improvement on 23/24?
Prevention	**Primary**		
	For those who are pre-diabetic, increase the take-up of the diabetes prevention programme.	No target set.	Not known at time of writing.
	Increase the number of people who receive the Tobacco Dependency Treatment Programme.	No target set.	Not known at time of writing.
	Increase the number of people with a high BMI who being managed on a weight management service.	No target set.	Not known at time of writing.
	Secondary		
	Increase the number of people who are being screened for diabetic retinopathy.	No target set.	Not known at time of writing.
	Increase the percentage of people aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%.	Not known at time of writing.	Not known at time of writing.
	Tertiary		
	Increase the proportion of people who meet all 3 diabetes treatment targets.	No target set.	Not known at time of writing.
	Reduce waiting times for pulmonary rehabilitation.	No target set.	Not known at time of writing.
	Increase the number of people with heart problems who are referred to and uptake a programme of cardiac rehabilitation.	No target set.	Not known at time of writing.
	Increase the percentage of patients with hypertension treated to NICE guidance to 77% by March 2024.	Not known at time of writing.	Not known at time of writing.

Our objectives for operational improvement fit with the prevention agenda.

Primary Prevention

Prevent disease or injury before it happen

- We will ensure that 75% of individuals listed on GP registers as having a learning disability, receive an annual health check.
- We will increase the number of people who are being managed on a weight management service.
- We will increase the number of people who attend smoking cessation.

Secondary Prevention

Detect and treat disease or injury before it becomes more severe

- We will increase the dementia diagnosis rate from 63.7% to 65.5% over the next 12 months.
- We will provide access for 28,294 people to receive Talking Therapies/Improving Access to Psychological Therapies (IAPT) services in 2023/24.
- We will double the number of women accessing specialist perinatal mental health services over the next 12 months.
- We will increase the number of children and young people accessing a mental health service by a third, over the next 12 months.
- We will reduce the number of people waiting for a diagnostic test by 30% over the next 12 months and, on average, 85% of people requiring a test will get one within 6 weeks.
- We will reduce category 2 ambulance response times to an average of 30 mins in 2023/24.
- We will ensure that at least 70% of people who are referred into the Urgent Community Response Service, are responding to within 2 hours.
- We will reduce frailty induced falls.
- We will ensure that at least 75% of people receive communication of a diagnosis for cancer or ruling out of cancer, or a decision to treat if made before a communication of diagnosis, within 28-days following an urgent referral for suspected cancer.
- For those who are pre-diabetic, we will increase the take-up of the diabetes prevention programme.
- We will increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%.

Tertiary Prevention

Manage and treat the complications of disease to prevent further deterioration

- We will increase the number of adults with a diagnosed mental illness accessing a mental health service by a third, over the next 12 months
- We will reduce the number of adults who are autistic, have a learning disability or both who are in beds commissioned by the ICB and NHSE to 23 and 13 respectively, by March 2024.
- We will reduce the number of inappropriate out of area placement beds days by 40% over the next 12 months.
- We will reduce the number of people waiting for treatment by 22% over the next 12 months and no person will be waiting longer than 65 weeks for their treatment by the end of March 2024.
- We will ensure that No less than 76% of patients attending A&E are admitted, transferred or discharged within four hours.
- We will bring on line up to 255 virtual ward ‘beds’ by March 24 -a four-fold increase in provision –covering 5 condition based pathways.
- We will reduce the number of people waiting for their first definitive treatment for cancer by 30% over the next 12 months, and no patient will be waiting longer than 62 days for this treatment by the end of March 2024.
- We will increase the number of people with a chronic respiratory condition who are referred to and uptake a programme of pulmonary rehabilitation.
- We will increase the number of people with heart problems who are referred to and uptake a programme of cardiac rehabilitation.
- We will increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024.

Better productive use of our assets is a pre-requisite for delivering planned improvements to operational performance…

1. Reduce general and acute bed occupancy to 92% on average

Delivering the activity required to reduce RTT waiting lists and also maintain flow along the UEC pathway requires more general and acute beds than we substantively have. We therefore have to reduce the overall G&A bed occupancy from 106% at the CRH and 99% at UHDB.

We plan to do this by:

- Increasing the supply of medical beds – reconfiguration works at the RDH.
- Reduce length of stay – by having less patients who are medically fit for discharge in delay and maximising the use of virtual ward capacity.
- Reducing admissions – particularly those related to frailty induced falls as a result of scaling the community offering over the next 12 months.

2. Fully utilising our theatre capacity

Our overall utilisation of theatres benchmarks well across the NHS – with the system ranked in the upper quartile nationally. However, there are areas for improvement and we will seek to increase output by 15-20%.

3. Fully utilising our outpatient capacity

The ICB's Did Not Attend (DNA) rate is one of the best in the NHS – operating in the upper quartile nationally. However, we will seek to move to top-decile performance and reduce our rate from 6.2% to 5.1% over the next 12 months. We will also focus on enhancing our use of Patient Initiated Follow-up (PIFU) so as to *convert* follow-up clinic capacity into new.

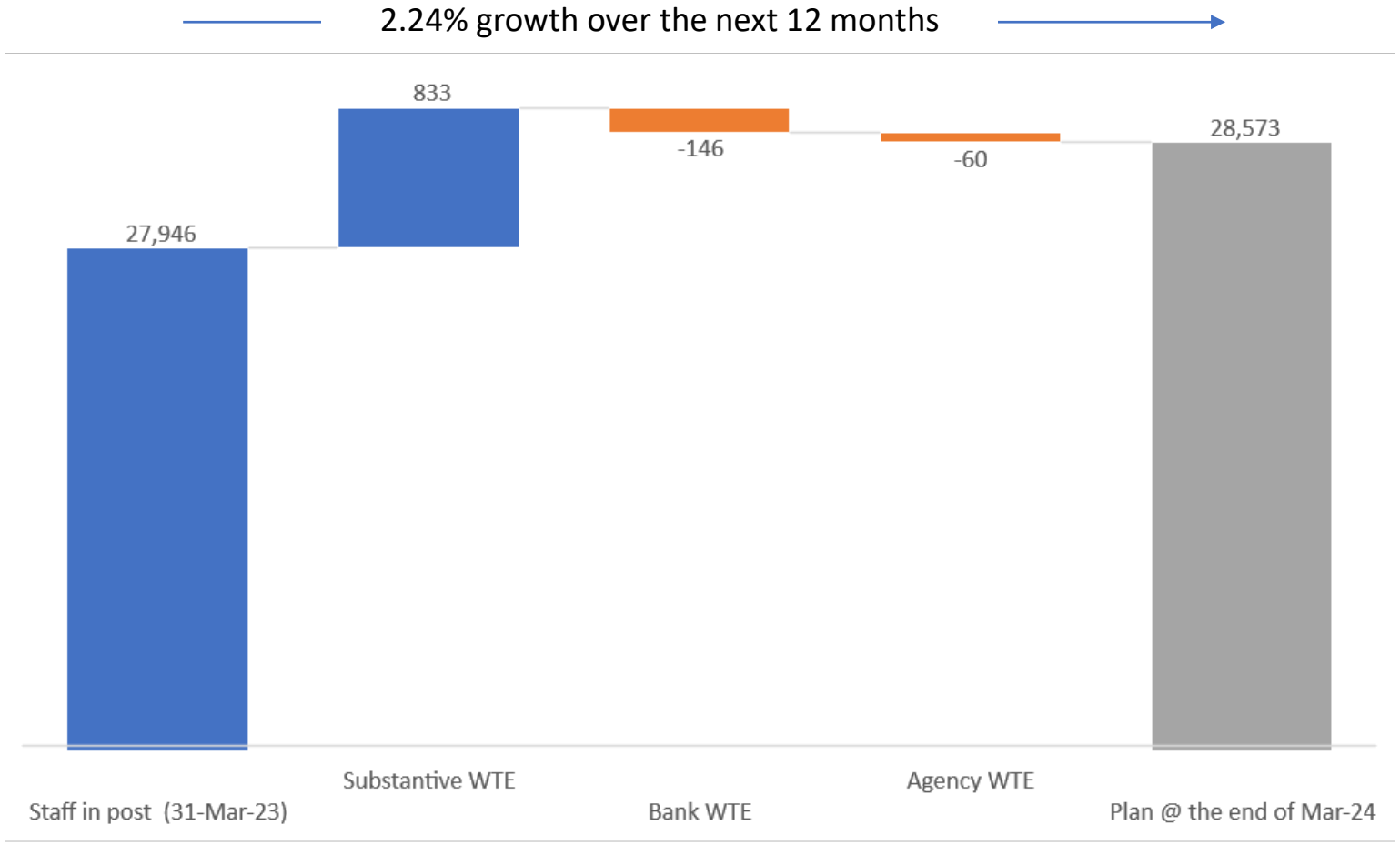
4. Controlling our sickness absence rates

The sickness absence rates in 2022/23 across our four Acute Trusts are unprecedented and is a key driver for why productivity has not returned to pre-pandemic levels. We will seek to keep our rates low over the next 12 months by looking after our people.

Our workforce plan – no material change to the 30/3/23 submission (a net 14 WTE increase), with improvements to operational performance achieved with minimal workforce growth.

With the 2.24% increase due to:

- Efficiencies/ recruitment to vacancies
- Care quality/safety (with the most material relating to Midwifery on the back of the Ockenden review).
- Income backed (e.g. MHIS, virtual wards, Community Diagnostic Centres).
- TUPE transfers (e.g. EMAS' new PTS contract portfolio).
- New services (e.g. PICU).
- Trainee clinical staff in the recruitment pipeline.



Improvements in operational performance

- Primary Care
- Mental Health, Autism & Learning Disabilities
- Planned Acute Care
- Cancer Care
- Urgent and Emergency Care
- Prevention - Diabetes, Respiratory & Cardiovascular Disease

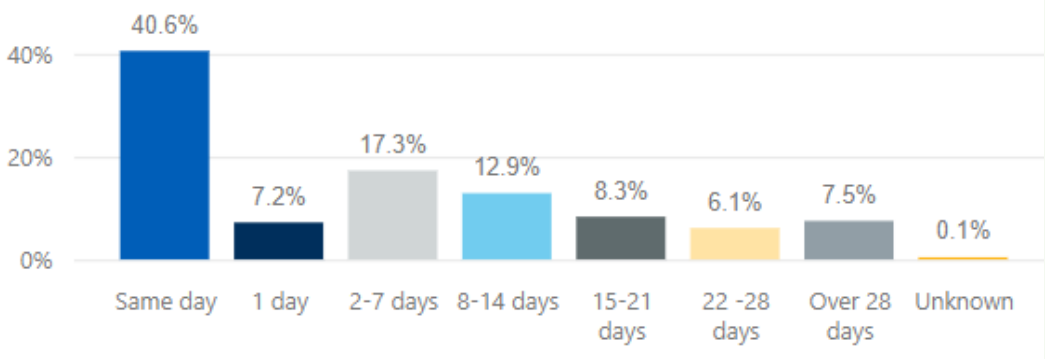
Primary Care

GP Consultations

Whilst further work is done to produce the ICB's 'GP Access Recovery Plan' during Q1 of 23/24, the current working assumption is that the average growth rate in GP consultations delivered over the last 3 years (excl. 20/21), continues into 2023/24.

Furthermore, the ICB is currently assuming that just under half of these appointments will be delivered within 1 day of the booking being made – effectively reflecting 2022-23 performance. This is an aspect that will be under review as part of the work to produce the Access Recovery Plan and therefore may change.

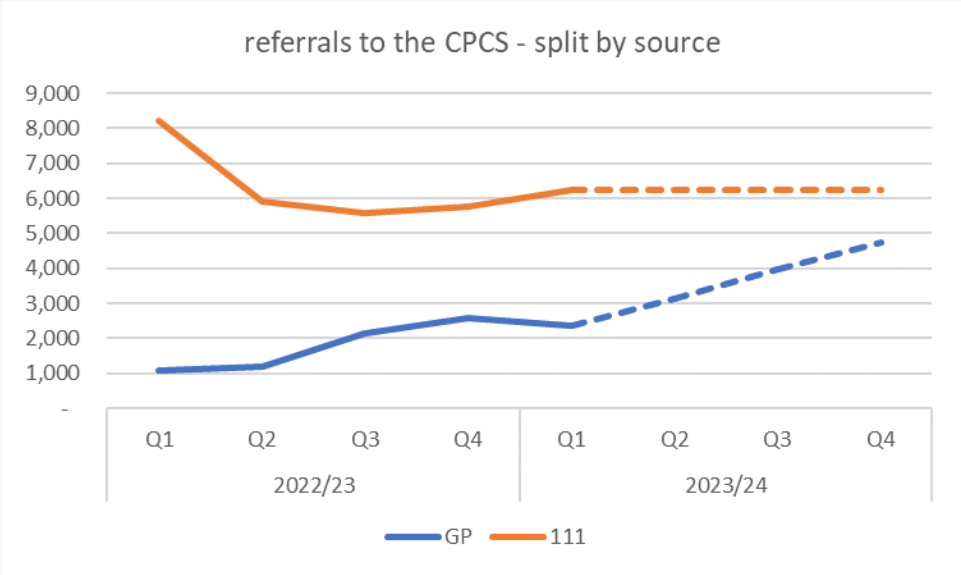
Percentage of GP appointments by time (days) between booking and appointment



Community Pharmacy

The NHS Community Pharmacist Consultation Service (CPCS) facilitate patients having a same day appointment with their community pharmacist for minor illness or an urgent supply of a regular medicine, improving access to services and providing more convenient treatment closer to patients' homes. The Service offers patients the option of having a face-to-face or remote consultation with a pharmacist following an initial assessment by an NHS 111 call advisor or a GP.

In 2023/24 our objective is increase the number of referrals to this service – with a particular focus on improving the use of this service by GPs.

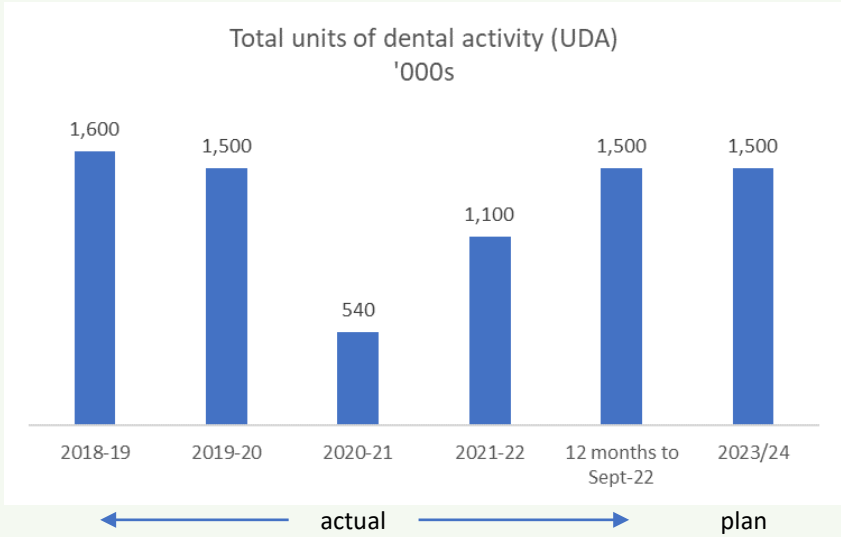


Primary Care

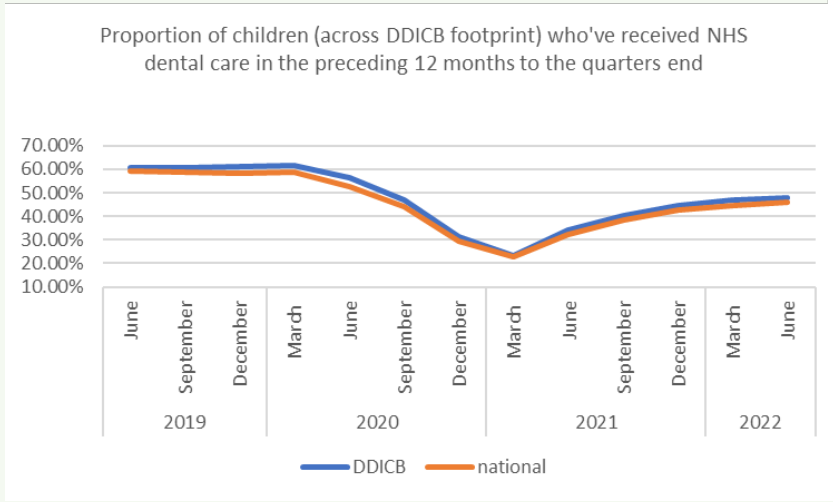
Dental Activity

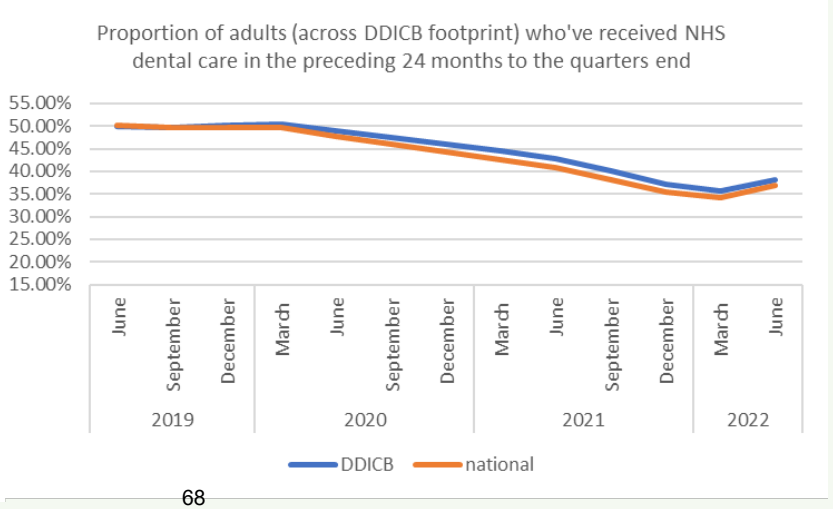
The responsibility for dental commissioning is being transitioned into the ICB's remit through 2023/24. As part of this transition, Local Area NHSE teams have been working to establish activity plans for each ICB – with an aim to ensure that dental activity levels recover to at least pre-pandemic levels.

Within this context, the current plan for 2023/24 assumes that ~1.5m units of dental activity will be delivered which is broadly in line with both the 12 month run rate and the 19/20 baseline. All non-recurrent access initiatives (already in play) are therefore assumed to continue into 23/24 - specifically, (i) The Community Dental Services support practice scheme; and (ii) The weekend access scheme.



However, despite this, access to care for the ICB's population (much like the position nationally) hasn't returned to pre-pandemic levels – with 38% of adults and 47% of children receiving NHS care in the preceding 24 and 12 months respectively.





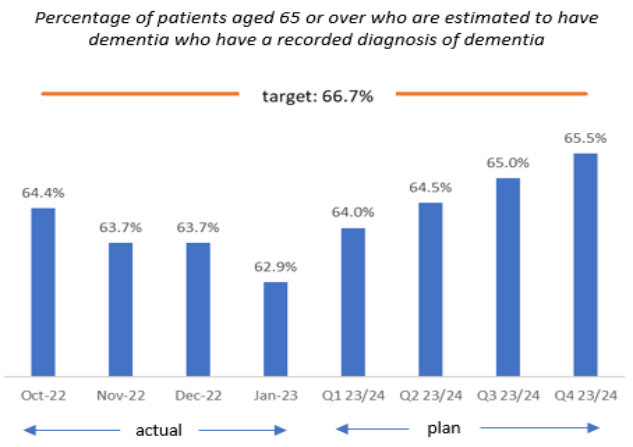
Mental Health, Learning Disabilities and Autism

Dementia Diagnosis

Whilst not compliant with the NHSE target, the ICB is planning to improve its performance in relation to diagnosing dementia – moving from the average rate delivered in 2022/23 (63.7%) to 65.5% by the end of the March 2024.

How?

- Recruiting workforce to establishment.
- Establishing a late diagnosis offer into residential and nursing homes.
- Improving data recording practice.



Health checks

The ICB is planning to ensure that at least 75% of individuals listed on a GP register as having a learning disability, will receive an annual health check within primary care.

How?

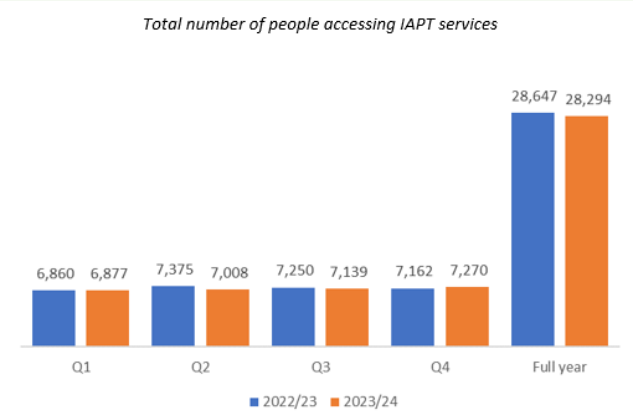
- The ICB commissions a 'LD strategic facilitation team' from DHcFT who work with GP practices to support data quality improvement, promote access to health checks, provide advice and guidance on common conditions and areas of health inequalities.
- QoF incentivisation.

Increasing Access to Psychological Therapies

The ICB is planning to meet the target set which broadly reflects what we delivered in 2022/23 – thus low risk.

How?

- Incentivisation:The ICB currently holds framework contracts with 4 providers of Talking Therapies services which is activity based.
- Improve the service offer for people with long term conditions and communities currently underrepresented.

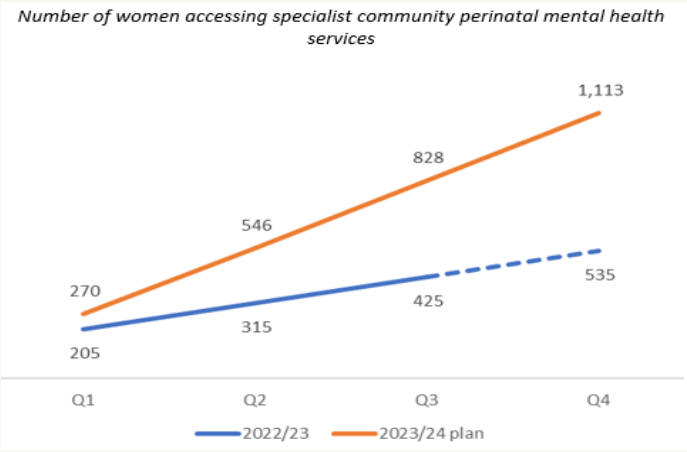


Access to specialist perinatal care

The ICB is planning to meet the target set and double the number of women accessing the service over the next 12 months.

How?

- Reduction in DNAs
- Increasing capacity by recruiting to establishment
- Target under-represented groups
- Improve data recording practice



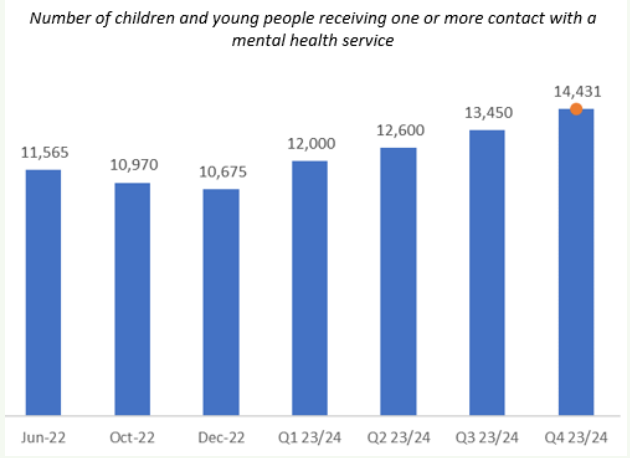
Mental Health, Learning Disabilities and Autism

Children and Young People

The ICB is planning to meet the target set and increase the number of children and young people accessing a mental health service by a third, over the next 12 months.

How?

- Contracts let for school services.
- CRISIS offering enhanced.
- Expanding the Eating Disorder offering - incl. prevention and early intervention.

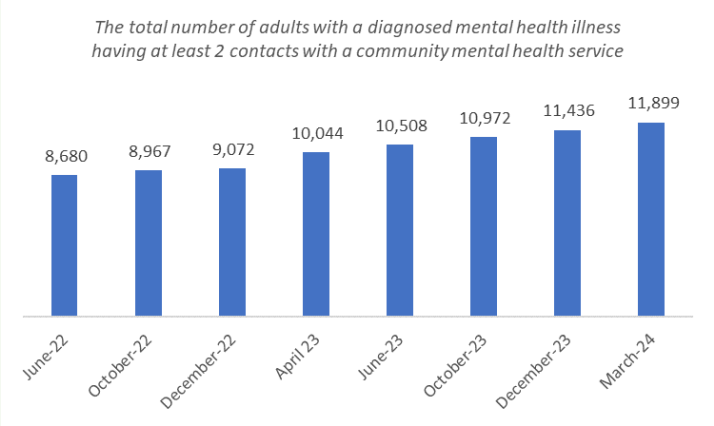


Adults with Severe Mental Illness

The ICB is planning to meet the target set and increase the number of adults receiving at least 2 contacts by a third, over the next 12 months.

How?

- CMHT vacancy and sickness reduction.
- New ARRS and VCSE posts coming on line.

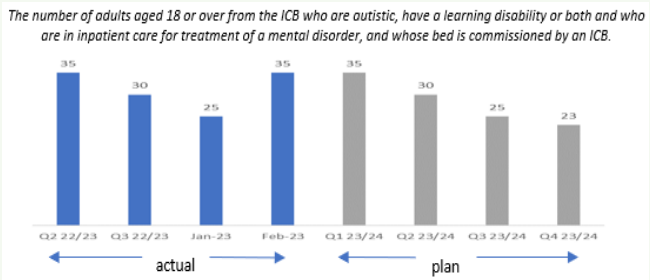


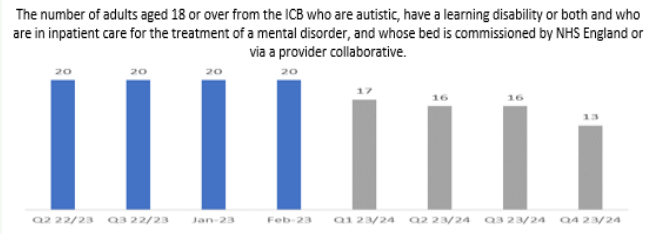
Inpatient care for people with Learning Disabilities

The ICB is planning to reduce the number of adults in beds that it commissions to 23 by March 2024. Whilst we do not anticipate to achieve the target, it is improvement on the current position (35 as at February 23). For NHSE commissioned provision, we anticipate the target to be achieved.

How?

- Additional in-reach support to inpatient wards to facilitate discharge
- 'Wrap round' support offer developed from NHS community service provision (IST/CLDT) to work alongside individuals core care team supporting MDT review of care provision



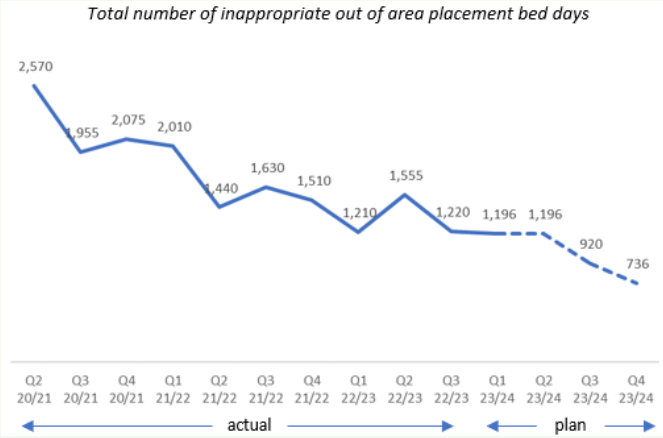


Out of area placements

The ICB is planning to reduce the number of inappropriate out of area placement beds days by 40%, on the 22/23 Q3 position, by the end of March 2024.

How?

- Additional step down capacity has been contracted for individuals identified as medically fit for discharge.
- Additional Crisis alternative service provision contracted by the ICB and will be brought on line during 23/24.
- Rolling recruitment program to fill current vacancies within inpatient teams and recruit to new posts required to support new build AMH wards



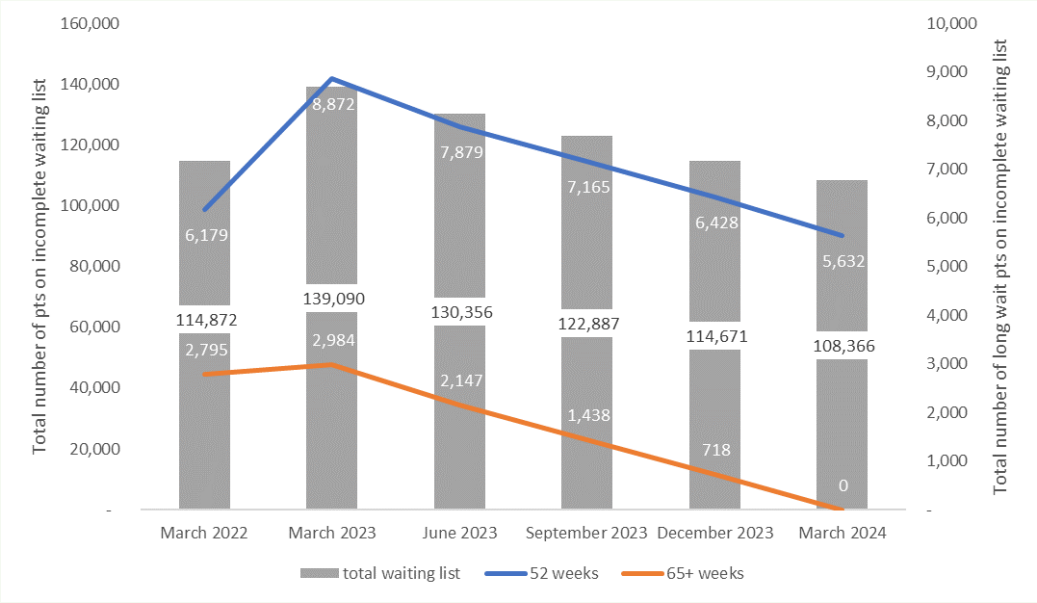
Elective Care

Reducing long RTT waits

The ICB is planning to reduce its overall waiting list by 22% over the next 12 months. From a long stay perspective, we anticipate seeing the number of 52+ week waits reduce in absolute terms by 40% and have no 65+ week waits by the end of March 24.

How?

- Both Providers delivering, at a minimum 103% of 2019/20 levels of activity output.
- Additionality on the 2019/20 level achieved by consistent delivery of 85% theatre utilisation, reducing G&A bed occupancy – particularly the medical aspect to reduce outliers on surgical wards.
- A reduction in the DNA rate to match top decile benchmark and enhanced utilisation of PIFU.
- Insourcing and outsourcing activity from the independent sector.
- New RTT demand moderated to keep within 2022/23 levels.



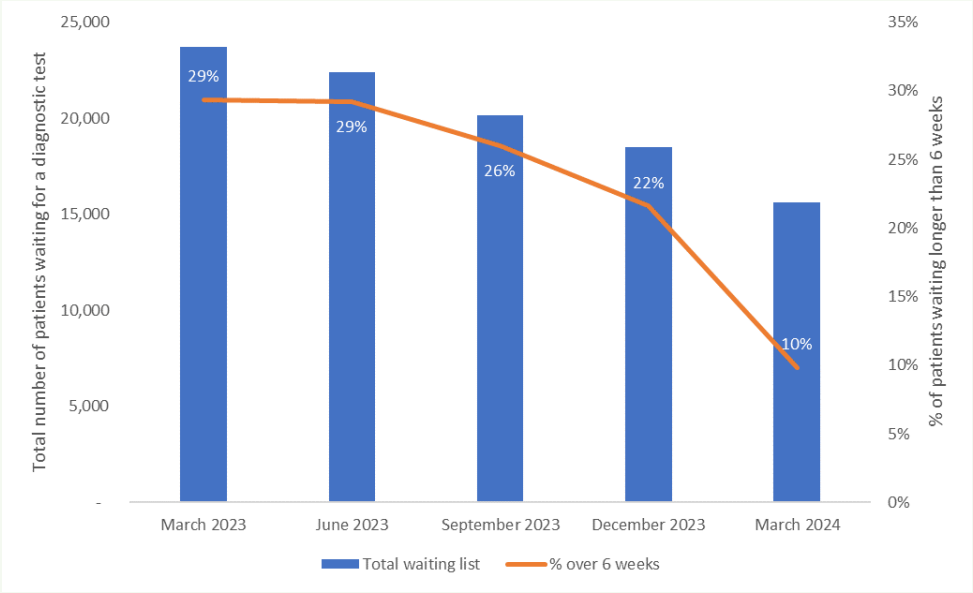
actual → ← plan →

Reducing diagnostic wait times

The ICB is planning to reduce its overall waiting list by 30% over the next 12 months and by the end of March 2024 have 90% of patients waiting 6 weeks or less for their test -which exceeds the target of no less than 85%.

How?

- The introduction of Community Diagnostic Centres is integral to delivering this target – with the programme requiring an indicative 109.39 WTE to be recruited.
- Recruitment required into UHDB endoscopy as per recovery plan to deliver increased activity.
- Echo improvement at UHDB dependent on delivery of the CDC programme and continued insourcing to the agreed minimum contract value.

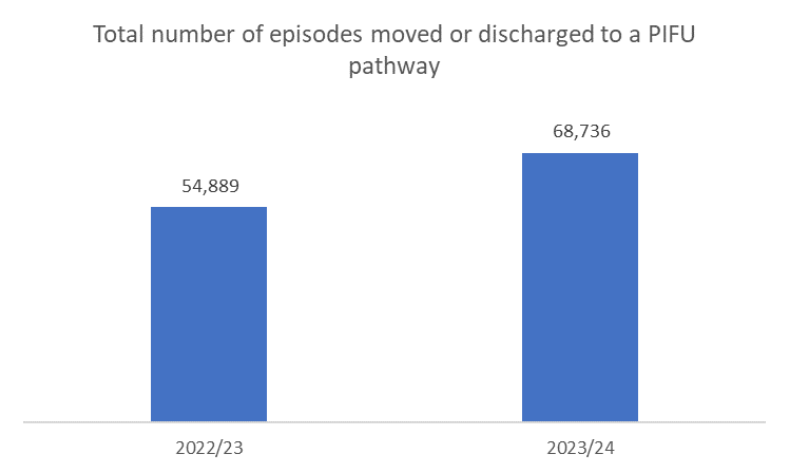


Outpatient provision

Patient Initiated Follow-ups

The ICB is in a relatively strong position as we exit 2022/23 in relation to the proportion of episodes moved or discharged to a PIFU pathway – with the system 3rd best in the Midlands at 4%,

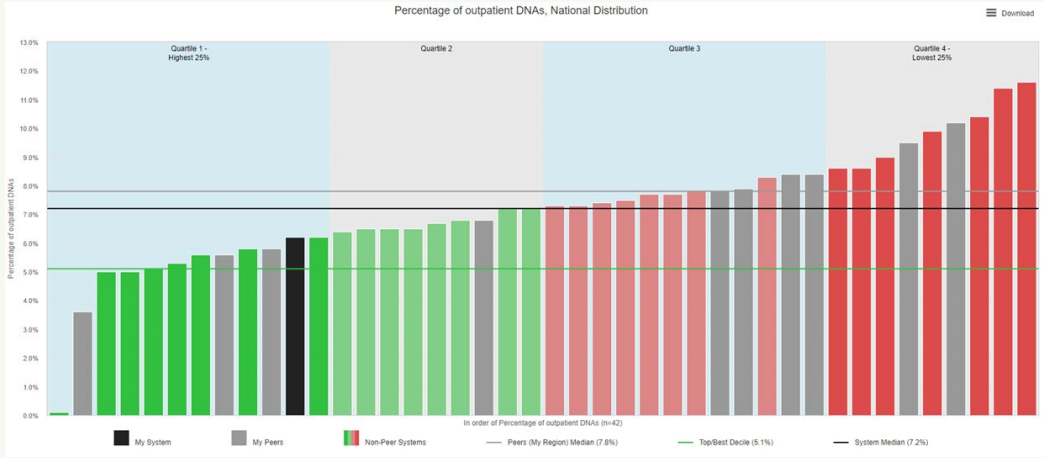
Over the course of the next 12 months, we are planning to increase the number of patients who are moved or discharged to a Patient Initiated Follow-up pathway so that we hit the NHSE target of 5%.



Did Not Attend rates

The ICB's DNA rate is operating at a relatively good level – within upper quartile range when compared with other Health System's nationally. Despite this, both Acute Providers are aiming to reduce their DNA rates over the next 12 months so that we can bring the ICB within top decile performance.

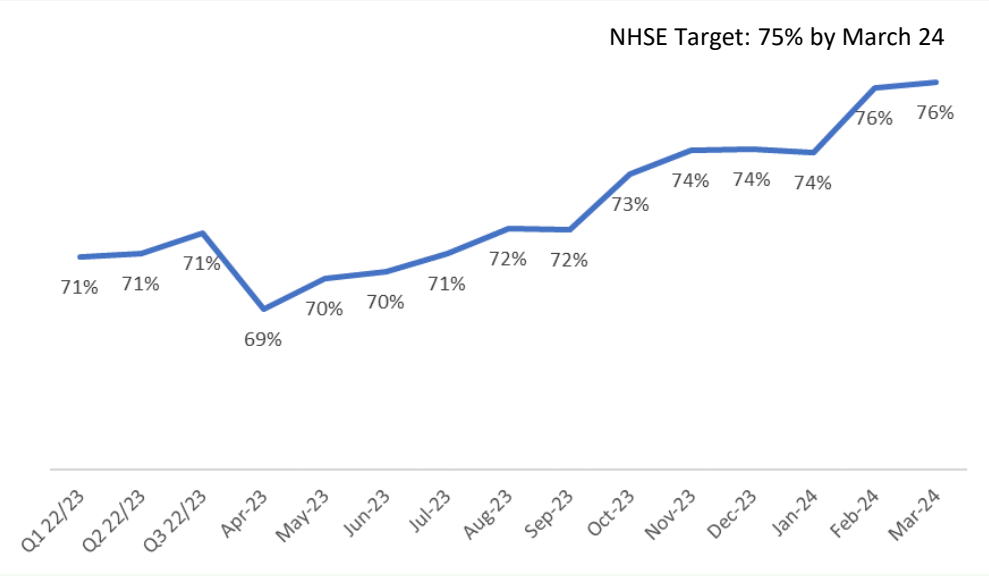
This means that we are looking to reduce the DNA rate from 6.2% to 5.1% by the end of March 2024.



Cancer Care

Faster diagnosis

The ICB is planning to ensure that at least 76% of people receive communication of a diagnosis for cancer or ruling out of cancer, or a decision to treat if made before a communication of diagnosis, within 28-days following an urgent referral for suspected cancer.

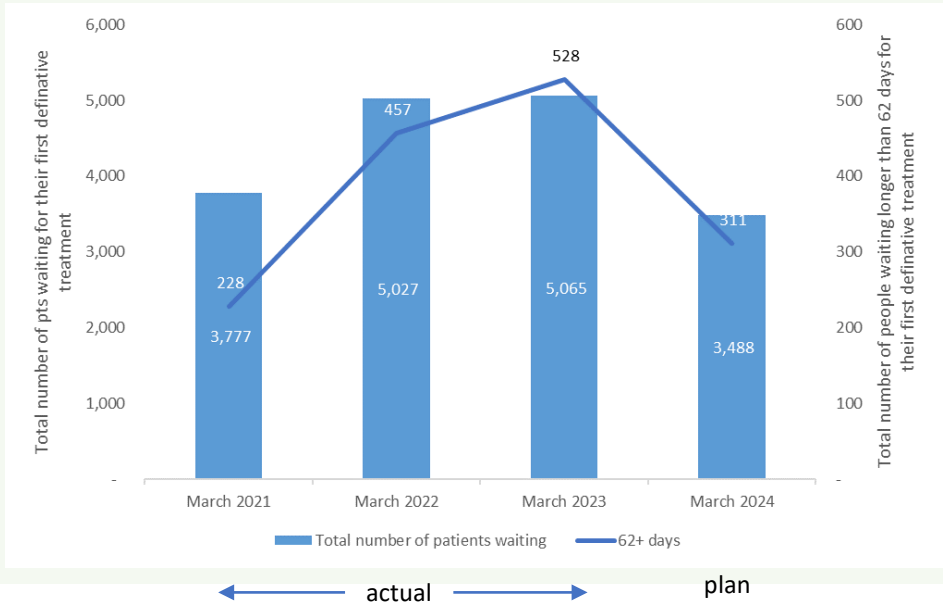


Reducing long waits

The ICB is planning to reduce its overall waiting list by 30% over the next 12 months. From a long stay perspective, we anticipate reducing the number of people waiting longer than 62 days for the first definitive treatment for cancer, by 40% by March 2024.

How?

- Use of FIT test in 80% of all suspected lower GI cancers
- Moderating the growth of the waiting list – No greater than 5% on the 22/23 level.
- Expansion of diagnostic imaging capacity via the CDC programme.
- Expansion of endoscopy capacity via planned recruitment.
- Improvement to histology provision – with a particularly focus on timeliness.



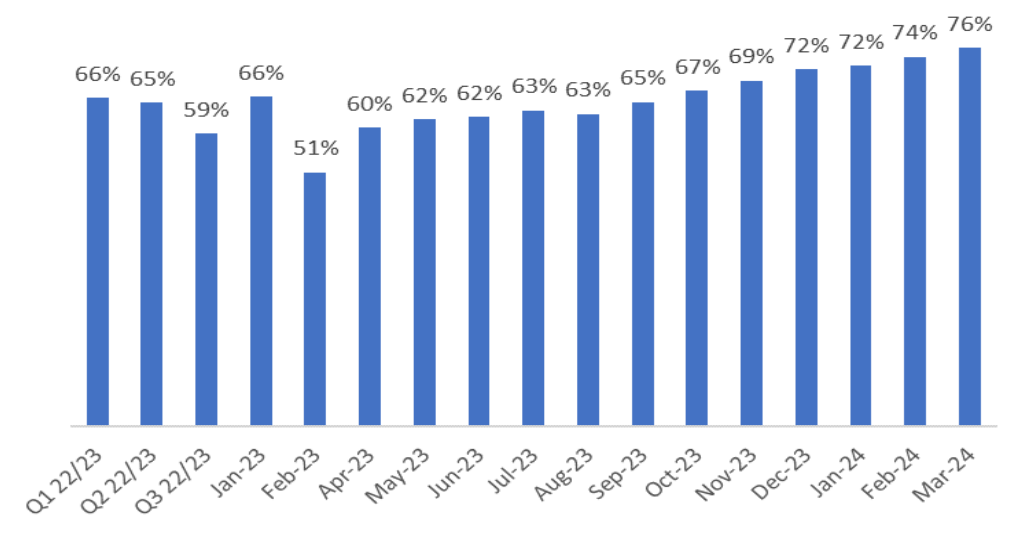
Urgent and Emergency Care

76% A&E Performance

The ICB is planning to achieve the target set which will see no less than 76% attending ED waiting longer than 4 hours either to be treated, admitted or discharged.

How?

- With DHU in a position to recruit substantively to the enhanced primary care service at the CRH and RDH, it will be in a position to ensure that patients are 'turned-around' within 4 hours, at least 95% of the time.
- Lower bed occupancy (see next 2 slides) will provide greater flexibility for both Acutes to achieve greater flow from the ED to inpatient wards.
- The Clinical Navigation Hub will be in operation all year, bringing additional capacity and better control to the decision as to where patients are best to be managed for the issue they have.



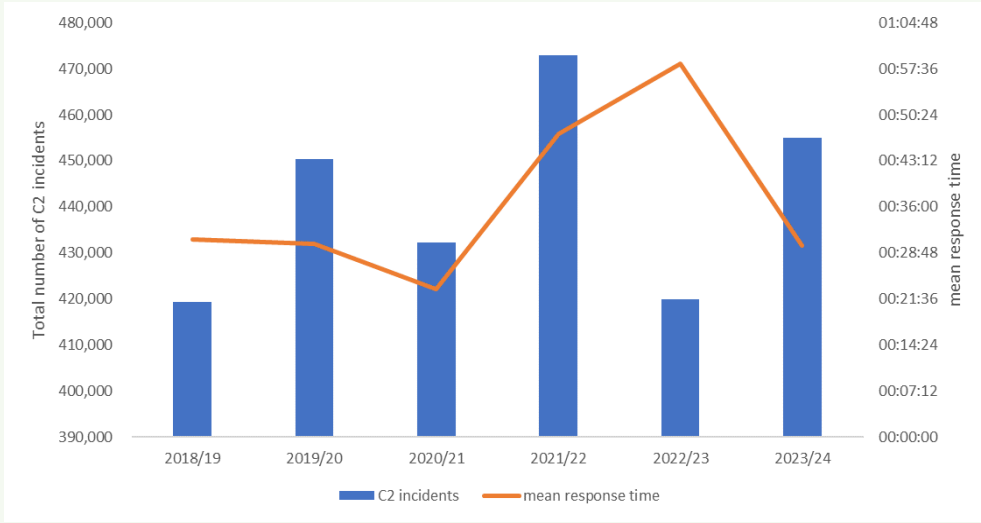
Category 2 EMAS Response

Across EMAS' entire operation, it is planning to reduce the mean time it responds to category 2 incidents to 30 mins in 2023/24 – representing a significant improvement on the 2022/23 position.

How?

Additional monies provided by NHSE to fund:

- Improvements to C2 Segmentation – expansion of clinical resource in control rooms will have a direct benefit of increasing hear and treat rates.
- Additional double crew capacity – in the short term sourced through the private sector whilst the organisation recruits.



Urgent and Emergency Care

General and Acute Bed Occupancy Plan at the Chesterfield Royal Hospital – mitigating an occupancy rate of 106.9% down to 91.4%

Delivering the activity required to reduce RTT waiting lists and also maintain flow along the UEC pathway requires more general and acute beds than we substantively have. We therefore have to reduce the overall G&A bed occupancy at the CRH from around 106% to 92% at least.

Our plan to achieve this includes:

1. Increasing the supply of medical beds during the winter months – 28 from November 2023 to March 2024.

2. Improving internal pathways will release beds Acute MI (2 days reduction), Sepsis (0.5 days reduction), AF (0.5 days reduction)

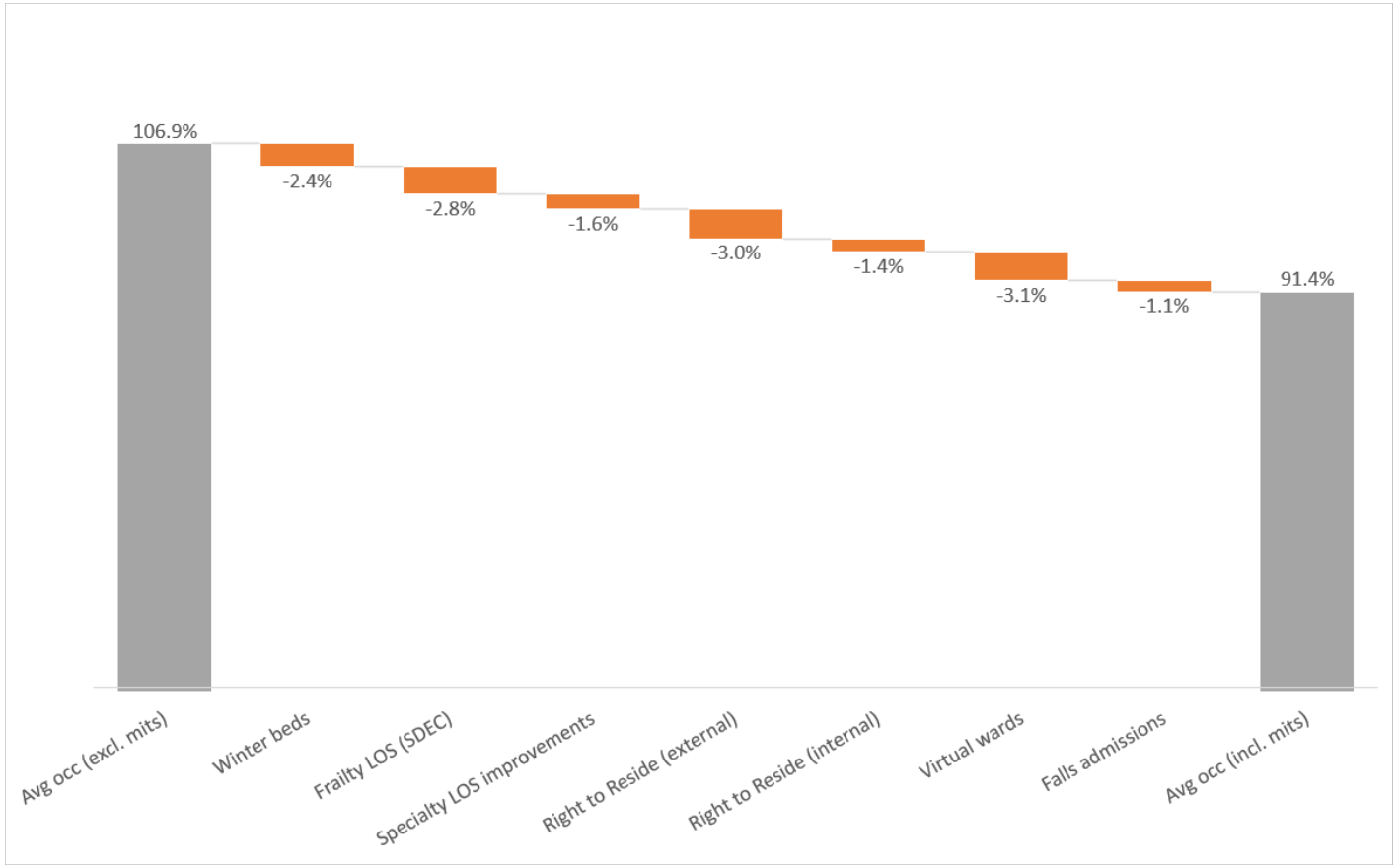
3. Further work is ongoing to improve the NEL bed base, High impact users scheme consistently delivering against agreed outcomes, Proactive Pull model from ED for Direct to specialty, SDEC consistently 7/7 (increase from 28% activity to over 30%) and Redirection and re-instigating LLOS reviews for 21 day+ and include 14+ day and 7+ day.

4. Better flow across P1 and P2 D2A community capacity.

5. Reducing length of stay by maximising the use of virtual wards.

6. Realising the benefit of enhancements to the frailty falls pathway in the community.

Chesterfield Royal Hospital NHSFT
Average G&A bed occupancy – 2023/24



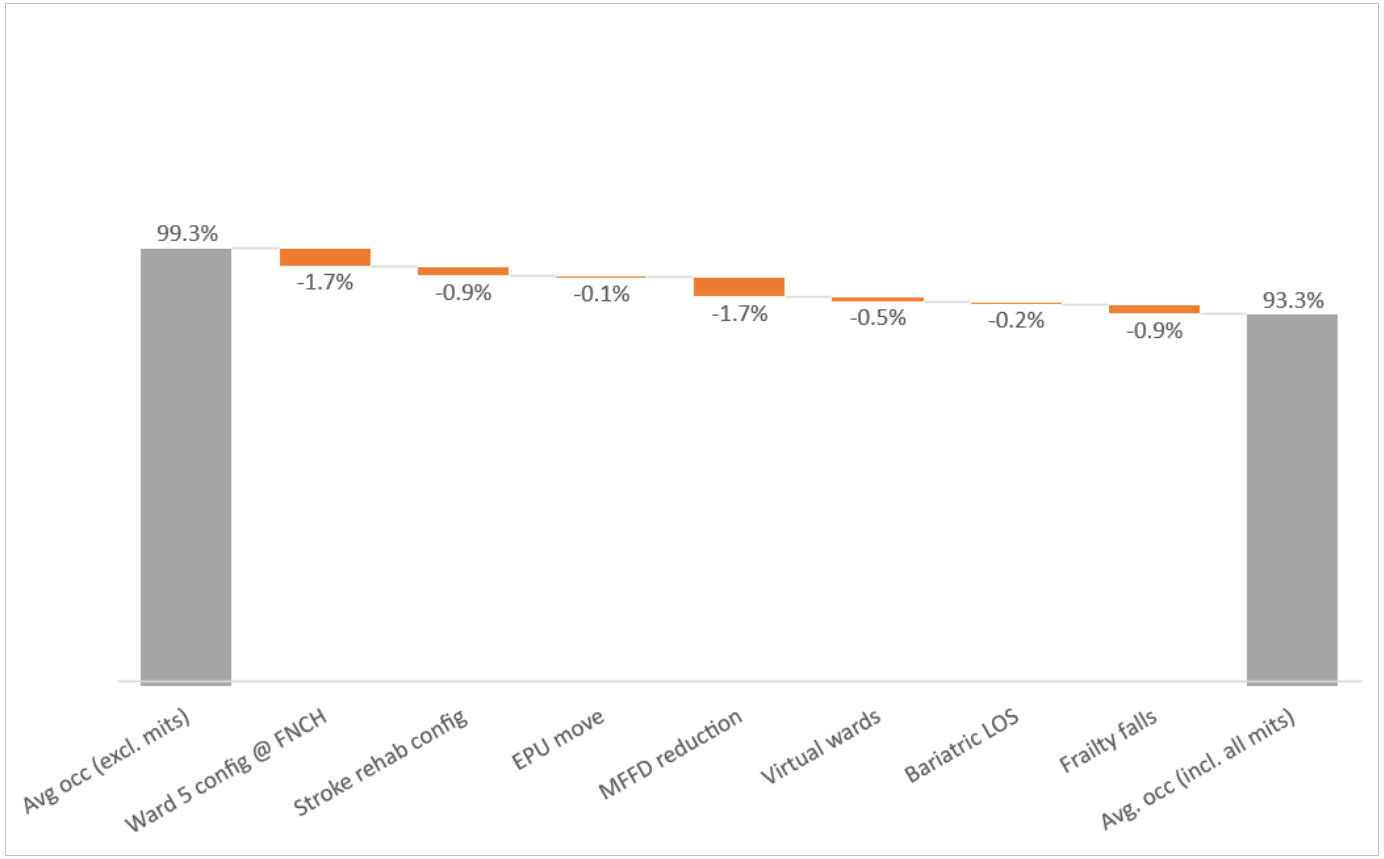
General and Acute Bed Occupancy Plan at the University Hospitals of Derby and Burton - mitigating an occupancy rate of 99.3% down to 93.3% .

Delivering the activity required to reduce RTT waiting lists and also maintain flow along the UEC pathway requires more general and acute beds than we substantively have. We therefore have to reduce the overall G&A bed occupancy at the CRH from around 99% to 92% at least.

Our plan to achieve this includes:

1. Increasing the supply of medical beds during the winter months. This includes a reconfiguration of ward 5 at the FNCH, stroke rehabilitation and moving the Elective Procedures Unit (EPU) from the RDH to Kings Treatment Centre.
2. Los reduction for delays relating to bariatric patients as a result of DCHS bariatric referral centre at St Oswald's Community Hospital.
3. Reducing the medically fit for discharge in delay cohort – via internal pathway improvements and better flow across P1 and P2 D2A community capacity.
4. Better flow across P1 and P2 D2A community capacity.
5. Reducing length of stay by maximising the use of virtual wards.
6. Realising the benefit of enhancements to the frailty falls pathway in the community.
7. If required opening escalation beds and enacting FCP protocols (in extremis).

University Hospitals of Derby and Burton NHSFT
Average G&A bed occupancy – 2023/24



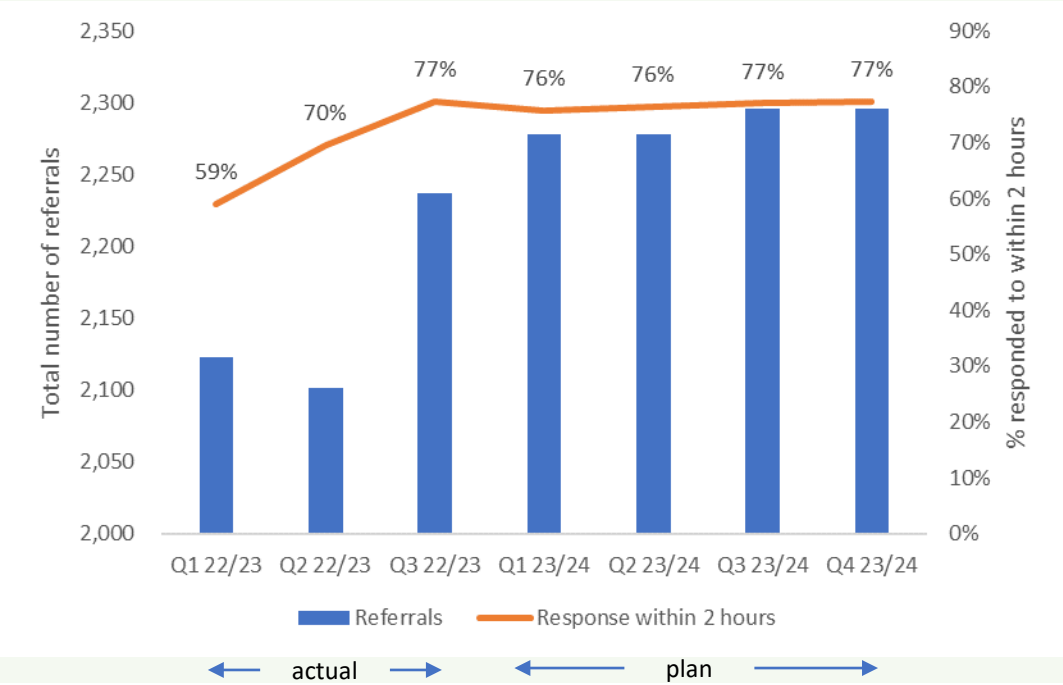
Urgent and Emergency Care

Urgent Community Response

The ICB is planning to ensure that at least 77% of referrals to the Urgent Community Response Service are responded to within 2-hours – exceeding the target of 70%.

How?
The already good performance of the existing services will be enhanced by:

- The new Clinical Navigation Hub will bring extra capacity and control to the decision as to where patients are best to be managed for the issue they have.
- Local Access points will be establishing in each of the eight PLACE localities – thus ensuring that the different parts of the service offering can be better co-ordinated to respond to a patient's need quickly.

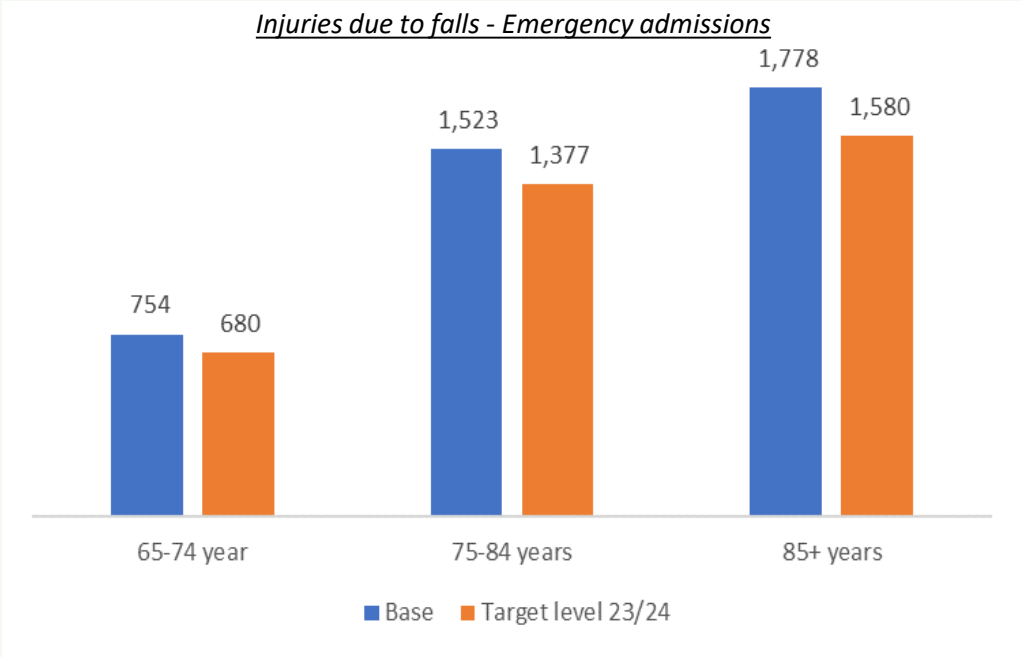


Reducing frailty induced falls

The ICB currently occupies the lowest performance quartile when it comes to the emergency admission rates for frailty induced injuries due to falls. Over the next 12 months, the ICB is planning to improve to at least match third quartile performance – resulting in less frail elderly people being admitted to hospital due to a fall.

How?

- The majority of the ICB's Anticipatory Care focus will be on this important issue over the next 12 months – targeting those individuals who are most at risk of falling.
- The capacity of the falls recovery service will be expanded building on the learning of the pilot/testing phase in the last 3 months.



Respiratory, Cardiovascular and Diabetes

At the time of writing, further work is being undertaken to establish SMART trajectories against the objectives listed below. They relate to key aspects of the NHS' contribution to the prevention agenda for conditions that have direct impact on morbidity.

	Primary Prevention	Secondary Prevention	Tertiary Prevention
Diabetes	For those who are pre-diabetic, increase the take-up of the diabetes prevention programme.	Increase the number of people who are being screened for diabetic retinopathy.	Increase the proportion of people who meet all 3 treatment targets.
Respiratory	Increase the number of people who receive the Tobacco Dependency Treatment Programme.	Spirometry focus - TBD	Reduce waiting times for pulmonary rehabilitation.
Cardiovascular	Increase the number of people with a high BMI who being managed on a weight management service.	Increase the percentage of people aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%.	Increase the number of people with heart problems who are referred to and uptake a programme of cardiac rehabilitation. Increase the percentage of patients with hypertension treated to NICE guidance to 77% by March 2024.

2023-24 priorities and operational planning

Recovery Plan Narrative Submission

Version Number	Date	Details of change
V1.0	26 Jan 2023	Initial version
V2.0	3 Feb 2023	Updates highlighted to (i) reflect the final UEC recovery planning requirements, (ii) update the link provided in the first question in the cancer section
V3.0	6 Feb 2023	UEC recovery plan narrative section added. Additional question on health inequalities added to 'Overall approach to recovery planning' section (highlighted)

Introduction

1. Overview

This template focuses on the immediate priority set out in the 2023/24 priorities and operational planning guidance: **to recover our core services and productivity**. ICBs are asked to submit a system narrative plan for the recovery of performance for the 2023/24 financial year, setting out:

- the overall system approach to recovery planning for their system
- key actions system partners will take to recover their core services and productivity
- key assumptions that underpin their numerical plan returns.

Narrative submissions will be reviewed by national and regional colleagues as part of plan assurance and to identify cross-cutting themes and issues.

2. Interactions with other templates and guidance

This submission focuses on the overall approach to recovery of core services and productivity as well as specific plans for elective, cancer, and diagnostics services. This version now also incorporates the narrative element of the UEC recovery plan submission requirements following publication of the national Delivery plan for recovering urgent and emergency care services. Further Information on the full UEC recovery plan submission requirements are available on the NHS Planning FutureNHS collaboration platform via the "UEC Recovery Plan" button on the main dashboard.[1] Collectively these returns will inform the process for the allocation of additional capacity funding for hospital and ambulance services above those already included within issued allocations.

The General Practice Access Recovery Plan is expected to be published at the end of February and there will be a linked system recovery plan submission requirement. We are therefore not asking for a narrative submission covering primary care as part of the 23 February draft plan submission.

3. Submission process and contacts

Narrative plans should be submitted at ICB level, using this template, to the appropriate regional planning mailbox (see table below) for **draft submission by 12noon Thursday 23 February 2023** and for **final submission by 12noon Thursday 30 March 2023.**

Further information including a list of all activity and performance metrics can be found within the submission guidance and supporting documents available on the NHS Planning FutureNHS collaboration platform.

Any queries relating to this submission should be directed to regional planning leads:

[1] You will need a FutureNHS account to access the pages and can get this at: FutureNHS Collaboration Platform following the registration process outlined.

Location	Contact information
North East and Yorkshire	england.nhs-NEYplanning@nhs.net
North West	england.nhs-NWplanning@nhs.net
East of England	england.eoe-planning@nhs.net
Midlands	england.midlandsplanning@nhs.net
South East	england.planning-south@nhs.net
South West	england.southwestplanning@nhs.net
London	england.london-co-planning@nhs.net

4. Guidance on completing the narrative submission

Responses to the elective, cancer and diagnostics sections should succinctly and clearly:

- summarise the current and planned position / performance
- articulate the actions and assumptions that underpin the numerical submission, including:
    - plans to deliver the key evidence-based actions set out in the annex of 2023/24 priorities and operational planning guidance
    - key demand and capacity assumptions
    - activity, workforce, and financial plans and transformation goals that will support delivery of the objective
- set out key delivery risks and/or dependencies on other elements of the system recovery plan
- make links where relevant to other ICB partner plans (e.g. Cancer Alliances).

Please complete all sections. Further instructions to support completion are set out below and within each section of the template.

2023/24 operational plan narrative- performance

System name:	Derby & Derbyshire ICB

Overall approach to recovery planning	
Please describe the approach your system has taken to recovery planning and how you have assured deliverability of the plan. Please set out any key assumptions, interdependencies and risks.	
Please describe the approach your system has taken to recovery planning: - **How have you balanced delivery across the national recovery objectives for 2023/24, including delivery of balanced financial position?** - **How have you planned to maximise productive capacity (including workforce) across the system to support delivery of the national recovery objectives?** - **How have you planned to continue to narrow health inequalities in access, outcomes, and experience?**	Improvement is hard-wired into this plan and for most metrics within scope, we aim to perform better in 2023/24 compared to 2022/23. This plan provides detail of how the ICB will improve operational performance over the next 12 months across all areas of care: • More people being admitted or discharged from A&E within 4 hours – with both Acute Trusts delivering the 76% target by the end of March 2023. • An increase in acute elective output on 22/23 levels (ELIP: 20%, DC:15%, OP1: 22%). This increased output, together with a moderation in new RTT period growth, will result in a lower waiting list (22% lower) in March 24 compared to March 23 and no 65+week waiters by March 24. • A cancer waiting list which is 30% smaller in March 24 compared to March 23 and less people waiting longer than 62+days for their first definitive cancer treatment – achieving the target that has been set. • 9% more diagnostic activity to support general elective and cancer recovery -brought about by the new Community Diagnostic Centre capacity coming online. This additional output will support our objective to reduce our diagnostic waiting list by 30% by March 24 and ensure that no less than 85% of people on the list are waiting longer than 6 weeks for their test.

	• An increase in General Practice appointment output – 2% more than what is expected to be delivered in 2022/23. • A compliant plan for most of the mental health, autism and learning disability standards that have been set for 2023/24 – except for out of area placements and TCP (although our trajectory represents improvement on the 22/23 FOT position). • EMAS' mean response time to a category 2 incident reducing to 30 minutes in 2023/24. This improvement is planned to be achieved by using our assets more productivity and requires minimal growth in workforce. Improving the Acute Sector specific aspects of this plan is dependent on Providers utilising its capacity in a more efficient way – with specific improvement assumptions currently incorporated: • Increasing theatre utilisation rates at both Trusts • Reducing DNAs so that outpatient capacity is fully utilised. • Increasing the use of Patient Initiated Follow-ups to free up capacity and use for reducing the backlog. • Ring fencing elective acute beds. • Reducing the medically fit for discharge who still reside in hospital at both acute sites. Health inequalities Joined Up Care Derbyshire (JUCD) has developed a draft Health Inequality (HI) Strategy. The Senior Responsible Officer for HI has worked closely with system workstreams to develop and align plans designed to deliver specific actions to tackle inequalities. This is with the consideration of national guidance including the adult and CYP Core20+5 guidance documents. The draft strategy content was approved by the ICP securing commitment across the system to address the causes of health inequalities and outcomes for the local population. Our long-term plan incorporates aims to: • restore NHS services inclusively • mitigate against 'digital exclusion' • ensure datasets are complete and timely

	• accelerate preventative programmes • strengthening leadership and accountability Our approach is based on the principle that prevention, early intervention and anticipatory care are critical to the effective management of long-term conditions and are key to improving population health and curbing the ever-increasing demand for healthcare services. Our CYP inequalities are aligned to the 5 Clinical Priorities within the LTP and JUCD. Our emerging +5 are SEND, LGBTQ+, Children who are looked after, Ethnicity, Speech, Language and Communication Needs. This will be a key theme throughout all our transformation plans and considered in all service changes whilst our Start Well priority is now a key area of focus in the ICP strategy and the CYP Delivery Board (system wide representation) is operationalising delivery of the ambition to improve school readiness in children with a clear lens on inequalities within our system. For the adult population, the prevention and health inequalities agenda is being driven by the Stay Well priority which is a key area of focus within ICP Strategy. This prioritises a prevention approach for the 3 main clinical conditions which contribute the greatest burden of ill health within our population - cancer, circulatory and respiratory disease. Within the plan our local priorities and goals for improvement are grouped under three main themes which are complimentary to the key areas of focus in the Integrated Care Strategy currently being developed and will form the basis of our Joint Forward Plan. These are: • Prevention: focussing on the effective implementation and optimisation of evidence-based interventions for primary, secondary and tertiary prevention to help alleviate the failure demand which is currently dominant across many non-elective care pathways and improve overall population health. • Access: with goals identified to improve specific general elective, cancer, mental health, general and dental practice and reduce inequalities in health outcomes, experience, access, and unwarranted variation resulting in improvements in outcomes. • Productivity: to encapsulate the enabling functions of workforce, finance, capital/estates, digital, integration and ways of working as a system.

	Proposed actions and key areas of progress We have established close working between key leaders in the system by coordinating work between system inequalities SROs for Derby City Council, Derbyshire County Council, Derbyshire Community Health, the ICB and other providers Services – organised through the work of a steering group that links into the ICB and ICP Executive.
How has the system leadership assured itself that the plan is deliverable and triangulated across activity, workforce and finance?	The ICB's Board and its Sub-Committees have reviewed this plan from the perspective of ensuring that there is sufficient 'improvement stretch' hardwired into plan, whilst also considering the inherent delivery issues and potential risks that may arise in year. Each organisation's workforce, activity and financial plans have been constructed, and subsequently reviewed, in an integrated fashion – so the process of how we constructed this plan provides assurance of its level of triangulation. We have ensured that any increase in workforce has a direct connection to the activity and finance side – i.e., *what is this additional workforce delivering*. To this end, there is good read-across with key drivers of the workforce increase (virtual ward recruitment, CDC recruitment, maternity safety, and other service level increases) having a direct correlation to the extra activity that has been assumed within Provider plans and/or mitigating known risks to G&A bed occupancy and/or safety (e.g., maternity). There is still further work to do to translate the financial CIP required at a Provider level to support delivery of the ICB's financial plan, into a revised workforce plan.
What are the key assumptions that underpin your recovery plan?	Overall general and acute bed occupancy • Delivering the elective plan and maintaining better flow for UEC activities requires a significant reduce in general and acute bed occupancy and we have identified several initiatives to mitigate an average occupancy rate of around 101% to 92-93% - with varying degrees of risk associated. ○ Increasing the supply of medical beds at the RDH, funded via Priority A investment monies to be received from NHS England.

	○ Expanding virtual ward capacity over the next 12 months, so that by the end of the year we have up to 255 virtual ward beds in operation and at least 80% of the provision being utilised. ○ A reduction in the medically fit for discharge cohort in 23/24 relative to the 22/23 level – achieved by both internal factors (e.g., consistent use of same day emergency care, long length of stay reviews) as well as external factors (more productive use of community discharge to assess capacity). ○ A reduction in frailty induced falls on the back on enhancements to the joint NHS and LA falls prevention service – moving the ICB position r.e. emergency admission rates from upper quartile to third quartile performance over the next 12 months. Urgent and Emergency Care • No growth in A&E attendances nor emergency admissions on the 2022/23 baseline. It is therefore assumed that the combined effect of key 'out of hospital interventions' e.g., the Clinical Navigation Hub and the developing 'Team-up' service offering, contribute to delivering this. • Emergency demand relating to COVID-19 and Influenza is no worse than the level seen in 2022/23. Planned Care – RTT • No new RTT period growth in the 2022/23 baseline thus giving both Acute Trusts the ability to focus on bringing the existing waiting list down. • Both Acute Trusts consistently delivering at least 85% utilisation of its theatre capacity. • Both Trusts reducing its Did Not Attend rate so that the ICB reduces its rate to top decile performance. • Ring-fencing of elective capacity – secured through reducing overall bed occupancy (linked above). Cancer • Limited growth (<5%) in the number of new cancer referrals on the 22/23 level.

Workforce

- 2.2% growth over the next 12 months in the total number of WTEs employed.
- All Provider workforce plans have been reviewed and revised considering the system financial position. As part of this, growth on 22/23 levels has been assumed due to specific issues:
  - Care quality/safety (with the most material relating to Midwifery on the back of the Ockenden review).
  - Income backed (e.g., MHIS, virtual wards, Community Diagnostic Centres).
  - TUPE transfers (e.g., EMAS' new PTS contract portfolio).
  - New services (e.g., PICU).
  - Trainee clinical staff in the recruitment pipeline.
- 8% Growth in Primary care workforce (269 WTE), with most of the increase on the back of the ICB's objective to increase ARRS funded roles.
- Staff sickness rates at an organisational level:

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
CRH	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%
DCHS	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
DHcFT	6.6%	6.5%	6.5%	6.4%	6.3%	6.3%	6.2%	6.1%	6.1%	6.0%	6.0%	5.9%
EMAS	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%
UHDB	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	4.9%	4.9%	4.9%	4.9%	4.9%	4.9%

Please summarise the key interdependencies across your plan?

In high level terms, it is important to draw out the following interdependencies:

- How delivering the UEC aspect of this plan will support planned care recovery - with overall bed occupancy and the extent to which the acute sector is able to protect its elective bed capacity, the key tests.

	- How delivering a high-quality urgent community response service can help contribute, in part, to securing no growth in A&E attendances and non-elective admissions. - How delivering the virtual ward programme will allow us to free up the equivalent of a general and acute ward – thus contributing to reducing overall occupancy.
What are the key risks to delivery and how have you mitigated these?	There are two specific risks to highlight at this stage: • Finance: The system continues to operate under financial pressure, with £137m worth of efficiencies required to hit break-even in 2023-24. This is being addressed as part of the financial sustainability work being developed by the ICB and its partners. • Workforce: Significant workforce issues across social care, particularly in the domiciliary care market, are being experienced across the ICB which will impact on discharge and flow. From an NHS staffing perspective, this plan does not take account of any lost productivity brought about by future industrial action. • Timescales for realising the benefit of improvement work: There are several areas in this plan where the impact of service redesign is required early in the financial year. This will be challenging given the status of works. For example: o Reducing the general RTT and cancer waiting lists (and the long stay patients therein), requires a significantly moderated 'new growth rate' from April 2024. o The variety of demand management schemes across the non-elective pathway effectively must mitigate any new A&E and admission growth in 2023/24. o Creating a substantively new solution to how we improve discharge performance before the winter is imperative.

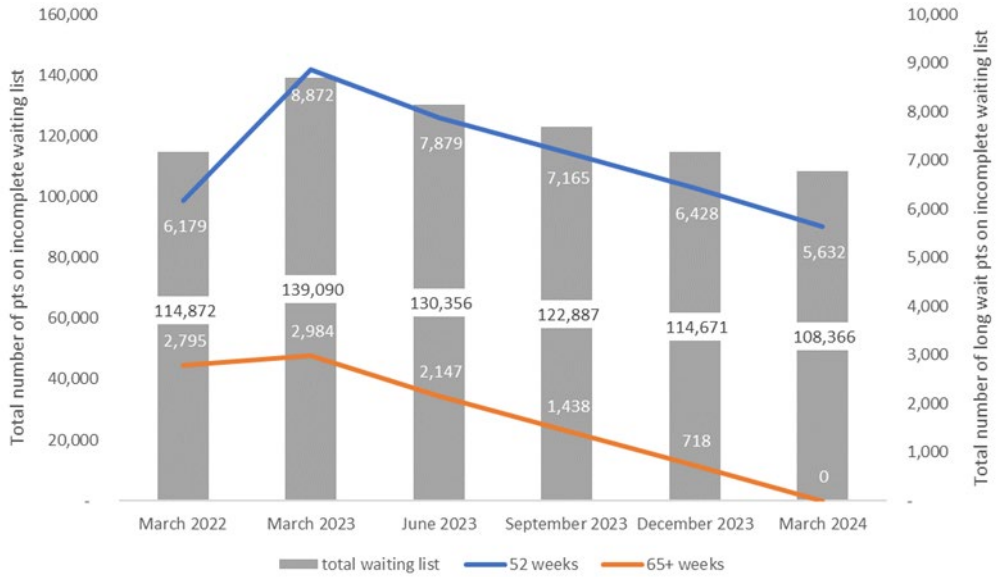
Elective care

How will your system eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)?

The ICB is planning to reduce its overall waiting list by 22% over the next 12 months. From a long stay perspective, we anticipate seeing the number of 52+ week waits reduce in absolute terms by 40% and have no 65+ week waits by the end of March 24.

How?

- Both Providers delivering 107% of 2019/20 levels of activity output.
- Additionality on the 2019/20 level achieved by consistent delivery of 85% theatre utilisation, reducing G&A bed occupancy – particularly the medical aspect to reduce outliers on surgical wards.
- A reduction in the DNA rate to match top decile benchmark and enhanced utilisation of PIFU.
- Insourcing and outsourcing activity from the independent sector.
- New RTT demand moderated to keep within 2022/23 levels.



How will you deliver the elective activity target set for your system?						
Activity type	19/20	22/23	23/24	variance		The increase will be achieved by…
				23/24 vs 19/20	23/24 vs 22/23	
ELIP	15,794	12,788	15,220	96%	119%	Improved theatre utilisation -- Ring fence elective inpatient beds -- insourcing/outsorucing
DC	113,842	103,594	122,141	107%	118%	Improved theatre utilisation
First OP	471,844	402,429	489,200	104%	122%	Improved clinical utilisation -- insourcing/outsourcing
Diagnostics	368,763	379,316	413,339	112%	109%	Community Diagnostic Centre -- Endoscopy recruitment
Total	970,242	898,127	1,039,900	107%	116%	

Cancer

How will your system reduce the number of patients waiting over 62 days in line with the provider level requirements? **Requirements can be found on the NHS Planning FutureNHS collaboration Platform > Supporting Materials > Cancer**	The system is taking a multifaceted approach to improve its performance against the cancer standards and thereby providing better outcomes and experience for our patients. • both Providers will continue to ensure that there is robust management of tumour site performance through patient level analysis and confirm and challenge of their PTLs. • where tumour sites have been struggling to achieve the standards, both Providers will continue to develop and refine tumour site recovery plans which will be used to drive improvement.

	• a range of measures are underway to increase diagnostic capacity through the CDC programme and to recruit to gaps in the endoscopy workforce to bolster our diagnostic services and contribute to the overall improvement in our cancer performance. • Funding has also bee agreed and allocated to support delivery of best practice time pathways, specifically: 1. **Lower gastrointestinal (LGI).** Work underway at UHDB and QHB to map out current pathway against best Practice Timed Pathway and develop improvement plan based on gap analysis of this work – end of Q1. 2. **Skin.** Work underway at UHDB and QHB to map out current pathway against best Practice Timed Pathway and develop improvement plan based on gap analysis of this work – end of Q1. Teledermatology models being explored in Burton and Chesterfield so a Derbyshire approach being explored with Alliance support in Q1. 3. **Gynaecology**. Work completed to map out current pathway against best Practice Timed Pathway and partially implemented in September 2022. Further work to complete implementation of pathway against planned milestones with development of an improvement plan to complete this– end of Q1. 4. **Urology** Work underway at UHDB and QHB to map out current pathway against best Practice Timed Pathway (current focus on prostate as biggest opportunity) and develop improvement plan based on gap analysis of this work – end of Q1. 5. **Non-Site Specific (NSS).** 100% NSS coverage across Derbyshire. Alliance ambition for Derbyshire to achieve 115% of 2022/23 NSS activity = 198. Q1 will see further development plans to support increased uptake of this pathway through GP communications. The Staffordshire system do not currently have access to Derbyshire NSS pathway due to restriction in the roll out of ICE. A solution to this is being developed across the system with further update to be shared in Q1. • To support an improvement in referral quality and completeness by ensuring compliance with NG12 guidance and the requesting, or completion of pre-diagnostic tests ahead of a referral being made Joined Up Care Derbyshire is exploring the establishment of a cancer referral hub. This is likely to be contained to Lower GI initially where we are looking ensure that 80% of referrals are support with a FIT before referral. The objective is to enable better triage and prioritisation of patients at highest risk of having cancer to enable them to be prioritised through the pathway to ensure that they get the appropriate care in a timely way. It is anticipated that this will contribute to an improvement in the 28 day Faster Diagnostic Standard,

	reduce the size of the PTL and contribute to a reduction in the number of patients currently waiting over 62 days. • We will continue to develop the content and self-populating referral forms on our Primary care Decision making Tool – Pathfinder and promote its use across the county as the platform's web version goes live in Q1/Q2. • We also plan to support alternative pathways to support non 2ww pathways – priority clinics, Specialist Advice and Guidance etc across high volume tumour sites to bring the volume of referrals back in line with the regional average.
How will your system meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days?	Both Trusts are planning to deliver the 75% target in 2023/24, with Chesterfield Royal Hospital planning to exceed it by achieving, on average, 79% over the next 12 months. The trajectory for University Hospitals of Derby and Burton NHSFT is slightly different, with the Trust planning to achieve month on month improvement so that it can deliver the 75% target by March 2024. Delivering this target will be dependent the actions summarised in the previous section. Whilst both Trusts are planning to achieve the target at a macro level, there are some suspected cancer types which we anticipate not to be hitting the 75% target, despite improvement on the 22/23 level -specifically, urological and gastrointestinal.
How will your system increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028?	The ICB is actively engaged with the East Midlands Cancer Alliance and over the next 12 months will target its work on the following areas: - We will work with the JUCD and Alliance teams to confirm and implement the 2023/24 Cancer education programme for Derbyshire. This will be evaluated in- year and further education developed based on system need.

	- Alliance plans agreed for the expansion of Targeted Lung Health Checks will be developed in Q1 for Derbyshire to agree implementation timescales. The Alliance will support in sharing best practice of implementing this programme in addition to support the system to understand any related costs and impact for the wider system. - The Alliance will plan regional approach for other interventions including Colon Capsule Endoscopy, Cytosponge, Lynch, liver surveillance and less survivable cancers to be confirmed in Q1. This plan will be developed to demonstrate the impact for Derbyshire in Q2. - he GP Direct Access (GPDA) baseline will be developed to include an improvement Plan for agreement with ICB Elective and Diagnostic Programme Leads

Diagnostics	
How will your system increase the percentage of patients that receive a diagnostic test within six weeks (in line with the March 2025 ambition of 95%)?	Both Trusts are planning to reduce the overall diagnostic waiting list in 2023/24 and reduce the proportion of people who wait over 6 weeks for their test. **Chesterfield Royal Hospital NHSFT** The Trust is planned to achieve a 20% reduction in its wating list over the next 12 months and see around 80% of patients receiving their diagnostic within 6 weeks by the end the year. The plan does not deliver the required improvement in Echocardiogram with the Trust forecasting that without further improvement more than 60% of patients will be waiting more than 6 weeks for their test. **University Hospitals of Derby and Burton NHSFT** The Trust's plan is built on the ambition to see 95% of patients (on average) waiting 6 weeks or less for a diagnosis test by March 24 in overall terms. However, there are two services - endoscopy and echocardiography - where we will not be compliant.
How will your system deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition?	**Chesterfield Royal Hospital NHSFT** The Trust is expecting to deliver its activity via improvements to productivity including reductions in DNAs and cancellations and increased utilisation of available capacity, as well as additional activity delivered through the CDC programme. **University Hospitals of Derby and Burton NHSFT** The Trust will deliver additional activity because of the CDC development at FNCH, Ilkeston and Sir Robert Peel. There are wider recruitment plans to support Endoscopy and Echo. Staffing is the main risk, there may be opportunities for outsourcing to mitigate but this will be at extra cost. The recovery in Echocardiography is uneven across both Providers. For example, CRH being an outlier with over 60% of patients waiting more than 6 weeks by the end of March 2024. The current plan does not address this risk. As part of the planning process consideration needs to be given to how we even out the recovery and

	or perhaps offer Mutual aid in NOUS where performance is forecast to be strong across Derbyshire in exchange for support from systems that have better Echo performance.
How will your system increase GP direct access in line with the national rollout ambition and develop plans for further expansion in 2023/24?	The ICB is currently not planning to increase GP direct access beyond those services currently in operation.

Productivity and efficiency

Describe the systematic approach you have taken to understand where productivity has been lost across the system due to the pandemic. What are the key areas that have been identified as reducing productivity?	At a macro level, there are several factors which have contributed to the lag in productivity that we have experienced in 2022/23. **Access to acute beds** Since the pandemic, there has been a significant increase in the amount of 'lost' general and acute bed capacity, due to discharge delays. At any one time, we have 200 people occupying an acute bed even though they are medically fit to be discharged. This has had a direct impact on our ability to use bedded capacity for planned care purposes. **Staffing** We have lost a significant number of working days due to sickness absence amongst our clinical workforce relative to the pre-pandemic level. For example, in the first 6 months of 22/23 (April – September 22) we lost around 17,800 FTE days on average in the acute sector due to sickness, which is 140% more than what we lost in the same period immediately before the pandemic (April-September 19). An increase in sickness absence has also affected the Community Health sector, with around 5,530 FTE days lost on average, which represents a 140% increase on the pre-pandemic period and the Mental Health sector, with around 3,900 FTEs days lost, which represents an increase of 128%. **Financial incentives – The impact of NHS pension taxation** Before the pandemic, a material amount of acute elective output was delivered via 'waiting list reduction initiatives' at both Acute Trusts. Over the last 18 months, we have seen fewer Consultants undertaking extra operating sessions due to the tax implications associated with the NHS pension schemes.
What actions will you take to restore underlying productivity?	Enhancing the productivity of our health and care system is a key priority of our developing Joint Forward Plan – with action organised around three strategic themes: 1. ***More productive use of our assets*** • **Theatres:** We will enhance theatre utilisation, moving beyond our current performance of 82% to at least 85% in 2023/24. • **General and Acute Beds:** We will reduce the number of delayed discharges at UHDB by 15% over the next 12 months and reduce the 21-day length of stay cohort at the CRH by 10%.

- **Outpatients:** We will reduce the DNA rate by over booking clinics to ensure that capacity is effectively utilised.
- **Diagnostics:** We will increase our diagnostic output over the next 12 months with the introduction of the community diagnostic capacity that is coming online.
- **Reducing duplication of works between secondary and primary care:** So that we can free up the 5-10% of GP consultations that are currently being delivered because of process issues in other parts of the system.

2. Looking after our people

- **Retaining our staff:** We will focus on maintaining our relatively good performance when it comes to keeping the registered nurse and midwife turnover rate low and seek to reduce the turnover rate for our medical workforce which is currently too high relative to the national average.
- **Reducing sickness absence:** We will look to reduce our sickness absence rates over the next 12 months
- **Reducing agency spend:** We will look to reduce agency spend the next 12 months.

3. Focussing on preventative care

This is a key objective within our developing Joint Forward Plan, and it is vital that we make improvement here to reduce the level of the failure demand that's currently in play across our health and care system.

We will focus on enhancing primary, secondary, and tertiary prevention efforts to affect the health burden associated with the following disease/syndrome areas:

- Cardiovascular
- Respiratory
- Dementia

With an objective to reduce acute admissions to at least the national average level in the short to medium term (1-3 year) and to move to top quartile performance in the long term (5-7 years).

What key changes will you make to improve operational efficiency within your system?	Further detail on this item will follow in our final plan submission – but three key areas to stress at this point: 1. **Utilizing technology:** We will focus on expanding the use of the Derbyshire Shared Care Record over the next 12 months – with key priorities being (i) integrating social care information; and (ii) integrating 111 and community & mental health data flows. By providing clinicians with access to information, this innovation will have a direct impact on enhancing operational efficiency – reducing duplication of work and over-processing. 2. **Data Analytics:** We will provide greater transparency on the drivers of operational efficiency by using data analytics in a more proactive and sophisticated way. This will involve developing and using patient level costing information, both within provider organisations and the wider system to make better data-driven decisions to improve efficiency. *3.* **Use of estates:** We will look to protect elective bed capacity by moving provision between sites and ring-fencing beds so that we can maintain elective output throughout the whole year.
What mechanism has your system put in place to ensure your planned efficiency can be delivered recurrently in full in 2023/24?	There are three key areas to stress at this point: • Cost Improvement Targets have been established at an organisation level with work required to finalise how the remaining CIP will be allocated across each organisation so that we can achieve a break-even position. • We will be ensuring that detailed post implementation review is conducted of all new investments made - at both an organisation and system level – with specific tests on both technical and allocative efficiency to be met. • Financial scrutiny and governance will be strengthened within the developing provider collaboration and delivery architecture.

UEC Recovery plan narrative

UEC recovery plan overview	
To deliver the ambitions in the UEC recovery plan systems will need to come together to develop robust implementation and delivery plans. Provide an overview of your initial plans for implementing the UEC recovery plan.	The ICB's Urgent and Emergency Care Delivery Board (UECDB), which is chaired by the Chief Executive of University Hospitals of Derby and Burton NHSFT and has representation from all NHS Provider Organisations, Primary Care, Primary Care, NHS 111 and both Local Authorities, is responsible for the delivery of the UEC Recovery Plan. The UECDB reports into the NHS Executive Team, which is comprised of Executive Directors of the Integrated Care Board and Chief Executive Officers of JUCD NHS Provider Organisations, will provide Executive oversight of the UEC Recovery Plan. This plan focusses on: 1. Using new monies provided by NHS England to increase ambulance capacity – vital to securing the improvement in mean category 2 response times. 2. How we will use revenue monies provided by NHS England to increase the supply of medical beds. 3. Implementing our virtual ward programme which we plan to scale up significantly over the next 12 months, so that by the end of March 24 we have up to 255 people being managed across our virtual ward provision at any one time. 4. Maximising the value of the Urgent Community Response service and the Clinical Navigation Hub to help mitigate any additional growth in A&E attendances in 2023/24.
Provide an overview of the assumptions that you have made in relation to your workforce plans.	We have assumed no additional growth on 22/23 outturn, in relation to the clinical workforce that is predominately focussed on providing urgent and emergency care.

The UEC recovery plan sets out the ambition to reach a minimum of 76% A&E (all-type) performance against the four-hour standard. **What impact will your plans have on overall time spent in A&E for admitted and non-admitted patients?**	We have set a plan to improve 4 hr performance at both Acute Sites through 2023/24, so that we exit the year being in a compliant position relative to the 76% target. This will mean that patients are spending less time in ED – irrespective of whether they are ultimately admitted or not. We plan to achieve this in the following way: • With DHU in a position to recruit substantively to the enhanced primary care service at the CRH and RDH, it will be able to ensure that patients are 'turned-around' within 4 hours, at least 95% of the time. • Lower bed occupancy will provide greater flexibility for both Acutes to achieve greater flow from the ED to inpatient wards. • The Clinical Navigation Hub will be in operation all year, bringing additional capacity and better control to the decision as to where patients are best to be managed for the issue they have. • Out of hospital crisis response both in terms of scale and coverage. • Better secondary and tertiary management of people with cardiovascular, respiratory, diabetes and dementia. • Enhancing the 'same-day/non admitted service' for a range of medical and surgical presentations and achieving more consistent early input from specialists.

Virtual wards

Provide an explanation of your baseline virtual ward capacity plan as of 1 April 2023	We exit 2022/23 with the following provision in play: ○ a community based early supported discharge service which is focussed on providing care to people with respiratory system problems. This service has the capacity to manage up to 30 patients at any one time. ○ a virtual diagnostic ward in place which is designed for low-risk patients who are well enough to go home but still require at least one further investigation (such as a colonoscopy, MRI scan or blood test) in a prompt timeframe. This service has the capacity to manage up to 30 patients at any one time.

<table>
<tr><td></td><td>
We have opened palliative care virtual ward at the Ashgate Hospice in Chesterfield which is currently in a trial/pilot phase – with 2 patients admitted thus far.
Whilst this is positive progress, we are not where we had originally planned to be due in the main to workforce recruitment delays and issues with the sourcing of the digital platform to support this programme. In 2023/24 we plan to scale up the offering so that, all other things being equal, we can be able to care for up to 255 patients at any one time:
<table>
<tr><th></th><th>April 2023</th><th>June 2023</th><th>September 2023</th><th>December 2023</th><th>March 2024</th></tr>
<tr><td>Total</td><td>120</td><td>156</td><td>195</td><td>255</td><td>255</td></tr>
<tr><td>CRH - Acute Respiratory Infection</td><td>20</td><td>25</td><td>30</td><td>40</td><td>40</td></tr>
<tr><td>CRH - Cardiology</td><td>20</td><td>25</td><td>30</td><td>40</td><td>40</td></tr>
<tr><td>CRH - Frailty</td><td>0</td><td>10</td><td>20</td><td>30</td><td>30</td></tr>
<tr><td>CRH - Haematology, Oncology & Supportive Care</td><td>5</td><td>5</td><td>10</td><td>10</td><td>10</td></tr>
<tr><td>UHDB - Cardiology</td><td>10</td><td>15</td><td>20</td><td>30</td><td>30</td></tr>
<tr><td>Ashgate Hospice - EOL/Palliative Medicine</td><td>5</td><td>8</td><td>10</td><td>15</td><td>15</td></tr>
<tr><td>DHU - Respiratory Early Supported Discharge (Community)</td><td>30</td><td>38</td><td>45</td><td>60</td><td>60</td></tr>
<tr><td>Diagnostics virtual wards</td><td>30</td><td>30</td><td>30</td><td>30</td><td>30</td></tr>
</table>
</td></tr>
<tr><td>Provide an explanation of how virtual wards will develop to avoid admission to hospital.</td><td>Most of the virtual ward provision is focussed on step-down care from the acute setting, except for the community based respiratory service which currently caters to meet step-up and step-down demand.

However, we are currently exploring how to create a hybrid model for the cardiology and frailty focussed pathways – particularly as the provision starts to increase in quarters 2 and 3 of 2023/24.</td></tr>
<tr><td>Provide an explanation of how virtual wards will develop to support timely discharge from hospital.</td><td>The following wards are planned to provide early supported discharge, with Community respiratory, and Diagnostics already in place. All wards are reliant on workforce being in place to ensure the service is delivered consistently.

The programme is currently planning to achieve the following impacts on general and acute bed demand over the next 12 months:</td></tr>
</table>

Reduction in G&A bed demand	Apr-23	Jun-23	Sept-23	Dec-23	Mar-24	Assumptions
CRH - Acute Respiratory Infection	1	2	4	5	5	Mean LOS on virtual ward per patient: 8 days. Mean reduction in acute LOS per patient: 3 days.
CRH - Cardiology	1	1	2	2	2	Mean LOS on virtual ward per patient: 8 days. Mean reduction in acute LOS per patient: 1.5 days
CRH - Frailty	0	2	5	7	7	Mean LOS on virtual ward per patient: 4 days. Mean reduction in acute LOS per patient: 3 days.
CRH - Haematology, Oncology & Supportive Care	0	0	1	1	1	Mean LOS on virtual ward per patient: 14 days. Mean reduction in acute LOS per patient: 5 days.
UHDB - Cardiology	0	1	1	2	2	Mean LOS on virtual ward per patient: 8 days. Mean reduction in acute LOS per patient: 1.5 days.
Ashgate Hospice - EOL/Palliative Medicine	0	1	1	2	2	Mean LOS on virtual ward per patient: 14 days. Mean reduction in acute LOS per patient: 5 days.
DHU - Respiratory Early Supported Discharge (Community)	2	3	6	9	9	Mean LOS on virtual ward per patient: 7 days. Mean reduction in acute LOS per patient: 3 days.
CRH - Diagnostics virtual wards	3	4	6	6	6	Mean LOS on virtual ward per patient: 5 days. Mean reduction in acute LOS per patient: 3 days.
Total	**8**	**13**	**25**	**34**	**34**	

Provide an explanation of how virtual wards will reach 80% utilisation at a minimum by the end of September 2023

The average utilisation of the current capacity in play stands at around 40% so we have a gap to close to ensure that 80% is achieved by the start of Winter 2023 at the earliest.

However, we are planning to achieve this by:

- Providing regular communication to all clinical teams on the benefits of intervention.
- Ensuring that clinical protocols include the virtual ward as a key intervention with clinical criteria under regular review.
- Enhance the use of remote monitoring as an option.

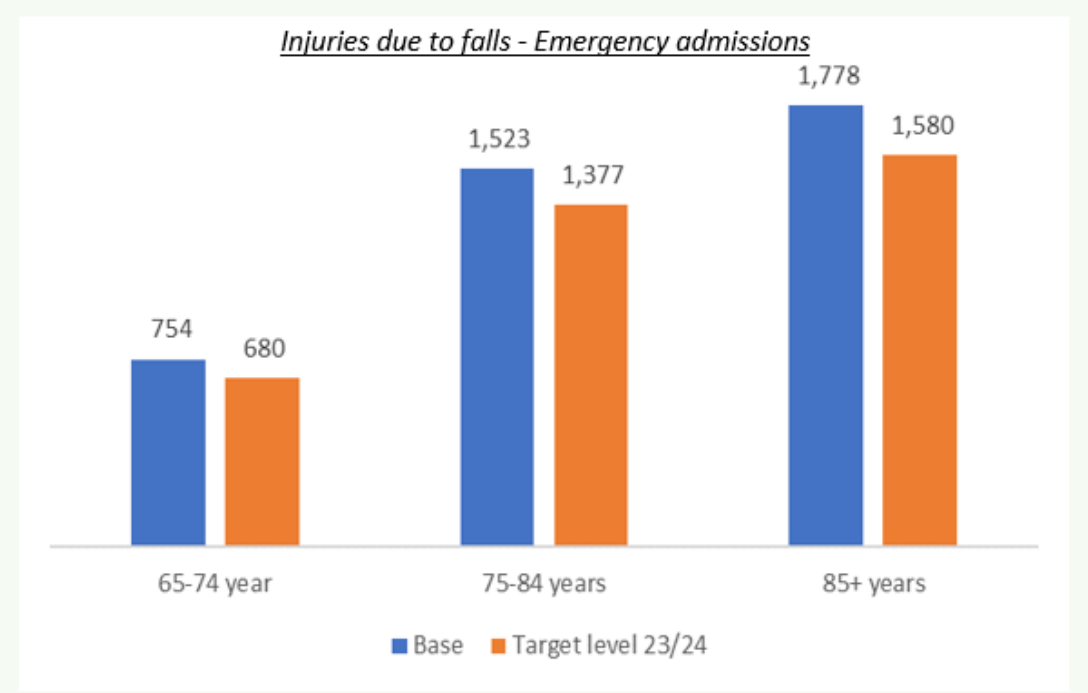
Expand new services out of hospital and avoid admission to hospital

How will your system improve quality and consistency of Urgent Community Response services, including consistently meeting or exceeding the 70% 2-hour urgent community response standard, maintaining full geographic coverage 8am-8pm 7 days a week, and maximising referrals from 111 and 999?	Urgent Community Response delivery across Derbyshire is part of a large transformation programme called Team Up – this programme 'teams up' existing services to deliver UCR, Enhanced Health in Care Homes and Anticipatory Care. Our Urgent Community Response offering consists of 4 integrated elements delivered on a local geographic footprint; rapid response nursing and therapy, falls recovery services, at scale home visiting services and short-term adult social care. The development of services incorporates a learning cycle process that supports our commitment to continuous improvement of the quality and consistency of the delivery. Our current service delivery consists of UCR (including 2 hours) Community Nursing and Therapy service operating 8:00 am - 6:30 pm, 7 days a week and achieving 78% against the 2hr target. Our service fully delivers against 7 of the 9 identified clinical conditions (not currently carer breakdown nor the enhanced requirement around Level 1 & 2 falls recovery – delivery in 23/24). Additionally, Derbyshire Health United (DHU) provide a multi-disciplinary 2-hr response to patients from 6.30pm-8pm. As a system, we are fully committed to the delivery of full geographic coverage 8-8, 7 days a week covering the 9 clinical conditions and for the 2 conditions not fully delivered: The service is supported from a care (and clinical condition 9 ‘carer breakdown’) perspective by Derby City and Derbyshire County Adult Social Care. • For Derby City Unpaid carer breakdown – 2-hour response is part of the integrated UCR response and fully operational and submitting via CSDS. • We are currently working with Derbyshire County for delivery of a 2-hour response in 2023. For L1 and L2 falls services. • the existing community rapid response service offers an element of response for people with mobility problems and who have fallen across the system.

	• During 2022/23 local Falls Recovery (Pendant Alarm) providers have piloted an integrated L1 and L2 response as part of the UCR offer across 50% of the population. The intention is that this is fully commissioned with full geographic coverage from Winter 2023. • Development of the pilots incorporates a PDSA approach to learn from each referral redirected from EMAS stack to improve associated systems and communication. The integrated UCR response is delivered at a local geographic level. A comprehensive plan increasing referrals from all key routes has been developed with key stakeholders and includes: • Ongoing audit and learning from establishment of single access point (called Clinical Navigation Hub) for the ability to use a PUSH functionality of codes – exploring options for different code PUSH to maximise re direction from EMAS stack • Development of CNH+ to enable clinical PULL of codes from EMAS stack • Further work with EMAS to explore additional options to increase flow • Exploration of direct flow from 111 to support patient direct access • Continuation of patient access via existing routes (CAP, Pendant Alarm companies) • Commissioning full geographic coverage of enhanced falls recovery service via pendant alarm companies and their direct access / involvement of the MDT UCR response. • Maximising use of DOS profile & prioritisation of those profiles to redirect referrals to the right place within the system • Exploration of acute front door turn around into local UCR / Teamed Up services that can be supported by CNH+ • Building local relationships with adult social care, pendant alarm companies, community & VCSE services and general practice to identify where step-up care into UCR is the most appropriate response and alternative to conveyance and strengthening local links into the UCR response. • Using UCR as catalyst for follow up and anticipatory care – with a focus on falls 23/24 • Enhance access to adult social care short term services to support step up and admission avoidance (County 23/24, City already operational) • Ongoing development and integration into UCR of GP led senior clinical assessment and triage capacity via at scale PCN Home Visiting Services. Development of existing fortnightly shared

	learning space across system partners (Team Up Learning in Practice – TULIP) to grow and evolve the current service offer. • Alignment of UCR service / Teamed Up teams with palliative care EOL service offer • Alignment of UCR service / Teamed Up Teams with Frailty Virtual Wards developments • Increased use of Derbyshire Shared Care Record allowing shared visibility of electronic records for Teamed Up Teams. The Derbyshire Shared Care Record is being implemented across JUCD and the ability to access citizen records will enable clinicians and professionals across they system to access records that will support them to deliver improved care. The system is working towards CSDS data submission for the Team Up team service delivery (incorporating rapid nursing and therapy, ASC short term service 2 hour response, enhanced falls recovery and at scale home visiting services). CSDS submission are currently delivered for the following elements: • Rapid nursing and Therapy (UCR) • City ASC short term service 2 hour response • Pilots delivering enhanced falls recovery
How will your system scale up falls and frailty services based on our learning from this winter, and ensure they are joined up with other services, including ambulances, UCR services and social care?	The UCR response described above sits within a wider system transformation as part of Team Up. Team Up is an ambitious programme enabling the integration of primary and community services. Team Up incorporates the other two elements of the Ageing Well Programme, namely Anticipatory care, and Enhanced Health in Care Homes (EHCH); and our service offer reflects this ambition. The Teamed Up local teams will offer not just a 2-hour response but incorporate the necessary follow up response and signposting into Anticipatory Care. The response covers people who reside in their own homes as well as those living in care homes. The teams consist of: • community rapid nursing and therapy • adult social care short term services • enhanced falls response (pendant falls alarm companies)

	• and at scale GP home visiting services. The service offer is delivered within geographic areas to enable: • an integrated offer is made to those people presenting with frailty • using a reactive episode to generate proactive care (falls recovery as the best predictor of future falls and thus holistic assessment, technology enablement, falls and equipment assessment etc) • Increased care coordination and identification of 'at risk' individuals to better support onward signposting into anticipatory and supportive care • local intelligence and relationship building across health and care networks to support step up and step-down care from the same teams • local access into the teams as well as via a single access point at Derbyshire level. With the development of these initiatives, the ICB is seeking to reduce the emergency admission rate for injuries relating to the frailty induced falls. We recognise that we are currently operating as an outlier in this regard, and we plan to move our rate from upper quartile status to at least the third quartile.

	
Provide details of other plans: - **to expand services out of hospital** - **to avoid admission to hospital, attendance at A&E** - **to support patients to leave hospital in a timely way** - **other improvement programmes related to admission avoidance and reducing length or stay that are not covered by other narrative questions.**	The ICB piloted a 'Clinical Navigation Hub' during the winter months and is planning for this to continue into 2023/24. There are two elements to the model: 1. **Clinical Navigation Hub** (CNH) • The CNH is the PUSH model. The CNH started to be rolled out from 1st December 2022and is a 1-year pilot. The CNH is included in the 2023/24 Plan. The Derbyshire CNH has been supported by findings from LLR Clinical Navigation model. • The current CNH model provides the multidisciplinary IUC Clinical Assessment Service (CAS) mandated in the National IUC Service Specification and NHS Long Term Plan and its scope is

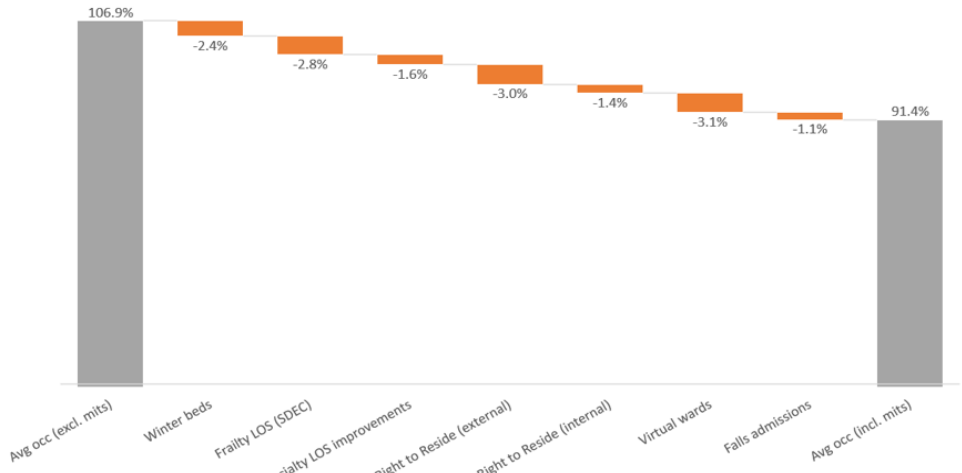
	focussed on category 3 & 4 patients, primary care dispositions and Level 1 falls patients through EMAS and NHS111.
	
	• The criteria are set by the authorised codes for each of the categories listed below.
	  ○ 24/7 validation of NHS111 telephony low acuity (Cat 3&4) ambulance dispositions
	  ○ 24/7 validation of NHS111 telephony and NHS111 online ED dispositions
	  ○ Out of hours primary care dispositions
	  ○ Out of hours health care professional access to home visiting, face to face appointments and advice
	  ○ 24/7 validation of an agreed cohort of patients reaching an ED disposition when using Chesterfield Royal Hospital ED Self Service Navigation Portal.
	  ○ 24/7 validation of NHS111 online low acuity (Cat 3&4) ambulance dispositions
	  ○ 24/7 validation of an agreed cohort of EMAS Cat 3-5 patients
	  ○ In hours validation of 1-, 2- and 6-hour primary care dispositions
	  ○ In hours validation of 1-, 2- and 6-hour primary care dispositions reached by patients using Chesterfield Royal Hospital ED Self Service Navigation Portal
	  ○ Level 1 Falls at Derby and Chesterfield (Implemented from 15 December 2022)
	• The CNH is proactive and dynamic in getting people to the right place first time, potentially reducing the number of touchpoints, reducing the number of ED attendances and subsequent hospital admission and support inflow and outflow.
	
	• The service is delivered by DHU and is staffed by local clinicians 24/7 and led by GP's and Advance practitioners (AP) utilising local clinicians with a high level of up-to-date local knowledge of the Derby and Derbyshire urgent care system. Together it delivers local clinical advice and assessment

	by triaging patients using a "consult and complete" model of delivery. These elements continue to be monitored via the existing routes. The Current CNH model costs £1m per year. **2. Clinical Navigation Hub Plus (CNH+).** • The **PULL/ DEFLECT** model. Based on Unscheduled Care Coordination Model and Rapid Improvement Fortnight from 31 October 2022. The CNH+ has been rolled out for 2 weeks to date the pilot is for 3 months. • The aim of a CNH+ is to expand and enhance the current CNH to support a faster and convenient way to direct more people to the right part of the health and care system in a timely manner. This is by having, where staffing capacity allows, a Multi-Disciplinary Team (MDT) made up of professionals including GP's, Advanced Clinical Practitioners, Nurses and EMAS Practitioners forming a Hub working alongside Social Care to support frontline clinicians by maximising the opportunities to find the right care, first time for patients who have called 111 or EMAS. • Furthermore, this would also support the "No decision in isolation" ethos described in the National IUC Service Specification whereby healthcare professional have direct access to clinical advice as a way of avoiding unnecessary ambulance conveyances or ED attendances. • The project will continue to support the aims of the CNH which are to: o Support the ethos of patients being seen in the right place first time o Contribute towards improving the patient experience o Ensure that the Derby and Derbyshire, including Glossop, UEC system is safe o Help improve patient access to urgent and emergency care (UEC) including the Urgent Community Response (UCR) Derby City and Derbyshire, including Glossop o Continue to embed the principles set out through the NHS 111 First programme o Support the reduction of risks associated with overcrowding across UEC services and the impact of Covid-19-

	○ Act as the single point of access for healthcare professionals. ○ Promote, foster, and nurture an open culture for clinicians to call the hub. ○ Develop a model that complements/supports the newly formed Operation Control Centre (OCC). • The CNH+ can support the Urgent Community Response FRS by, creating a further opportunity to improve the quality and experience for the remaining 60%-70% of falls patients potentially not captured through the CNH. • Discussions have started on how the CNH+ can potentially be the same as the Hub to support discharge and the Single Point of Access (SPA) in response to NHSEI Recovery Plan published in January 2023.

Planning assumptions (linked to the numerical 'Demand, capacity and flow' numerical submission)

Provide an explanation of assumptions made in relation to unmitigated occupancy across elective and non-elective G&A beds.	• An 'unmitigated' G&A average G&A bed occupancy level is currently assumed to be 101% in 2023/24. This is based on: ○ No change on the 22/23 outturn level r.e. MFFD. ○ Delivering the elective inpatient and daycase volumes within 'core' substantively funded provision. ○ No change in Length of Stay or admission volumes on 22/23 level.

Provide an explanation of your opening G&A bed capacity position for 2023/24.	**Chesterfield Royal Hospital NHSFT** The current plan is to mitigate the 106.9% average G&A bed occupancy to achieve 91.4%. Delivering the activity required to reduce RTT waiting lists and also maintain flow along the UEC pathway requires more general and acute beds than we substantively have. We therefore have to reduce the overall G&A bed occupancy at the CRH from around 106% to 92% at least. Our plan to achieve this includes: 1. Increasing the supply of medical beds during the winter months – 28 from November 2023 to March 2024. 2. Improving internal pathways will release beds Acute MI (2 days reduction), Sepsis (0.5 days reduction), AF (0.5 days reduction) 3. Further work is ongoing to improve the NEL bed base, High impact users scheme consistently delivering against agreed outcomes, Proactive Pull model from ED for Direct to specialty, SDEC consistently 7/7 (increase from 28% activity to over 30%) and Redirection and re-instigating LLOS reviews for 21 day+ and include 14+ day and 7+ day. 4. Better flow across P1 and P2 D2A community capacity. 5. Reducing length of stay by maximising the use of virtual wards. 6. Realising the benefit of enhancements to the frailty falls pathway in the community. *Chesterfield Royal Hospital NHSFT* *Average G&A bed occupancy – 2023/24* 

University Hospitals of Derby and Burton NHSFT

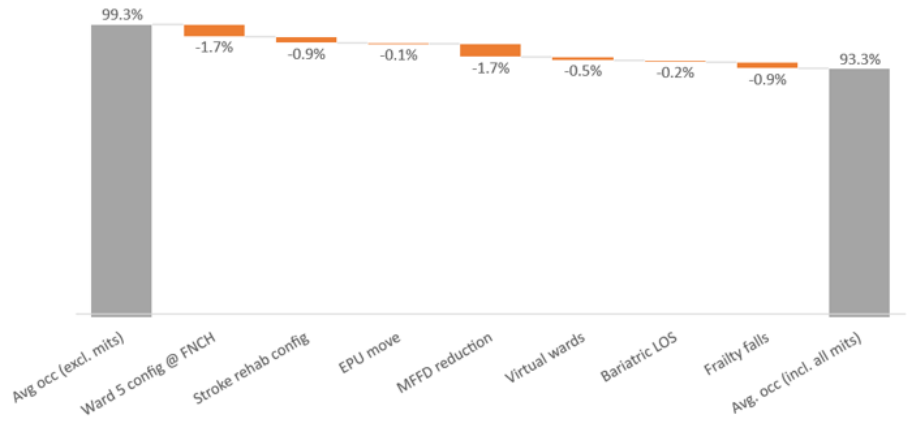
The current plan is to mitigate the 99.1% average G&A bed occupancy to achieve 93.3%.

Delivering the activity required to reduce RTT waiting lists and also maintain flow along the UEC pathway requires more general and acute beds than we substantively have. We therefore have to reduce the overall G&A bed occupancy at the CRH from around 99% to 92% at least.

Our plan to achieve this includes:

1. Increasing the supply of medical beds during the winter months. This includes a reconfiguration of ward 5 at the FNCH, stroke rehabilitation and moving the Elective Procedures Unit (EPU) from the RDH to Kings Treatment Centre.
2. Los reduction for delays relating to bariatric patients as a result of DCHS bariatric referral centre at St Oswald's Community Hospital.
3. Reducing the medically fit for discharge in delay cohort – via internal pathway improvements and better flow across P1 and P2 D2A community capacity.
4. Better flow across P1 and P2 D2A community capacity.
5. Reducing length of stay by maximising the use of virtual wards.
6. Realising the benefit of enhancements to the frailty falls pathway in the community.
7. If required opening escalation beds and enacting FCP protocols (in extremis).

University Hospitals of Derby and Burton NHSFT
Average G&A bed occupancy – 2023/24



Provide an explanation of the G&A occupancy level that the ICS needs to maintain to achieve a minimum of 76% A&E performance against the four-hour standard (all-types).	• Our current working assumption is that achieving an average monthly occupancy rate of 93% across both Trusts will facilitate delivery of the 76% target, all other things being equal.
Provide an explanation of planning assumptions made regarding intermediate care (step down) capacity and use of the Adult Social Care Fund and Better Care Fund	Our plan currently assumes that the following elements of capacity will be funded via the Adult Social Care Fund and the Better Care Fund: • 204 community/residential beds: o Funding to spot purchase up to 176 beds as required o Funding to support 20 P2a beds o Funding to support 8 step-down residential beds for people with severe mental illness. • 687 packages of care for per month.

Operational Performance Brief by Area

April 2023

Appendix 2

Technical Annex – Urgent and Emergency Care

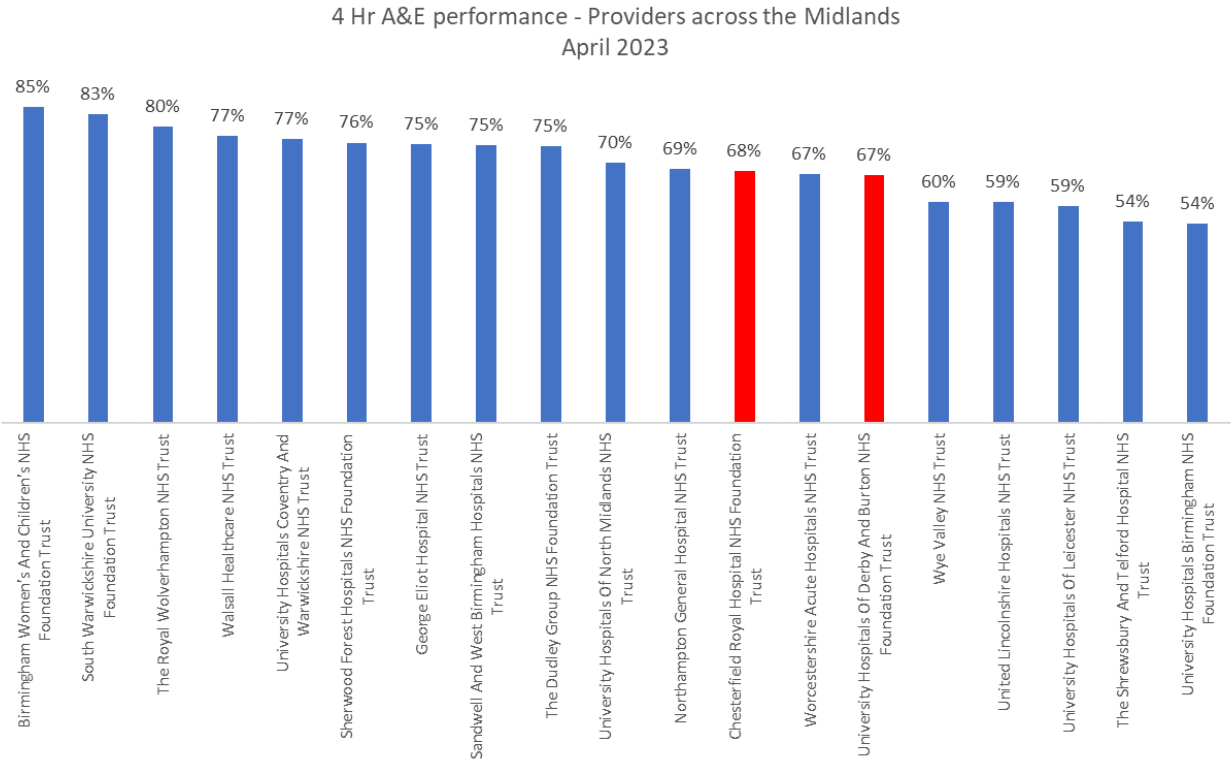
Data sources

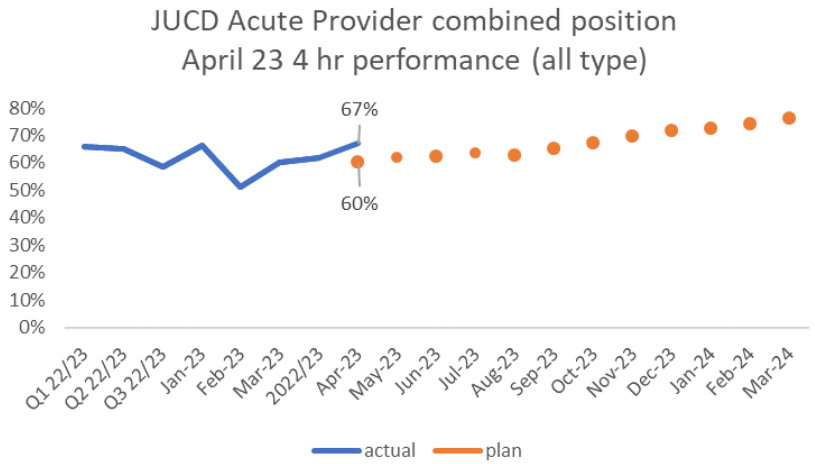
- A&E 4 hour performance - NHS England, https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
- EMAS Category 2 response times – NHS England, https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/
- Ambulance handover delays – NHS England Analytics Hub – *Ambulance Dashboard*, https://tabanalytics.data.england.nhs.uk/#/views/AmbulanceDashboard/CoverPage?:iid=1
- General and Acute Bed Occupancy – NHS England Analytics Hub – *National A&E Dashboard*, https://tabanalytics.data.england.nhs.uk/#/views/NationalAEDashboardNewLayout/KeyMetricTrends?:iid=1
- Long length of Stay - NHS England Analytics Hub – *The Long Stays Dashboard,* *https://tabanalytics.data.england.nhs.uk/views/TheLongStaysDashboard/CoverPage?%3Aembed=y&%3Aiid=1&%3AisGuestRedirectFromVizportal=y#1*
- Patients remaining in hospital who no longer meet the criteria to reside – NHS National Data Platform Foundry.

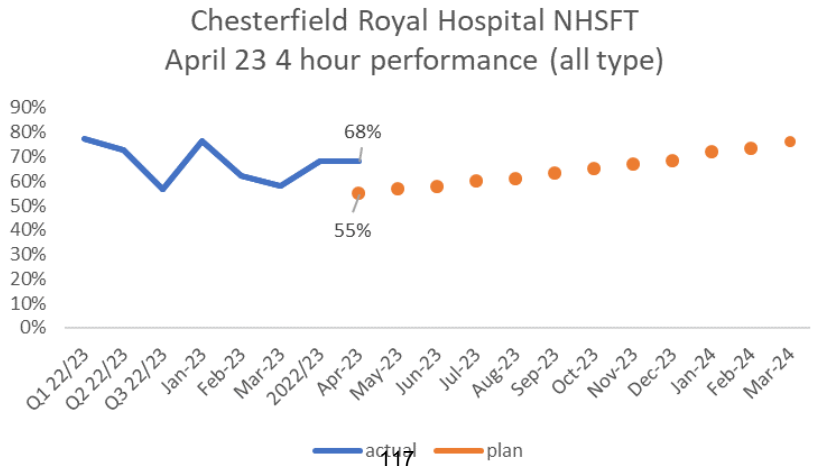
A&E 4 hour performance

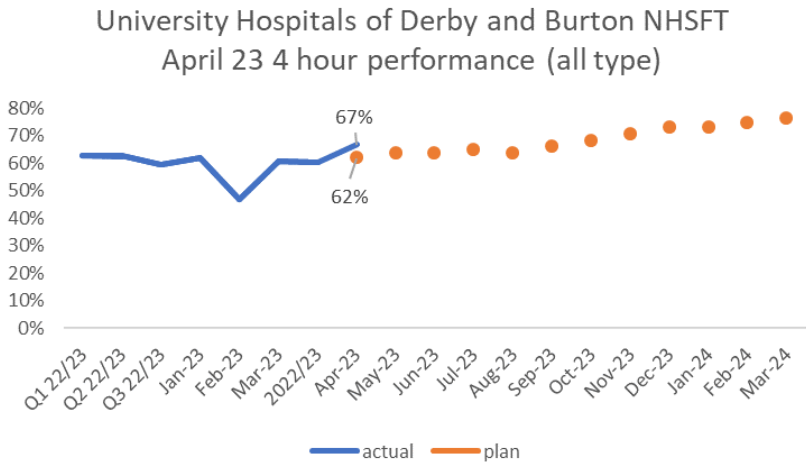
Both Trusts met their A&E 4hr target in April 2023, with the Chesterfield Royal Hospital (CRH) achieving 68% against a target of 55% and the University Hospitals of Derby and Burton (UHDB) achieving 67% against a target of 62%.

Over the last 6 week period, performance has held up with a 6 week average level of 76% and 67% at the CRH and UHDB respectively.





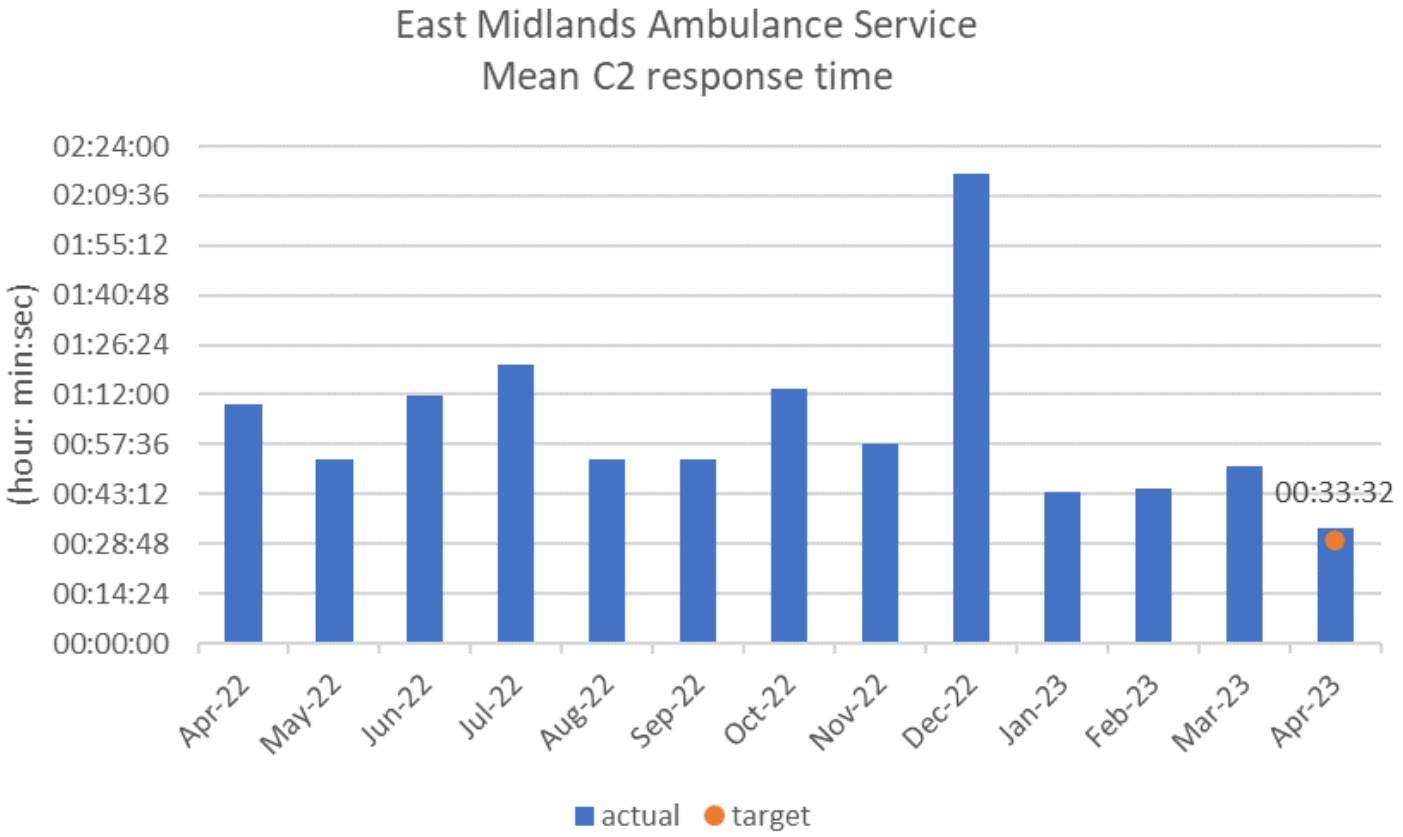




Category 2 Response

When it comes to average C2 response times, the East Midlands Ambulance Service exceeded the target in April 2023 – with performance standing at 33 minutes compared to a target of 30 mins.

Whilst just short of the target, performance was much better on a like for like basis compared to April 2022.

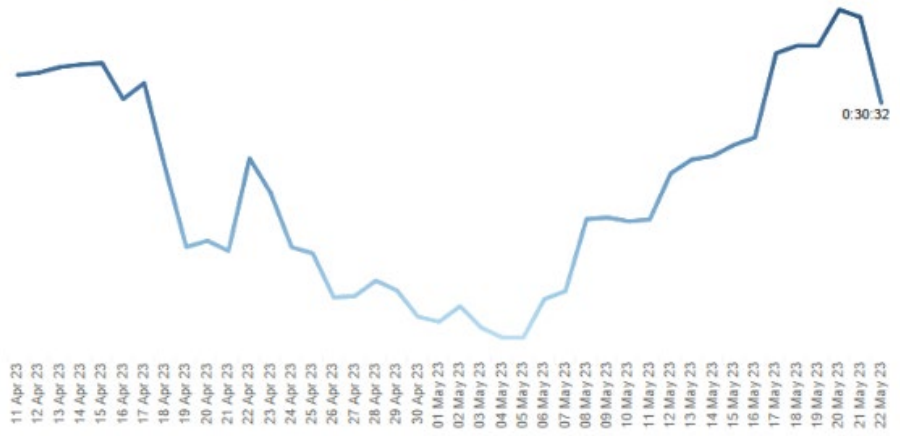


Ambulance handover delays

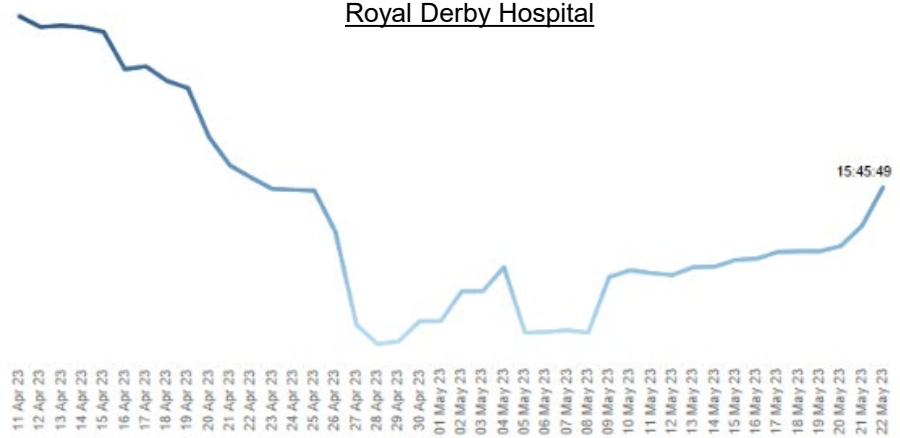
Over the last 30 days, performance has been relatively stable at both sites, with the average amount of time lost per day standing at 30 minutes and 15 mins at the Chesterfield Royal Hospital and Royal Derby Hospital respectively.

Time lost to handovers per day – 30 day rolling average as at 22 May 2023

Chesterfield Royal Hospital



Royal Derby Hospital



Time lost to handovers per day across the Midlands – 30 day rolling average as at 22 May 2023

Ambulance Trust	Site	
West Midlands	Worcestershire Royal Hospital	41:08:56
West Midlands	Royal Stoke University Hospital	34:58:47
West Midlands	Royal Shrewsbury Hospital	31:33:47
East Midlands	Nottingham University NHS Trust -..	28:51:19
East Midlands	Lincoln County Hospital	23:31:18
East Midlands	Leicester Royal Infirmary	19:41:12
West Midlands	The Princess Royal Hospital	16:21:30
East Midlands	Royal Derby Hospital	15:45:49
West Midlands	Heartlands Hospital	15:41:35
West Midlands	Queen Elizabeth Hospital Birming..	15:14:10
West Midlands	Good Hope Hospital	14:14:03
West Midlands	University Hospital (coventry)	10:25:19
East Midlands	Peterborough City Hospital	10:05:42
West Midlands	Russells Hall Hospital	9:29:56
East Midlands	Northampton General Hospital (ac..	9:19:16
West Midlands	Alexandra Hospital	6:28:18
West Midlands	Hereford County Hospital	6:19:55
East Midlands	Scunthorpe General Hospital	5:55:17
West Midlands	Sandwell General Hospital	5:25:30
East Midlands	Diana, Princess Of Wales Hospital	4:46:56
East Midlands	Kettering General Hospital	4:32:48
East Midlands	Pilgrim Hospital	3:55:12
West Midlands	Queen's Hospital, Burton Upon Tr..	3:46:59
West Midlands	City Hospital	2:10:40
East Midlands	Queen's Hospital, Burton Upon Tr..	1:50:01
West Midlands	George Eliot Hospital - Acute Serv..	1:30:56
West Midlands	New Cross Hospital	0:56:59
East Midlands	Hull Royal Infirmary	0:43:00
East Midlands	Stepping Hill Hospital	0:39:12
West Midlands	Stafford General Hospital	0:35:49
East Midlands	Chesterfield Royal Hospital	0:30:32
West Midlands	Manor Hospital	0:27:35
East Midlands	Bassetlaw Hospital	0:24:54
East Midlands	George Eliot Hospital - Acute Serv..	0:24:27
West Midlands	Birmingham Children's Hospital	0:22:31
East Midlands	King's Mill Hospital	0:19:07
West Midlands	Warwick Hospital	0:16:20
East Midlands	Grantham & District Hospital	0:14:12
East Midlands	Leicester General Hospital	0:07:46

General and Acute bed occupancy and long length of stay

120

Bed occupancy and long length of stay

Chesterfield Royal Hospital

The Derbyshire health and care system set an objective to deliver an average adult G&A bed occupancy rate of 92% in 2023/24. Over the last 6 week period, the position at the CRH has exceeding the target – with performance standing at 96.6%.

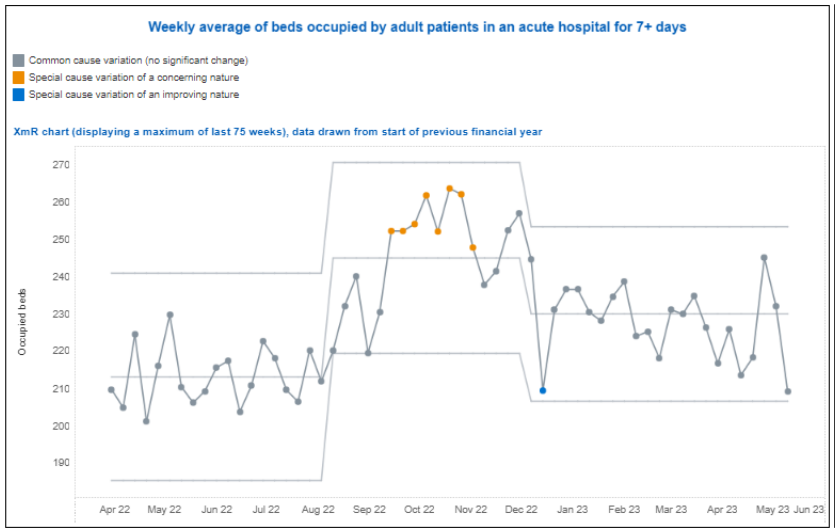
Capacity

	9 May 2023	10 May 2023	11 May 2023	12 May 2023	13 May 2023	14 May 2023	15 May 2023	16 May 2023	17 May 2023	18 May 2023	19 May 2023	20 May 2023	21 May 2023	22 May 2023	1 week average	6 week average	6 week same day average
Bed occupancy	97.6%	93.6%	94.4%	94.3%	93.9%	98.9%	95.1%	96.4%	96.8%	93.2%	92.0%	94.1%	96.0%	93.9%	94.6%	94.6%	96.2%
Total G&A beds open	532.0	529.0	532.0	529.0	521.0	532.0	529.0	531.0	531.0	532.0	526.0	522.0	528.0	528.0	528.3	528.4	529.2
Core beds available	504	504	504	504	504	504	504	504	504	504	504	504	504	504	504.0	504.0	504.0
Escalation beds open	28	25	28	25	17	28	25	27	27	28	22	18	24	24	24.3	24.4	25.2
Adult total G&A bed occupancy	98.4%	93.7%	95.5%	95.9%	95.8%	98.8%	97.4%	98.2%	98.0%	95.1%	93.5%	97.0%	97.8%	96.4%	96.6%	96.1%	97.4%
Adult total G&A beds open	509.0	507.0	509.0	507.0	499.0	509.0	506.0	508.0	508.0	509.0	504.0	500.0	506.0	506.0	505.9	506.2	507.0
Paediatric total G&A bed occupancy	78.3%	90.9%	69.6%	59.1%	50.0%	100.0%	43.5%	56.5%	69.6%	52.2%	59.1%	27.3%	54.5%	36.4%	51.0%	60.0%	68.4%
Paediatric total G&A beds open	23.0	22.0	23.0	22.0	22.0	23.0	23.0	23.0	23.0	23.0	22.0	22.0	22.0	22.0	22.4	22.0	22.2
Proportion of occupied beds by 7+ day patients	47.0%	45.3%	44.2%	44.3%	46.8%	45.6%	43.9%	41.2%	40.1%	41.3%	42.1%	41.5%	42.0%	41.5%	41.4%	44.7%	44.3%
Beds occupied by long stay patients (7+ days)	244.0	224.0	222.0	221.0	229.0	240.0	221.0	211.0	206.0	205.0	204.0	204.0	213.0	206.0	207.0	223.2	225.5
Proportion of occupied beds by 14+ day patients	30.4%	31.1%	30.3%	29.5%	31.3%	29.3%	29.4%	27.3%	25.9%	26.6%	27.7%	27.1%	27.2%	25.6%	26.8%	28.4%	28.1%
Beds occupied by long stay patients (14+ days)	158.0	154.0	152.0	147.0	153.0	154.0	148.0	140.0	133.0	132.0	134.0	133.0	138.0	127.0	133.9	141.9	142.8
Proportion of occupied beds by 21+ day patients	10.8%	12.7%	12.9%	14.0%	13.1%	12.2%	12.3%	12.3%	12.3%	12.7%	13.4%	14.1%	14.0%	13.7%	13.2%	13.5%	65.5
Beds occupied by long stay patients (21+ days)	56.0	63.0	65.0	70.0	64.0	64.0	62.0	63.0	63.0	63.0	65.0	69.0	71.0	68.0	66.0	67.7	12.9%
Adult critical care bed occupancy	53.3%	80.0%	60.0%	73.3%	46.7%	46.7%	53.3%	60.0%	93.3%	100.0%	93.3%	93.3%	80.0%	100.0%	88.6%	80.6%	80.0%
Adult critical care beds available	15.0	15.0	15.0	15.0	15.0	15.0	15.0	15.0	15.0	15.0	15.0	15.0	15.0	15.0	15.0	15.0	15.0
Paediatric intensive care bed occupancy																	
Neonatal intensive care cots occupancy	100.0%	66.7%	66.7%	66.7%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	66.7%	33.3%	81.8%	66.7%	72.2%
TotalBedsClosedD&V	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.0	0.0	0.7	15.4	12.8
TotalBedsClosedD&Vunoccupied	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.3	3.3
Urgent cancelled ops in previous 24h	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0	0.0	0.0

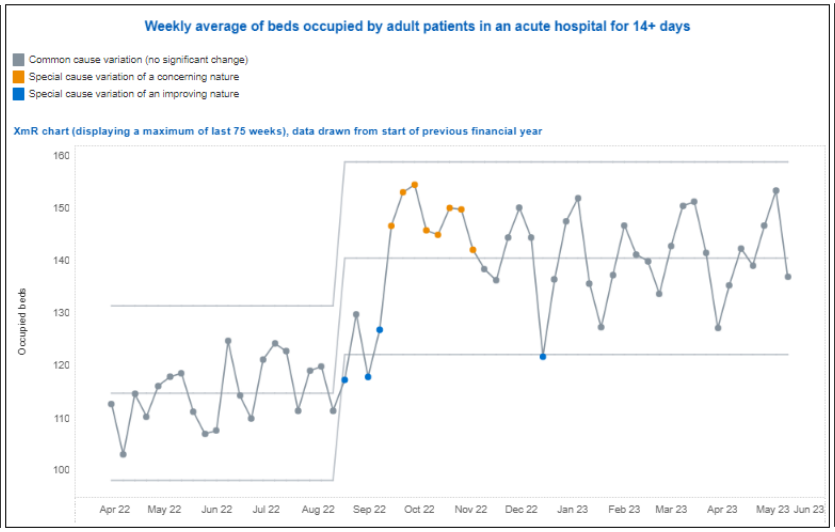
Chesterfield Royal Hospital

When it comes to long length of stay performance, there has been no significant change so far this financial year in the number of occupied beds by adults for 7+,14+ and 21+ days.

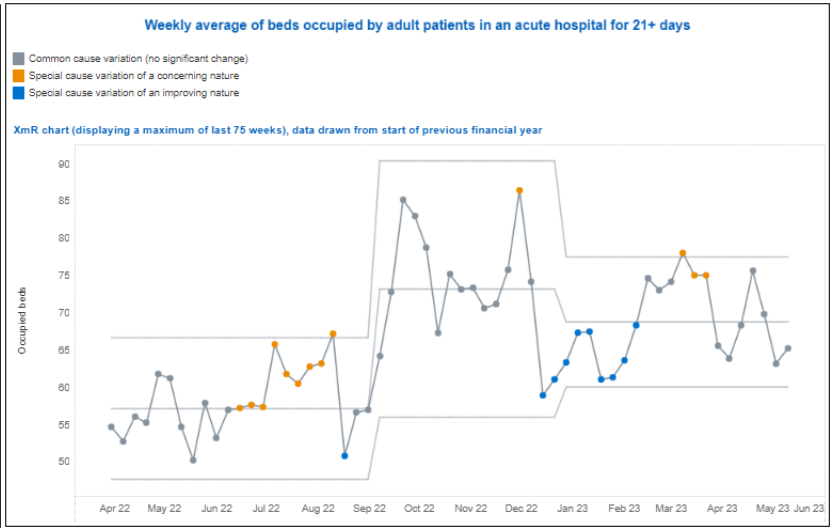
Patients occupying a bed for 7+ days



Patients occupying a bed for 14+ days



Patients occupying a bed for 21+ days



Bed occupancy and long length of stay

Royal Derby Hospital

The Derbyshire health and care system set an objective to deliver an average adult G&A bed occupancy rate of 92% in 2023/24. Over the last 6 week period, the position at the RDH has exceeding the target – with performance standing at 93.0%.

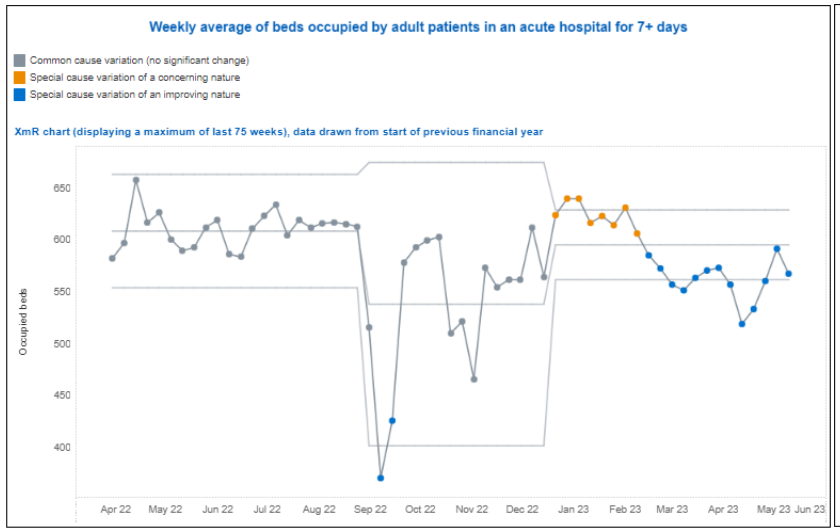
Capacity

	9 May 2023	10 May 2023	11 May 2023	12 May 2023	13 May 2023	14 May 2023	15 May 2023	16 May 2023	17 May 2023	18 May 2023	19 May 2023	20 May 2023	21 May 2023	22 May 2023		1 week average	6 week average	6 week same day average
Bed occupancy	96.8%	95.7%	95.5%	91.9%	90.9%	95.0%	97.0%	96.2%	92.4%	91.7%	89.2%	87.9%	89.4%	97.7%		92.1%	91.4%	94.3%
Total G&A beds open	999.0	999.0	999.0	997.0	996.0	997.0	998.0	999.0	995.0	981.0	996.0	992.0	993.0	994.0		992.9	986.4	989.2
Core beds available	964	964	964	964	964	964	964	964	964	964	964	964	964	964		964.0	964.0	964.0
Escalation beds open	35	35	35	33	32	33	34	35	31	17	32	28	29	30		28.9	22.4	25.2
Adult total G&A bed occupancy	98.3%	97.0%	96.5%	92.9%	92.0%	96.3%	98.0%	97.2%	93.3%	92.6%	89.6%	88.9%	90.7%	98.8%		93.0%	92.4%	95.2%
Adult total G&A beds open	975.0	975.0	975.0	973.0	972.0	973.0	974.0	975.0	971.0	957.0	972.0	968.0	969.0	970.0		968.9	962.4	965.2
Paediatric total G&A bed occupancy	37.5%	41.7%	54.2%	50.0%	45.8%	41.7%	54.2%	54.2%	54.2%	58.3%	70.8%	45.8%	37.5%	54.2%		53.6%	53.2%	56.3%
Paediatric total G&A beds open	24.0	24.0	24.0	24.0	24.0	24.0	24.0	24.0	24.0	24.0	24.0	24.0	24.0	24.0		24.0	24.0	24.0
Proportion of occupied beds by 7+ day patients	42.6%	42.8%	42.9%	43.7%	44.3%	44.1%	41.8%	43.2%	42.8%	44.6%	42.9%	44.6%	44.7%	42.6%		43.6%	42.4%	42.7%
Beds occupied by long stay patients (7+ days)	412.0	409.0	409.0	400.0	401.0	418.0	405.0	415.0	393.0	401.0	381.0	389.0	397.0	414.0		398.6	382.8	398.0
Proportion of occupied beds by 14+ day patients	22.9%	21.9%	21.2%	22.1%	23.3%	22.7%	21.9%	23.3%	24.0%	23.9%	23.8%	25.3%	24.5%	22.3%		23.9%	22.5%	22.2%
Beds occupied by long stay patients (14+ days)	221.0	209.0	202.0	202.0	211.0	215.0	212.0	224.0	221.0	215.0	211.0	221.0	218.0	217.0		218.1	203.1	207.0
Proportion of occupied beds by 21+ day patients	13.0%	13.2%	13.3%	13.4%	13.3%	13.0%	12.8%	13.7%	13.6%	13.6%	14.1%	14.9%	14.4%	13.4%		13.9%	13.2%	121.8
Beds occupied by long stay patients (21+ days)	126.0	126.0	127.0	123.0	120.0	123.0	124.0	132.0	125.0	122.0	125.0	130.0	128.0	130.0		127.4	118.7	13.1%
Adult critical care bed occupancy	90.2%	97.6%	87.8%	82.9%	80.5%	82.9%	92.7%	85.4%	78.0%	90.2%	92.7%	95.1%	95.1%	92.7%		89.9%	90.7%	92.7%
Adult critical care beds available	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0		41.0	41.0	41.0
Paediatric intensive care bed occupancy																		
Neonatal intensive care cots occupancy	71.4%	75.0%	78.6%	78.6%	82.1%	85.7%	89.3%	89.3%	96.4%	100.0%	100.0%	100.0%	96.4%	100.0%		97.4%	88.0%	85.1%
TotalBedsClosedD&V	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	30.0	30.0	30.0	0.0	0.0		12.9	2.1	0.0
TotalBedsClosedD&Vunoccupied	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0	5.0	6.0	0.0	0.0		2.1	0.4	0.0
Urgent cancelled ops in previous 24h	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0.0	0.0	0.0

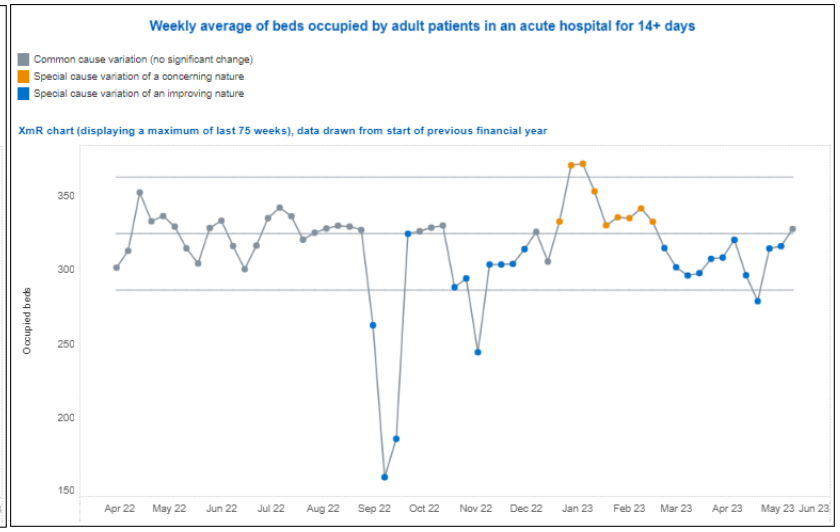
University Hospitals of Derby and Burton NHSFT (all sites)

When it comes to long length of stay, performance has been of an improving nature across all 3 time bands.

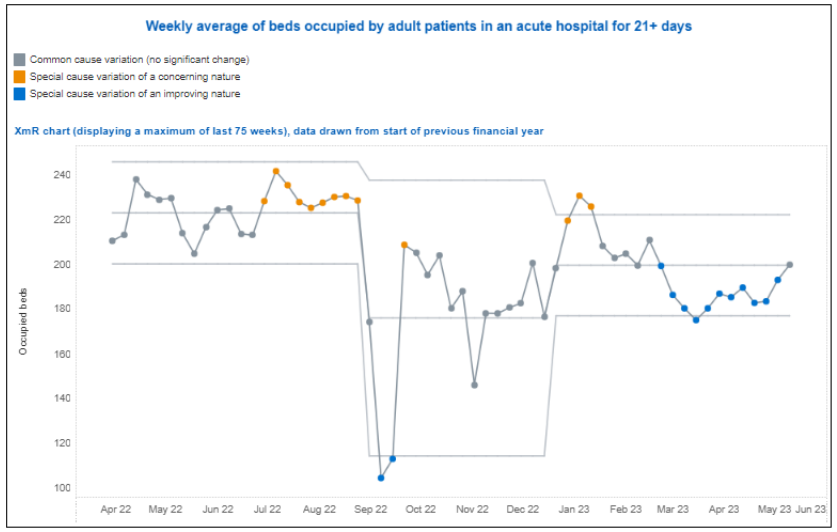
Patients occupying a bed for 7+ days



Patients occupying a bed for 14+ days

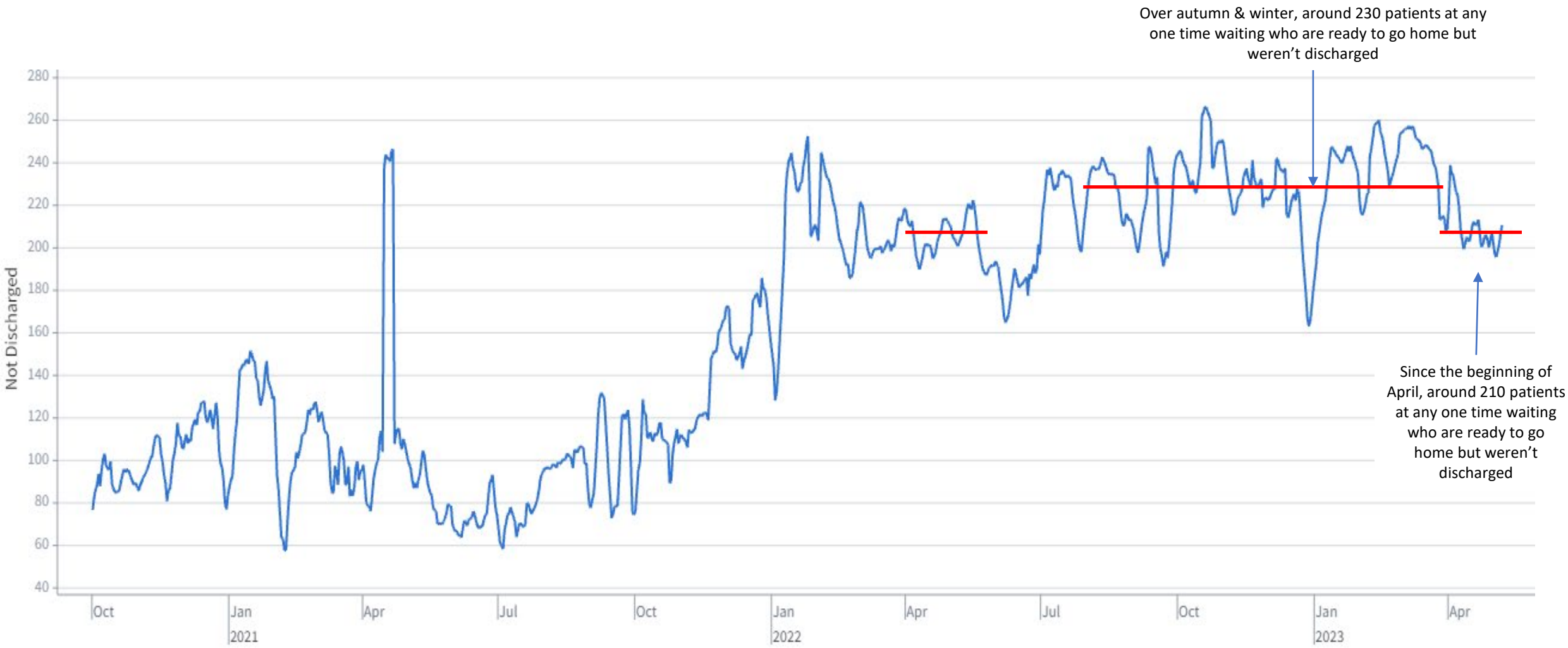


Patients occupying a bed for 21+ days

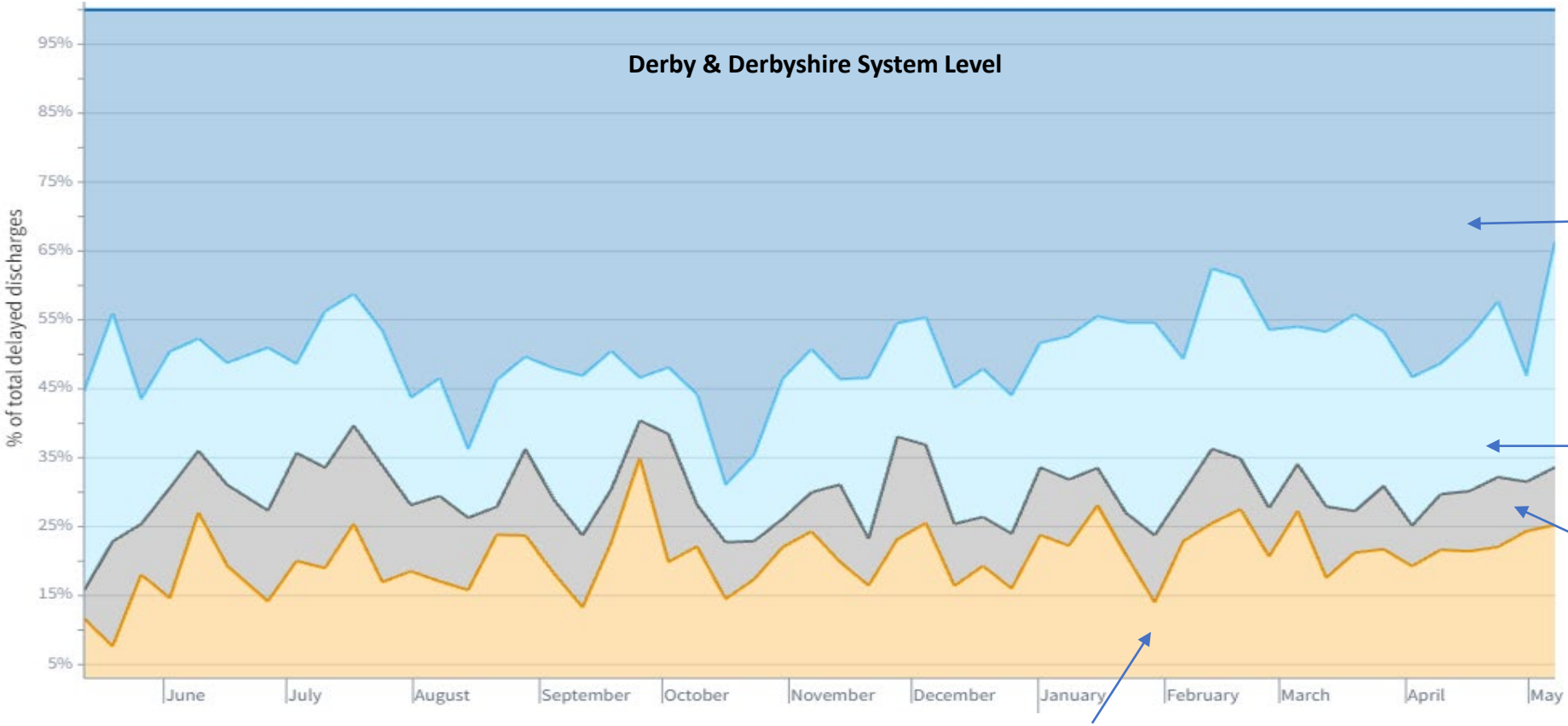


Delays to discharge from the Acute Trusts

Over the winter there were around 230 patients across UHDB and the CRH who were in hospital but don't meet any clinical criteria to reside. Since the beginning of April this has dropped by around 20 patients, which is an improvement but meets with seasonal expectations as it's similar to the same period last year.



Reasons for Delayed Discharges – relating to patients who no longer meet the CTR (Criteria to Reside) but remain in hospital for 7 days or longer: A quarter of the delays that relate to people who been in delay for 7 days or longer are associated with hospital process issues. **34%** are due to social care capacity and **33%** are due to community bed availability – which has grown as an issue during May, potentially due to industrial action within the community trusts.



WS 4 (Social & LA Care) – 34%

- Pathway 1 (total): awaiting availability of resource for assessment and start of care at home
- Pathway 3: awaiting availability of a bed in a residential or nursing home that is likely to be a permanent placement
- Awaiting community equipment and adaptations to housing
- Homeless/no right of recourse to public funds/no place to discharge to

WS 3 (Community Care) – 33%

- Pathway 2: awaiting availability of rehabilitation bed in community hospital or other bedded setting

WS 2 (Interface) – 8%

- Awaiting confirmation from community hub/single point of access that referral received and actioned
- Individual/family not in agreement with discharge plans
- Safeguarding concern preventing discharge or Court of protection
- Repatriation/Transfer to another acute trust for specialist treatment or ongoing treatment
- Remains in hospital to avoid spread of (non-Covid 19) infectious disease and because there is no other suitable location to discharge to

WS 1 (Hospital processes) – 25%

- Declared as not meeting the criteria to reside at morning ward round and then later in day meets the criteria to reside so discharge stopped.
- Awaiting a medical decision/intervention including writing the discharge summary.
- Awaiting therapy decision to discharge.
- Awaiting referral to community single point of access.
- Awaiting medicines to take home.
- Awaiting transport.
- No Plan.
- Awaiting Diagnostic test.

Technical Annex – Planned Acute Care

Data sources

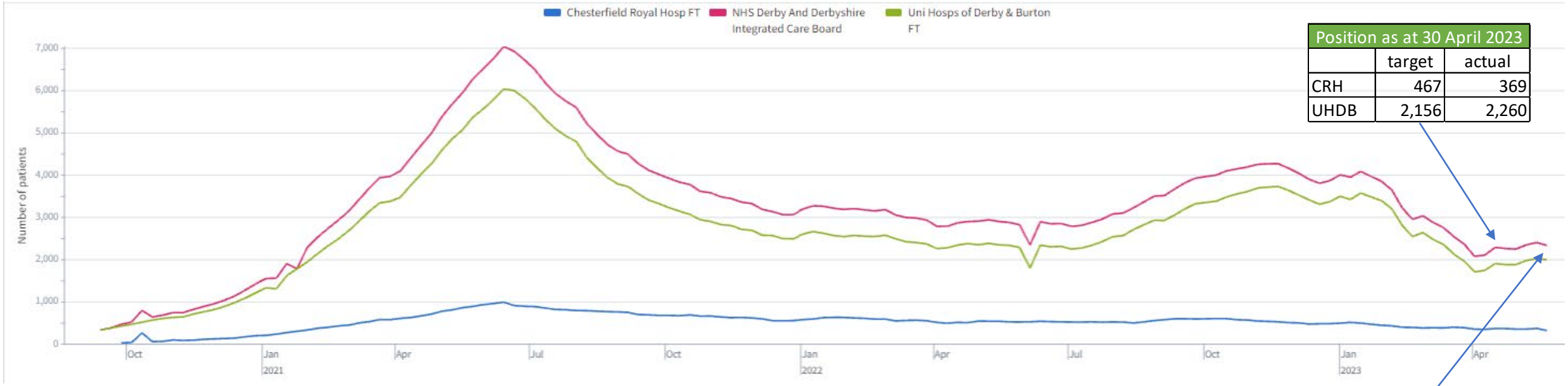
- **The number of incomplete RTT pathways of 65 weeks or more** – Waiting List Minimum Viable Dataset (WLMDS) Weekly Data Collection, NHS National Data Platform Foundry.

- **The number of people waiting 63 days or more for their cancer treatment or removed from the PTL** - Cancer Waiting Times Data Collection with the weekly data drawn from the the Cancer PTL, NHS National Data Platform Foundry.

The number of incomplete RTT pathways of 65 weeks or more

The number of patients waiting 65 weeks or more was slightly higher at the end of April 2023 compared to the start of it (2,260 patients as at 30/4/23 vs 2,087 as at 2/4/23).

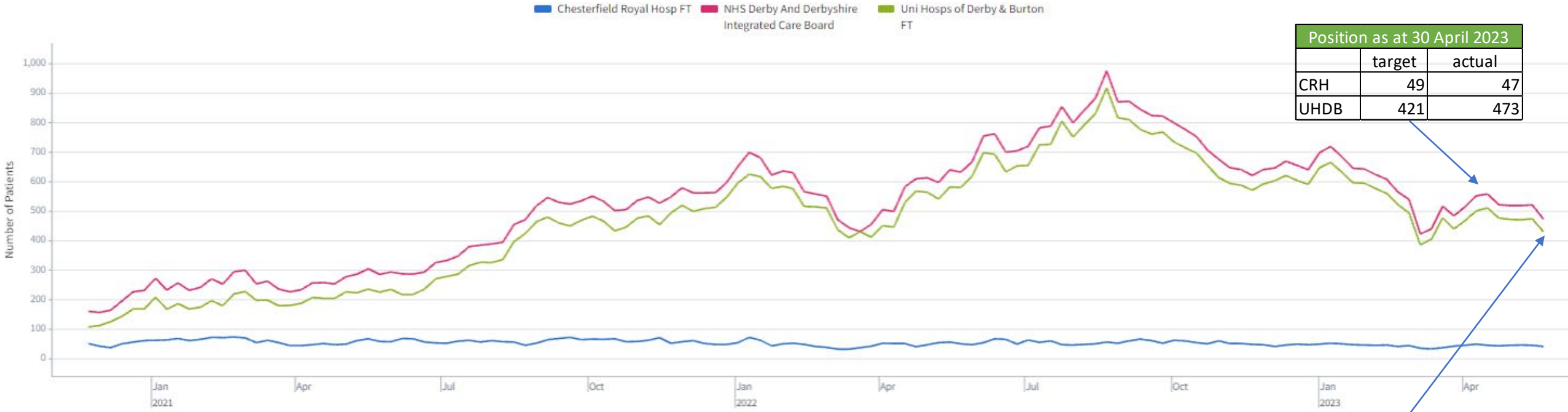
The Chesterfield Royal Hospital is ahead of its target trajectory (369 patients as at 30/4/23 against a target of 467) and the University Hospitals of Derby and Burton behind its target trajectory (2,260 patients as at 30/4/23 against a target of 2,156).



Position as at 30 April 2023		
	target	actual
CRH	467	369
UHDB	2,156	2,260

Position as at 21 May 2023		
	target*	actual
CRH	452	334
UHDB	1,935	2,345
*target relates to end of May		

62 day+ cancer waits



Position as at 30 April 2023		
	target	actual
CRH	49	47
UHDB	421	473

Position as at 21 May 2023		
	target*	actual
CRH	51	43
UHDB	411	431

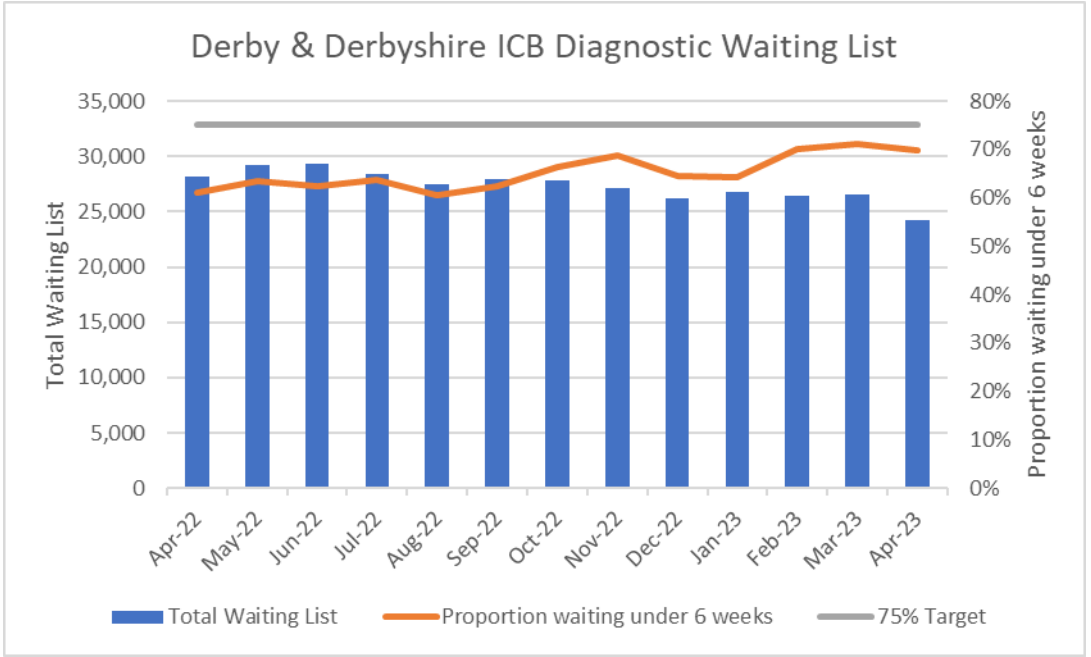
*target relates to end of May

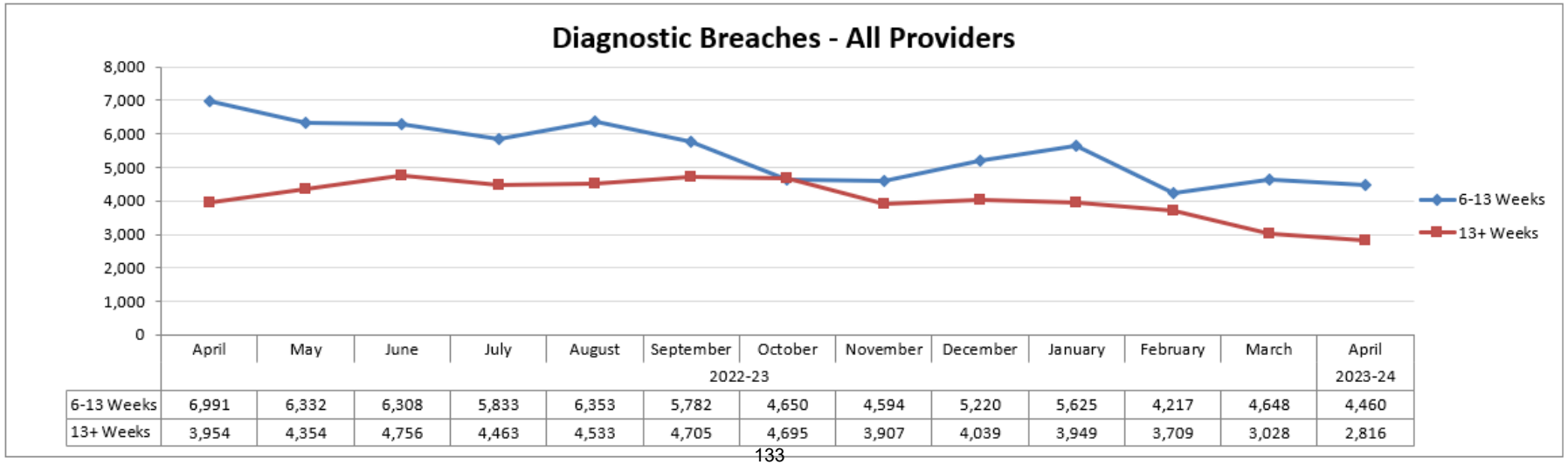
Technical Annex – Diagnostics

Diagnostics

April 2023 numbers are unvalidated

Diagnostic waiting lists have gradually reduced in number along with the numbers of breaches. This has resulted in an improving trajectory, with 70% waiting less than 6 weeks in April 2023 (unvalidated) which is approaching the 75% target, along with a lower waiting list overall.
Endoscopies and Echocardiogram tests contribute to most of the breaches.

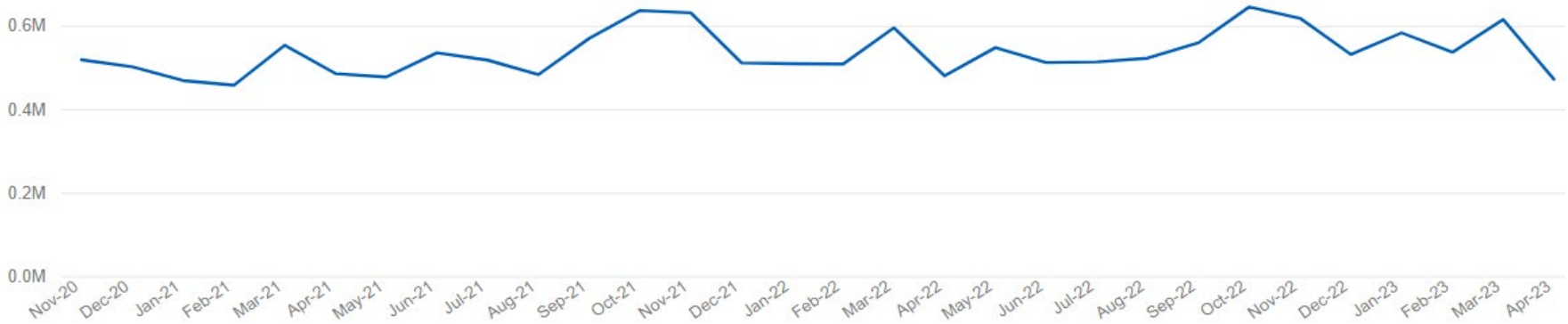




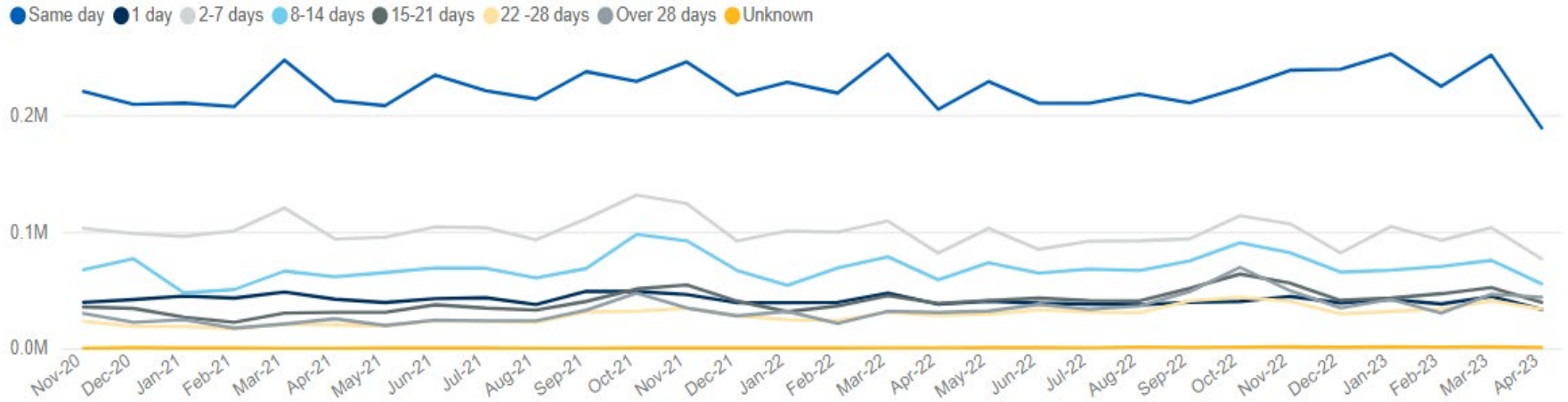
	April	May	June	July	August	September	October	November	December	January	February	March	April
	2022-23												2023-24
6-13 Weeks	6,991	6,332	6,308	5,833	6,353	5,782	4,650	4,594	5,220	5,625	4,217	4,648	4,460
13+ Weeks	3,954	4,354	4,756	4,463	4,533	4,705	4,695	3,907	4,039	3,949	3,709	3,028	2,816

Technical Annex – GP Appointments

Primary Care – GP Appointments



Number of appointments by time between booking and appointment (DDICB)



- During April there were 471,753 GP appointments
- 76.1% of the appointments were held face to face
- 40.0% of patients were seen on the same day that the GP was contacted

Technical Annex – Community Health Services

2 Hour Urgent Community Response

% seen within 2 hours	
	Apr-23
Rapid Nursing	78%
Rapid Therapy	76%
Falls Recovery Service	0%
Total	78%

Technical Annex – Mental Health Services (Unvalidated)

23/23 Op Planning Objectives	Description	Planning Work		M1 expected performance
		23/24 Requirement	Submission	Expected against agreed trajectory
CYP Increase in Access	Access 1+ Contact	14431	14331	
IAPT Increase in access	IAPT Access (contacts)	28293	28293	
Recover dementia diagnosis rate to 66.7%	Dementia diagnostic activity	67%	65.5%	
Improve Access to Perinatal Services	Perinatal Activity	1086	1113	
Community MH Services increase in access	Access 2+ contacts	11899	11899	
TCP reduction of people in inpatient care	**Number of adults in ICB commissioned beds**	16	**23**	
	Number of adults in Secure inpatient care	14	**13**	
	Number of CYP In Specialised/secure inpatient care	3	**3**	
Reducing LD Health Inequalities	**Number of annual health checks**	4602	**4385**	
Reduction in use of Out of Area Placements	OAP Bed days	TBC	736	

Operational Plan for 2023/24
Workforce Month 1 – position

Appendix 3

Appendix 3a. 2023-24 Month 1: Employment Costs

NHS
Derby and Derbyshire
Integrated Care Board

2023/24 M1 Employment Costs

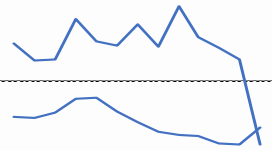
In the absence of the M1 PWR reporting and recognising that the national team are amending the PWR template to reflect the WTE submission template , the information below is intended to provide an initial view of the M1 position. It is anticipated that this information will be more readily available from the ledger as month end accounts have been undertaken and the pay bill will be known.

Notes:
**The Pay figures below include the impact of YTD efficiencies where this is planned in M1*

ICB Total	YTD Pay Budget	YTD Pay Actual	YTD Pay Variance *	Establishment Plan (Baseline) as per workforce plan **	Establishment (Funded) M1 Actual as per finance	Variance	Staff in Post (substantive) M1 Plan	Staff in Post (substantive) M1 Actual	Variance	Net Vacancy Actual	Vacancy Rate	Bank M1 Plan	Bank M1 Actual	Variance	Agency M1 Plan	Agency M1 Actual	Variance	Net Staffing (Substantive, Bank and Agency total) PLAN	Net Staffing (Substantive, Bank and Agency total) ACTUAL	TOTAL V PLAN Variance
	£'000	£'000	£'000	WTE	WTE	WTE	WTE	WTE	WTE	WTE	%	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Total	120,649	123,212	2,563	28,670	28,325	-345	27,122	27,014	-107	1,311	4.6	1,209	1,344	135	287	338	51	28,617	28,696	79

Appendix 3b. Workforce Dashboard: Month 1

NHS
Derby and Derbyshire
Integrated Care Board

	Reporting Period: Apr 2023						FOT	
KPI	Previous Month (M12)	Current Month (M1)	Current trend	YTD Trend	Plan (M1)	Variance from Plan	Plan (M12)	Variance from Plan
Workforce								
Total Workforce (WTE)	28,680.72	28,696.27	↑		28,617.33	78.94	29,110.58	-414.31
Substantive (WTE)	26,824.80	27,014.44	↑		27,121.52	-107.08	27,695.89	-681.45
Bank (WTE)	1,499.02	1,343.58	↓		1,208.78	134.80	1,167.22	176.36
Agency (WTE)	356.90	338.25	↓		287.03	51.22	247.47	90.78
KPI								
Number of Starters (1 month behind)	276	128	↓		320	-192	323	-195
Number of Leavers (1 month behind)	140	96	↓		199	-104	226	-131
Staff Turnover (%)	8.55%	3.33%	↓		10.00%	-6.67%	9.00%	-5.67%
Sickness Absence (%)	6.30%	5.33%	↓		5.90%	-0.57%	5.70%	-0.37%
Number of Vacancies	1,095	1,311	↑					
Vacancies (%)	3.82%	4.57%	↑					
Cost								
Pay Cost (£'000)	235,491	123,212	↓		120,649	2,563		123,212

30th April 2023 (M01)

1. Introduction

This report details the JUCD System Financial Position as at 30th April 2023, focusing on the I&E position, delivery of efficiencies, capital, and cash. This is followed by details of the key actions being taken over the coming months to mitigate the risks to delivering this significant financial challenge.

2. Executive Summary

Income and Expenditure Performance

The JUCD System submitted a breakeven plan to NHSE on 4th May 2023. This plan requires the delivery of £136.1m of in-year efficiencies and these have been phased based on an increasing rate of delivery as the year progresses. Although some organisations have delivery planned evenly throughout the year, which may give rise to the questions about the consistency in the development of plans.

The table below demonstrates that planned expenditure and income for 2023/24 are phased relatively evenly throughout the year, but it should be noted that a significant increase in the delivery of efficiencies is planned from the second quarter. It will therefore be important to provide assurance to this committee that the plans to deliver and the confidence in those plans gathers momentum in quarter one.

Table 2.1 Income, Expenditure and Efficiency plan

Organisation and Planned Category	Month 1 £m's	Month 2 £m's	Month 3 £m's	Month 4 £m's	Month 5 £m's	Month 6 £m's	Month 7 £m's	Month 8 £m's	Month 9 £m's	Month 10 £m's	Month 11 £m's	Month 12 £m's	Total £m's
NHS Derby and Derbyshire ICB													
Income	(184.5)	(185.6)	(193.6)	(187.0)	(187.3)	(186.4)	(187.5)	(187.1)	(185.9)	(187.2)	(185.1)	(182.7)	(2,240.0)
Expenditure	188.0	186.9	194.9	188.9	189.3	189.3	190.5	190.2	189.3	190.9	188.7	186.3	2,273.2
Efficiencies	(3.5)	(1.2)	(1.3)	(1.8)	(2.0)	(2.9)	(3.0)	(3.1)	(3.4)	(3.8)	(3.7)	(3.5)	(33.2)
Total	**(0.0)**	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**
Chesterfield Royal Hospital													
Income	(29.4)	(29.4)	(29.4)	(29.4)	(29.4)	(29.4)	(29.7)	(29.7)	(29.7)	(29.9)	(29.9)	(29.9)	(355.2)
Expenditure	30.5	31.1	31.7	31.4	31.5	31.2	30.8	30.8	29.9	30.8	30.6	30.6	370.9
Efficiencies	(1.0)	(1.0)	(1.0)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.6)	(1.6)	(1.6)	(15.7)
Total	**0.1**	**0.7**	**1.3**	**0.7**	**0.7**	**0.4**	**(0.2)**	**(0.2)**	**(1.0)**	**(0.7)**	**(1.0)**	**(0.9)**	**0.0**
Derbyshire Community Health Services													
Income	(17.5)	(17.5)	(17.5)	(17.5)	(17.5)	(17.5)	(17.5)	(17.5)	(17.5)	(17.5)	(17.5)	(17.5)	(210.6)
Expenditure	18.2	18.2	18.2	18.2	18.2	18.2	18.5	18.5	18.5	18.5	18.3	18.3	219.8
Efficiencies	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(9.2)
Total	**(0.1)**	**(0.1)**	**(0.1)**	**(0.1)**	**(0.1)**	**(0.1)**	**0.2**	**0.2**	**0.2**	**0.2**	**0.0**	**0.0**	**0.0**
Derbyshire Healthcare													
Income	(16.9)	(16.9)	(16.9)	(16.9)	(16.9)	(16.9)	(16.9)	(16.9)	(16.9)	(16.9)	(16.9)	(16.9)	(203.1)
Expenditure	17.4	17.4	17.5	17.5	17.6	17.7	17.7	17.7	17.7	17.8	17.8	18.0	211.9
Efficiencies	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(8.8)
Total	**(0.3)**	**(0.2)**	**(0.2)**	**(0.2)**	**(0.1)**	**(0.0)**	**0.1**	**0.1**	**0.1**	**0.2**	**0.2**	**0.4**	**0.0**
East Midlands Ambulance Service													
Income	(23.7)	(23.7)	(23.7)	(24.5)	(24.5)	(24.5)	(24.5)	(24.5)	(24.5)	(24.5)	(24.5)	(24.5)	(291.3)
Expenditure	24.6	24.6	24.6	25.4	25.4	25.4	25.4	25.4	25.4	25.4	25.4	25.4	302.4
Efficiencies	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(11.2)
Total	**0.0**	**(0.0)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.0)**	**0.0**
University Hospitals of Derby And Burton													
Income	(91.5)	(91.5)	(91.5)	(91.4)	(91.4)	(91.4)	(92.7)	(92.7)	(92.7)	(92.7)	(92.7)	(92.7)	(1,104.7)
Expenditure	96.4	96.3	96.0	96.2	96.6	96.6	95.4	95.4	95.5	95.7	95.7	95.9	1,151.7
Efficiencies	(1.1)	(1.3)	(2.6)	(3.1)	(3.3)	(4.9)	(4.9)	(4.9)	(4.9)	(5.4)	(5.4)	(5.4)	(47.0)
Total	**3.8**	**3.5**	**2.0**	**1.6**	**1.9**	**0.3**	**(2.1)**	**(2.1)**	**(2.0)**	**(2.4)**	**(2.3)**	**(2.2)**	**(0.0)**
JUCD Total (Surplus)/Deficit	**3.6**	**3.9**	**2.9**	**2.0**	**2.4**	**0.6**	**(2.0)**	**(2.0)**	**(2.8)**	**(2.7)**	**(3.1)**	**(2.8)**	**0.0**

There are several areas of pressure already arising in the first month of the financial year. However, with 11 months of the year remaining there is sufficient time to mitigate these pressures and the commitment remains to deliver a breakeven position at 31st March 2024.

There is an expectation that the industrial action in April will have had an impact on activity, Elective in particular, that will have a consequential impact on the Elective Recovery Fund (ERF). As a result, the expectation is that the ICB will have underspent on their contracts with NHS providers in month one. However, this is not reflected in the month one position below as actual activity is not yet known and whilst the ICB may expect an underspend, the JUCD System Providers may also expect a corresponding reduction on their income, which is also not reflected below.

This will be adjusted in the month two reporting once actual activity is known. It should also be noted that the current expectation is that any underperformance on elective activity in month one will be compensated by over delivery in the subsequent eleven months. The Planned Care Delivery board will be monitoring this position.

Table 2.2 *JUCD I&E Position Summary as at 30th April 2023*

I&E Position by Provider Type Month 1 Position	Month 1 Planned Variance £m's	Month 1 Actual Variance £m's	Month Variance to Plan £m's		Annual Planned Variance £m's	Annual FOT Variance £m's	FOT Variance to Plan £m's
Chesterfield Royal Hospital	(0.1)	(0.5)	(0.4)		0.0	0.0	0.0
Derbyshire Community Health Services	0.1	(0.5)	(0.5)		0.0	0.0	0.0
Derbyshire Healthcare	0.3	0.0	(0.3)		0.0	0.0	0.0
EMAS	0.0	0.0	0.0		0.0	0.0	0.0
University Hospital of Derby and Burton	(3.8)	(5.9)	(2.1)		0.0	0.0	0.0
Other NHS Acute	0.0	(0.0)	0.0		0.0	0.0	0.0
Other NHS Mental Health	0.0	(0.0)	0.0		0.0	0.0	0.0
Other NHS Community Services	0.0	0.0	0.0		0.0	0.0	0.0
Acute Independent Sector	0.0	(0.2)	(0.2)		0.0	0.0	0.0
Mental Health Independent Sector	0.0	(0.3)	(0.3)		0.0	(1.0)	(1.0)
Community Services Non NHS	0.0	(0.4)	(0.4)		0.0	0.0	0.0
Continuing Health Care	0.0	0.8	0.8		0.0	0.0	0.0
Primary Care Prescribing	0.0	(0.3)	(0.3)		0.0	0.0	0.0
GP Co-Commissioning	0.0	(0.0)	(0.0)		0.0	0.0	0.0
Other GP Primary Care	0.0	0.2	0.2		0.0	0.0	0.0
Pharmacy, Optom and Dental	0.0	0.0	0.0		0.0	0.0	0.0
ICB Running Costs	0.0	0.1	0.1		0.0	0.7	0.7
ICB Operational Costs Other Programme	0.0	0.1	0.1		0.0	0.3	0.3
Grand Total	**(3.6)**	**(7.0)**	**(3.4)**		**0.0**	**0.0**	**0.0**

Capital

The system has had £55.1m of notified Capital Allocations to date for the financial year. A challenging Capital planning process to agree how this would be used has taken place, and there was significantly more planned expenditure than capital resources available. Further details on the Capital plan are set out below.

Cash

The JUCD organisations cashflow forecasts for the year reflect the planned delivery of cash releasing efficiencies. However, if these do not materialise it will significantly impact on in-year cashflow, which is crucial to ensuring organisations have sufficient cash to meet their commitments as the year progresses.

3. Income and Expenditure Performance

As at 30th April 2023, the system position is a £7.0m deficit against a £3.6m planned deficit, however all JUCD organisations are committed to deliver a breakeven position at year-end.

The table below gives the range of forecasts for the system outturn positions, which demonstrates even at this early stage of the financial year risks have been identified, but the expectation is that further mitigations will be found should these risks materialise. It is important to recognise that each organisation has committed to delivering a breakeven position and it is their responsibility to ensure this is achieved.

It is understandable and acceptable in month one for the best case scenarios to be breakeven, but as the year progresses and some risks will not come to fruition, some of the mitigations should be taken forward with a view to trying to deliver a possible surplus. There are varying approaches to identifying these forecasts and the respective finance teams are working on a more consistent approach for this report next month.

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

Month 01 Position	2023/24 Organisations Forecast Range		
Organisation	Best Case £m's	Likely Case £m's	Worst £m's
NHS Derby and Derbyshire ICB	0.0	0.0	(13.5)
Chesterfield Royal Hospital	0.0	0.0	(7.1)
Derbyshire Community Health Services	0.0	0.0	(4.3)
Derbyshire Healthcare	0.0	0.0	(7.5)
East Midlands Ambulance Service	0.0	0.0	(4.0)
University Hospitals of Derby And Burton	0.0	0.0	(7.2)
JUCD Total Surplus/(Deficit)	**0.0**	**0.0**	**(43.6)**

Risks

Table 3.2 *System Identified Risks during the planning process*

Risks and mitigations - EXCLUDING Elective Recovery Funding clawback	ICB Total £m's	CRH Total £m's	DCHS Total £m's	Derbyshire HC Total £m's	EMAS Total £m's	UHDB Total £m's	Total Total £m's
(Risks)/(Offsets to benefits):							
Additional cost risk (capacity, pressures, winter)	(1.3)	(2.0)	0.0	(2.0)	0.0	(4.5)	**(9.8)**
Additional cost risk (inflation)	(10.7)	(2.0)	(2.0)	(0.5)	0.0	(5.5)	**(20.7)**
Contract risk (excl. ERF)	(4.5)	0.0	0.0	0.0	0.0	(12.5)	**(17.0)**
Income risk (excl. ERF)	0.0	0.0	0.0	0.0	(5.0)	(5.0)	**(10.0)**
Industrial Action Risk	0.0	0.0	0.0	0.0	0.0	(1.7)	**(1.7)**
Efficiency risk	(11.5)	(8.0)	(2.3)	(5.0)	(11.2)	(11.7)	**(49.6)**
Total Risks	**(27.9)**	**(12.0)**	**(4.3)**	**(7.5)**	**(16.2)**	**(40.9)**	**(108.8)**
Mitigations/benefits:							
Additional cost control or income (excl. ERF)	1.7	4.0	1.0	0.0	0.0	0.0	**6.7**
Transformational / Pathway changes	1.3	0.0	0.0	0.0	0.0	0.0	**1.3**
Efficiency mitigation	11.5	4.0	0.0	0.0	11.2	0.0	**26.7**
Mitigations not yet identified	13.5	4.0	3.3	7.5	5.0	40.9	**74.2**
Total Mitigations/benefits:	**27.9**	**12.0**	**4.3**	**7.5**	**16.2**	**40.9**	108.8
Total Net Risk (excluding ERF)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	0.0

The table above has been updated since the plans were submitted on 4th May 2023 as additional risks have been identified around additional excess inflation and the impact of continued Junior Doctors strikes. The main risk identified during planning was the risk on the achievement of the efficiency challenge, action is being taken across the system to identify robust plans and get them operational.

An additional risk has materialised in the ICB with regard GP Co-Commissioning as a large practice has recently become very unstable as several of the GP partners have retired and as a result of building pressures other GP partners have also left the practice, seriously compromising patient care. Historically this has required the ICB to manage the practice and find an interim provider at short notice, both of which come at considerable additional cost.

A planning requirement is that, where possible, mitigations are found to balance out these risks, but as can be seen there remains a considerable amount of unidentified mitigation, in addition much of this mitigation identified is additional efficiencies.

Managing, and in some cases eliminating, risks will again be a key component of delivering a breakeven position at 31st March 2024. The System Finance and Estates Committee will receive a monthly update on any changes to the risks and mitigating actions being taken, along with an assessment of the effectiveness of these actions.

Efficiencies

As has been stated several times in this report the delivery of efficiencies is crucial to JUCD being able to deliver a balanced financial position on 31st March 2024. The list of efficiencies required currently stands at £136.1m, although this could increase if manageable cost pressures continue to materialise and cannot be brought under control.

The plan submitted required these efficiencies to be categorised in several ways. The table below shows how well developed the efficiency plans are.

Table 3.3 *System Planned Efficiency schemes (plan development)*

Efficiency Plans	ICB Total £m's	CRH Total £m's	DCHS Total £m's	Derbyshire HC Total £m's	EMAS Total £m's	UHDB Total £m's	Total Total £m's
Fully Developed	17.7	5.4	1.5	2.5	6.5	7.7	**41.4**
Plans in Progress	14.1	3.0	2.6	6.2	4.6	11.3	**41.9**
Opportunity	12.4	7.3	2.8	0.0	0.0	20.6	**43.1**
Unidentified	0.0	0.0	2.3	0.0	0.0	7.4	**9.7**
Total Efficiencies - by scheme	**44.2**	**15.7**	**9.2**	**8.8**	**11.2**	**47.0**	**136.1**

There was also a requirement to risk rate those schemes in terms of the level of risk there was to deliver the planned level of efficiencies. For example, you could have a very well developed scheme but there was a high level of risk that it would not deliver the required efficiencies, due to some uncontrollable influence.

Table 3.4 *System Planned Efficiency schemes (delivery risk)*

Efficiency Risk	ICB Total £m's	CRH Total £m's	DCHS Total £m's	Derbyshire HC Total £m's	EMAS Total £m's	UHDB Total £m's	Total Total £m's
High	0.0	4.0	2.3	0.0	1.3	21.2	**28.8**
Medium	26.5	8.7	2.8	6.4	2.6	17.8	**64.8**
Low	17.7	3.0	4.1	2.4	7.3	8.0	**42.5**
Total Efficiencies - by scheme	**44.2**	**15.7**	**9.2**	**8.8**	**11.2**	**47.0**	**136.1**

The table below sets out the month one efficiencies by organisation and the actual delivery against those plans.

Table 3.5 *System Efficiency Delivery*

Efficiencies by Provider Month 01 Position	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	Full Year Plan £m's	Full Year Forecast £m's	Forecast Variance £m's
NHS Derby and Derbyshire ICB	4.7	5.2	**0.5**	44.2	44.2	**0.0**
Chesterfield Royal Hospital	1.0	0.5	**(0.5)**	15.7	15.7	**0.0**
Derbyshire Community Health Services	0.8	0.2	**(0.5)**	9.2	9.2	**0.0**
Derbyshire Healthcare	0.7	0.4	**(0.3)**	8.8	8.8	**0.0**
EMAS	1.0	1.2	**0.2**	11.2	11.2	**0.0**
University Hospital of Derby and Burton	1.1	1.1	**0.0**	47.0	47.0	**0.0**
JUCD Total	**9.3**	**8.6**	**(0.7)**	**136.1**	**136.1**	**0.0**

Efficiency Savings plans are to be recorded in the ePMO system by the individuals in each JUCD organisation who are responsible for delivery, as a matter of urgency and by the end of May at the latest. Information on delivery is then entered each month, by those same individuals and details of this will be shared with the System Finance and Estates Committee. It is fundamental to the delivery of efficiencies and by implication a breakeven 2023/24 position that the ePMO system is up to date and a monthly update completed in a timely manner.

Given the criticality of efficiency delivery and cost control the governance in this area will be strengthened and a Financial Delivery Committee is to be established that will monitor and report in greater detail the delivery of efficiencies, holding organisations and individuals to account.

4. Activity, Workforce and Finance Triangulation

Key to ensuring a sustainable financial position across JUCD is having a triangulated approach to activity, workforce and finance. A considerable amount of work went into this triangulation for the plans submitted on 4th May 2023, but it is important that this continues to be refined and the interdependencies understood.

Activity Performance

The tables below identifies for the JUCD Acute organisations key activity performance information based on their submitted activity plans that are likely to impact on financial performance. It is recognised that activity and productivity data is acute provider focused and the ICB Finance team are working with colleagues to identify data for non-Acute providers.

Table 4.1 *Activity Plan for 2023/24 with 2022/23 M12 delivery*

Activity per day (All Ages)	2022/23 FOT	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Submitted Plans 2023/34	Net change	% Change
A&E attendances (Types 1, 2 & 3)	1,244	1,078	1,097	1,115	1,077	1,011	1,044	1,055	1,107	1,117	930	1,024	1,070	1,060	-183.4	-14.7%
Type 1 A&E attendances	625	702	703	717	689	654	675	671	718	694	600	655	686	680	55.5	8.9%
Zero day non-elective admissions	129	112	111	112	113	109	111	109	112	111	110	107	111	111	-18.2	-14.1%
1+ day non-elective admissions	240	229	228	229	226	226	227	225	233	230	233	222	229	228	-12.1	-5.0%
Ordinary elective spells	65	78	79	69	76	75	77	74	73	76	70	71	85	75	10.5	16.2%
General & Acute Beds (Adults)																
Open General & Acute (G&A) beds	1867	1,804	1,804	1,804	1,804	1,804	1,825	1,825	1,853	1,853	1,853	1,853	1,874	1830	-37.0	-2.0%
Occupied G&A beds (Non-elective)	1648	1,607	1,610	1,595	1,595	1,542	1,576	1,537	1,505	1,570	1,571	1,543	1,597	1571	-77.7	-4.7%
Occupied G&A beds (Elective)	130	126	137	149	136	131	137	137	134	126	112	125	130	132	2.1	1.6%
Ave. number vacant beds	89	71	57	60	73	131	112	151	214	157	170	185	147	127	38.6	43.5%
Bed occupancy for G&A beds	95.2%	96.1%	96.8%	96.7%	96.0%	92.7%	93.9%	91.7%	88.5%	91.5%	90.8%	90.0%	92.2%	93.0%	-2.2%	-2.3%
General & Acute Beds (Children)																
Open General & Acute(G&A) beds	72	58	58	58	58	58	58	58	58	58	58	58	58	58	-13.8	-19.2%
Occupied G&A beds (Non-elective)	48	41	43	43	44	39	43	44	48	50	43	45	43	44	-4.0	-8.4%
Occupied G&A beds (Elective)	2	3	4	4	4	3	4	4	4	4	4	4	4	4	1.8	85.3%
Ave. number vacant beds	22	14	11	11	10	16	11	10	6	4	11	9	11	10	-11.5	-52.7%
Bed occupancy for G&A beds	69.6%	75.9%	81.0%	81.0%	82.8%	72.4%	81.0%	82.8%	89.7%	93.1%	81.0%	84.5%	81.0%	82.2%	12.6%	18.1%
% T1 attendances admitted on a same day basis	20.6%	15.9%	15.8%	15.7%	16.3%	16.6%	16.5%	16.3%	15.6%	16.1%	18.3%	16.4%	16.2%	16.3%	-4.4%	-21.1%
% T1 attendances admitted on an over-night basis	38.4%	32.6%	32.5%	32.0%	32.8%	34.5%	33.6%	33.6%	32.4%	33.1%	38.8%	34.0%	33.3%	33.5%	-4.9%	-12.8%
Average length of stay (1+ day LoS NEL Spells)	7.1	7.2	7.2	7.1	7.3	7.0	7.1	7.0	6.7	7.0	6.9	7.1	7.2	7.1	0.0	0.0
Open virtual ward beds	118	120	138	156	169	182	195	215	235	255	255	255	255	203	84	1

Workforce

The JUCD workforce is its most valuable asset, which must be utilised in the most efficient and effective way to ensure the planned activity is delivered within the financial constraints. The workforce link to efficiency delivery is critical and as a significant proportion of expenditure is pay related, the only way to deliver savings must require a reduction in workforce.

Unfortunately, there were shortcomings in the quality and completeness of workforce data in the planning process and provided limited assurance. The workforce plan below shows an increase in workforce throughout the year and further work with workforce colleagues will commence to understand the gross impact of the changes in workforce.

There should also be a reduction in non-contractual pay as part of efficiency plans, but that would not be sufficient to deliver all the required efficiencies.

The table below is a summary of the workforce plan for 2023/24 for each organisation.

Table 4.2 *Workforce Plan for 2023/24*

Staffing Categories	Staff in post outturn 31-Mar-23	Establishment 31-Mar-23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
	Total WTE	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*
Total Substantive	26,862	28,670	27,122	27,150	27,159	27,381	27,375	27,490	27,514	27,551	27,604	27,645	27,646	27,696
Total Bank	1,326	0	1,209	1,208	1,205	1,194	1,193	1,189	1,170	1,164	1,170	1,169	1,168	1,167
Total Agency	307	0	287	284	280	274	270	268	263	259	254	252	249	247
Total Workforce (WTE)	28,495	28,670	28,617	28,642	28,645	28,849	28,838	28,948	28,948	28,974	29,029	29,067	29,064	29,111

The System has been set an agency cap for 2023/24 of £38.7m, however, a plan has been set to only spend £27.2m. This plan is significantly below the agency spend for last year which was £38.7m. The table below shows the last years actual spend and the plan for 2023/24.

Table 4.3 *2023/24 Agency Staff Plan*

Provider Agency Plan	2022/23 Agency & Contract staff £m's	2022/23 Total pay bill £m's	Agency costs as % of gross staff costs %	2023/24 Agency & contract staff £m's	2023/24 Total pay bill £m's	Agency costs as % of gross staff costs %
Chesterfield Royal Hospital	15.5	253.4	6.1%	9.1	232.0	3.9%
Derbyshire Community Health Services	1.4	170.8	0.8%	1.3	156.7	0.8%
Derbyshire Healthcare	7.6	155.6	4.9%	5.3	149.9	3.5%
EMAS	0.7	198.0	0.3%	0.8	201.8	0.4%
University Hospital of Derby and Burton	14.5	750.5	1.9%	10.7	696.7	1.5%
JUCD Total	39.68	1,528.31	2.6%	27.15	1,437.17	1.9%

Total agency spend is expected to be £12.5m less than 2022/23 but we do not yet have the actual month one information from the workforce team. Ideally weekly information should be provided to the People and Culture Committee by HR Directors.

The System Finance and Estates Committee will receive regular updates on delivery against these key activity and workforce indicators. For additional assurance, updates will also be provided on the continued work developing this process of triangulation.

5. Population Health

Population Health Management uses data and an evidence informed approach to proactively improve the health and wellbeing of a population. It addresses health inequalities, the unfair and avoidable differences in health across the population and between different groups within society. Four main health behaviours that have a negative impact are smoking, alcohol, lack of physical activity and lack of healthy diet.

The following resources have been identified to support the above, with all but the differential Primary Care growth agreed to be found by the Finance Directors across the system, from within their organisational share of the allocations received by the ICB. The resources held with the Mental Health and Community providers are recognised as JUCD System resources and it is now the responsibility of the ICB Population Health & Strategic Commissioning Committee, along with Place and the Provider collaborative to identify areas of investment, which will improve patient flow in and out of acute settings, whilst ensuring appropriate governance is in place.

Table 5.1 *Population Health Funding*

Funding description	£'m
Health Inequalities Investment Reserve	5.5
Differential Growth Commitment - Community Services	4.9
Differential Growth Commitment - Mental Health Services	4.7
Differential Growth Commitment - Primary Care	4.3
	19.4

6. Capital

JUCD have a balanced capital plan for 2023/24. Due to the level of funding available to the system the plan attracts a level of risk for each organisation and there has had to be some compromise in agreeing this plan when committing to Digital investments and Backlog maintenance. Risks include:

- CRH will not have capacity for all clinical systems unless equipment is replaced, but has a potential system backup.
- DCHS requires the use of the overage, if NHSE do not provide authorisation to use it, there will be a pressure of £1.4m and if brokerage is not made available for the PICU development only one of the PICU or Bakewell projects can be completed.
- DHc require £4.9m to complete the PICU development if this is not agreed then the development will not be continued.
- If EMAS is unable to fulfil the ambulance replacement program, they will see increased revenue costs for maintenance.
- UHDB capital position is relying on the catheterisation laboratory completion outside the performance measure of capital and there is significant amount of high risk medical equipment replacement being delayed until the following year, leaving potential for revenue repairs.

A group of Deputy Directors of Finance are drawing up a governance framework to reduce the risks including if any further funding be available.

This report currently only covers CDEL allocations and other elements of capital allocations will be tracked and reported in future months. There are significant unidentified risks on our capital commitments and work is underway to understand and report on them.

Table 4.1 *CDEL Capital plan for the system*

Capital Plan	YTD plan £'m	Full year plan £'m
Chesterfield Royal Hospital	0.5	8.1
Derbyshire Community Health Services	0.6	3.9
Derbyshire Healthcare	1.6	19.5
East Midlands Ambulance Service	2.4	8.9
University Hospitals of Derby And Burton	0.4	14.7
Total	**5.6**	**55.1**

7. Cash

The JUCD Provider organisations all commenced the year with varying levels of cash, and currently are forecasting a sustained level throughout the year based on the break-even plan for 2023/24. However, NHS Providers will be required to balance its expenditures against its receipt of contract income as we move through the financial year to maintain this position; any slippage of efficiencies may have an impact on liquidity in the immediate term.

The table below identifies the opening cash balances of each JUCD provider organisation, although it must be recognised that these will include elements for the subsidiary organisations the acute providers have and sufficient resources to meet accrued capital commitments. Should efficiency delivery start to fall behind plan, clearly those JUCD Provider organisations who started the year with smaller available cash balances will be impacted early in the financial year.

Further guidance is anticipated to be received that will describe the opportunity for systems to flexibly move cash between JUCD System Providers.

Table 7.1 *Provider Opening and Planned Closing Cash Balance*

Provider Cash	Opening Balance 01/04/2023 £'m	Plan Year ending 31/03/2024 £'m
Chesterfield Royal Hospital	20.2	19.9
Derbyshire Community Health Services	32.8	34.1
Derbyshire Healthcare	34.8	23.7
EMAS	19.3	13.7
University Hospital of Derby and Burton	49.1	35.6
JUCD Total	156.2	127.0

The ICB follows a different cash regime where an Annual Cash Drawdown Requirement (ADCR) allowance based on planned expenditures for the financial year is drawn against monthly; any slippage of efficiencies would require a justified request to NHSE for additional cash support towards the end of the financial year.

8. Recommendations

The ICB Board are asked to note and discuss the details outlined in the report, particularly

- Implications of the profiling of efficiencies
- Fundamental need to use ePMO to monitor and report on efficiencies
- Financial risks arising since the start of the new financial year
    - Junior Doctors industrial action
    - Unstable General Practice

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

15th June 2023

Item: 032.1

Report Title	Organisation Development and People - ICB Staff Survey							
Author	James Lunn, Head of Human Resources & Organisational Development							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Helen Dillistone, Executive Director of Corporate Affairs							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Staff Survey Results Summary 2022							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	ICB Staff matters are the responsibility of the Audit and Governance Committee; the action plan relating to this paper will be overseen by that Committee.							

Recommendations
The ICB Board is recommended to **NOTE** the results of the 2022 staff survey for NHS Derby and Derbyshire ICB.
Purpose
To provide assurance that the organisation will deliver an Action Plan as a consequence of the results of the NHS Staff Survey and this will align with the NHS People Plan.
Background
The 2022 National Staff Survey is the fourth one that NHS Derby and Derbyshire ICB (formerly CCG) have undertaken. Our response figure at 88% is a slight improvement on last year (87%) and above the comparative average for similar organisations which is 76%. Picker was commissioned by 28 Integrated Care Boards, including the Derby and Derbyshire ICB. The organisational response to this report will be pivotal in driving forward improvement measures relating to our people. For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

In support of this, the results of the NHS Staff Survey are measured against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale).

The ICB is able to measure progress against the 7 People Promise themes compared to the 2021 survey data and with the previous 3 surveys for the Staff Engagement and Morale themes.

Report Summary

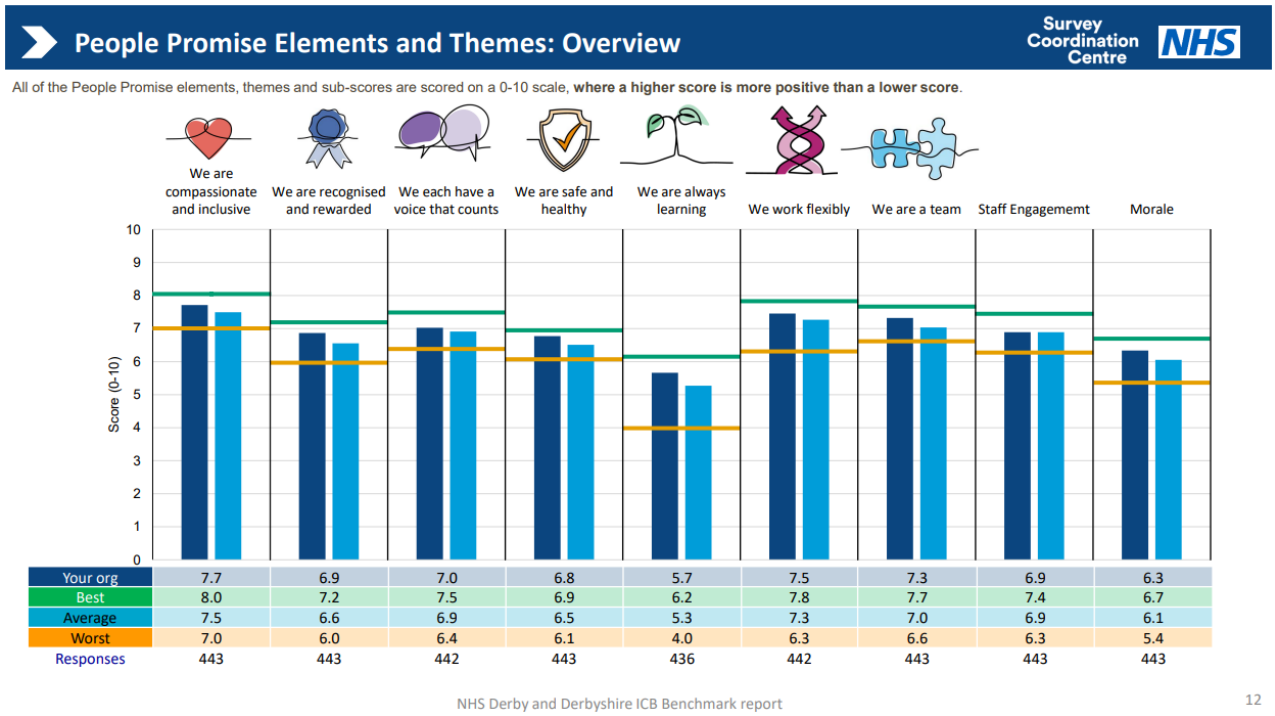
The infographic at Appendix 1 below provides a summary of the results of the staff survey.

When compared with the previous years staff survey results, the ICB has improved in one area, stayed the same in 3 areas and worsened in 5 areas (see table below).

Table 1 – Staff Survey 2022 results compared to 2021

	2021	2022
We are compassionate & inclusive	7.7	7.7
We are recognised and rewarded	7.0	6.9
We each have a voice that counts	7.3	7.0
We are safe and healthy	6.8	6.8
We are always learning	5.7	5.7
We work flexibly	7.6	7.5
We are a team	7.2	7.3
Staff Engagement	7.0	6.9
Morale	6.4	6.3

When compared to the similar organisations, DDICB is above average **in all themes, with the exception of Staff Engagement which is in line with comparable average.**



The full management report on the DDICB Staff Survey 2022 is attached at Appendix 2. This document details the findings from the NHS National Staff Survey 2022, carried out by Picker, on behalf of the ICB.

Of the 97 questions, 52 questions were scored significantly higher than the Picker average, 40 questions showed no significant difference with 4 questions being significantly lower (Table 2). A threshold of 3% is set to identify significant increase/decrease.

Table 2 - DDICB v the Picker average (28 comparable organisations)

	Picker Average 2022	2022	2021	2020	2019
Able to make suggestions to improve the work of my team/dept	79.0%	74.9%	79.1%	82.4%	78.4%
Team members often meet to discuss the team's effectiveness	68.4%	64.3%	62.9%	71.0%	68.2%
Don't work any additional paid hours per week for this organisation, over and above contracted hours	94.4%	90.9%	89.1%	91.8%	94.0%
Organisation offers me challenging work	76.2%	70.4%	72.6%	*	*

Of the 97 questions 90 were compared to 2021. 23 questions scored significantly lower in 2022 (Table 4), with 63 no significant difference, and 5 areas scoring higher (Table 3).

The questions seeing the largest increase are:

- In the last 12 months, have not experienced musculoskeletal problems as a result of work activities (+6%)
- Appraisal helped me improve how I do my job (+ 5.2%)
- Feel a strong personal attachment to my team (+4.2%)

The questions seeing the largest reduction are:

- Teams within the organisation work well together to achieve objectives (-10.1%)
- Disability: organisation made reasonable adjustment(s) to enable me to carry out work (-10%)
- Would feel secure raising concerns about unsafe clinical practice (- 9.1%)

Table 3 – Questions scoring significantly higher in 2022

	2022	2021	2020	2019
Feel a strong personal attachment to my team	67.3%	63.1%	*	*
Immediate manager takes a positive interest in my health & well-being	86.5%	83.3%	85.5%	77.7%
In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	74.5%	68.4%	70.9%	76.7%
Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	94.1%	90.5%	95.6%	96.1%
Appraisal helped me improve how I do my job	20.7%	15.4%	*	19.6%

Table 4 – Questions scoring significantly lower in 2022

	2022	2021	2020	2019
Able to make suggestions to improve the work of my team/dept	74.9%	79.1%	82.4%	78.4%
Able to meet conflicting demands on my time at work	48.9%	52.4%	55.0%	42.7%
Enough staff at organisation to do my job properly	40.6%	48.6%	56.3%	42.6%
Satisfied with recognition for good work	66.8%	70.4%	72.7%	62.2%
Satisfied with extent organisation values my work	55.3%	61.1%	61.3%	41.8%
Satisfied with level of pay	55.8%	62.3%	60.3%	60.8%
Satisfied with opportunities for flexible working patterns	78.1%	83.1%	80.7%	67.1%
Organisation is committed to helping balance work and home life	71.0%	76.6%	*	*
Team members understand each other's roles	65.2%	68.3%	*	*
Teams within the organisation work well together to achieve objectives	43.8%	53.9%	*	*
Organisation takes positive action on health and well-being	72.7%	79.4%	*	*
Last experience of harassment/bullying/abuse reported	39.7%	43.2%	37.9%	40.2%

Would feel secure raising concerns about unsafe clinical practice	72.9%	82.5%	77.0%	71.8%
Would feel confident that organisation would address concerns about unsafe clinical practice	68.8%	77.9%	70.2%	62.2%
Feel organisation respects individual differences	77.1%	81.6%	*	*
Received appraisal in the past 12 months	89.6%	94.7%	*	92.5%
Organisation acts on concerns raised by patients/service users	70.6%	78.8%	75.3%	58.1%
Would recommend organisation as place to work	64.6%	71.0%	72.8%	48.6%
If friend/relative needed treatment would be happy with standard of care provided by organisation	61.8%	65.0%	65.7%	47.0%
Feel safe to speak up about anything that concerns me in this organisation	71.3%	75.3%	77.7%	*
Feel organisation would address any concerns I raised	62.8%	69.3%	*	*
I don't often think about leaving this organisation	47.0%	52.5%	51.3%	41.4%
Disability: organisation made reasonable adjustment(s) to enable me to carry out work	77.3%	87.3%	87.0%	*

Equality, Diversity & Inclusion

Over the past 12 months, there has been a continued focus in activity designed to make diversity and inclusion part of our DNA. We have reviewed the terms of reference of the diversity and inclusion network, promoted key inclusion dates and implemented a Disability and Long-term conditions Policy, including a reasonable adjustment passport.

Appendix D provides a breakdown of the staff survey reponses by various protected characterisics, including, Age, Disability, Ethnicity, Gender, Sexual Orientation and Religion.

In the 2022 survey the experiences of our colleagues with a Disability are significantly worse in 33 areas and significantly better in just 1 area. The experiences of colleagues with a disability are worse in all areas assessed under the Workplace Disability Equality Scheme (WDES). The biggest areas of difference between colleagues with a disability and those without are detailed in Table 5.

Table 5

Disability	Disability Yes	Disability No
Often/always enthusiastic about my job	51.20%	66.56%
Satisfied with recognition for good work	56.00%	71.34%
Feel valued by my team	64.00%	78.59%
In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	62.40%	79.62%

In last 3 months, have not come to work when not feeling well enough to perform duties	33.60%	57.64%
Never/rarely feel every working hour is tiring	52.00%	68.47%
Never/rarely lack energy for family and friends	33.60%	51.91%
Organisation acts fairly: career progression	51.61%	66.03%
Feel supported to develop my potential	49.60%	67.83%

The experiences of our minority ethnic colleagues (Mixed, Multiple, Asian, Asian British, Black, African, Caribbean, Black British and Other Ethnic Group) are significantly better than white colleagues in 27 areas with relationships within the team being overall more positive, our minority ethnic colleagues feel they have realistic time pressures and are more likely to feel that their role makes a difference to patients and service users.

However, there are 26 questions which are significantly worse. Most notably, our minority ethnic colleagues feel less satisfied with the level of pay, and *less satisfied that the organisation acts fairly regarding career progression*, and less satisfied that the organisation respects individual differences. A comparison of the WRES questions is shown in table 6 below.

Table 6 – Comparison of WRES questions

	2022 Minority ethnic	2022 White	2021 Minority ethnic	2020 Minority ethnic	2019 Minority ethnic
Not experienced physical violence from patients/service users, their relatives or other members of the public	95.3%	93.9%	100%	100%	96%
Not experienced harassment, bullying or abuse from other colleagues	86%	88.5%	87.1%	80%	85%
Organisation acts fairly: career progression	37.2%	64.8%	45.7%	45%	56%
Not experienced discrimination from manager/team leader or other colleagues	88.4%	94.9%	88.6%	71%	85%

The experiences of our colleagues who identify as Gay, Lesbian, Bisexual and Other are significantly worse in 50 areas, significantly better in 15 areas (when compared to heterosexual colleagues). The biggest areas of difference are detailed in table 7 below.

Table 7

	Heterosexual / straight	Gay / lesbian, Bisexual, Other
Time often/always passes quickly when I am working	75.65%	56.52%
Always know what work responsibilities are	76.64%	56.52%
Achieve a good balance between work and home life	77.69%	52.17%
Immediate manager gives clear feedback on my work	83.51%	65.22%
In last 3 months, have not come to work when not feeling well enough to perform duties	53.93%	26.09%

Not felt pressure from manager to come to work when not feeling well enough	89.77%	64.71%
Not experienced harassment, bullying or abuse from other colleagues	94.41%	78.26%
Feedback given on changes made following errors/near misses/incidents	57.09%	37.50%
Feel organisation respects individual differences	79.84%	56.52%

The diversity data, including WRES data, from the survey has been shared with members of the Diversity & Inclusion Network and joint workshops with the Organisational Effectiveness and Improvement Group (OEIG) members has been held on 6 June 2023 to review, identify root causes and recommend actions (this report has been written prior to this date).

Next Steps

The staff survey results have been shared with our senior leaders, internal engagement forums and all ICB staff to encourage discussion and help with the formulation of the action plan.

Directors will include feedback from their teams to assist in the development of their own local Organisational Development plans and inform the wider ICB action plan.

In addition, a joint OEIG and Diversity & Inclusion Network workshop has been held on 6 June 2022 to discuss improvement strategies, suggest actions and set targets.

Agreed actions will be incorporated into the ICB People Plan, and WRES/WDES action plans as appropriate. A full action plan will be shared with the Governance Committee for assurance in July, with progress update bi-annually.

It is envisaged that actions will include, but not be limited, to the below:

- Implement Fair & Inclusive Recruitment & Selection training and Unconscious bias e-learning (ongoing action from previous staff survey
- Look at a more in-depth EDI training for all staff to support valuing individual differences
- External facilitation for groups of staff by protected characteristic to explore staff survey outcomes
- Promote the FTSU Guardian role and culture of speaking
- Implement new FTSU Policy and Dignity, Civility & Respect Policy
- Publish figures on bullying and what doing about it during National Bullying week Bullying
- To ensure consistency across the ICB, HR to deliver line management briefings for new Policies including case studies to reinforce learning
- Introduce a leadership induction – to include values and behaviours expected of new leaders
- Practical HR induction for new line managers
- Review of annual review conversation process, including rolling out a 360 degree appraisal process for managers.

Identification of Key Risks

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

SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐			

Staff experiences whilst working in the ICB can impact organisational performance and delivery. It is important to listen to and take action on the results of the survey to improve the experience of all staff working within the ICB.

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒

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

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

Not applicable.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

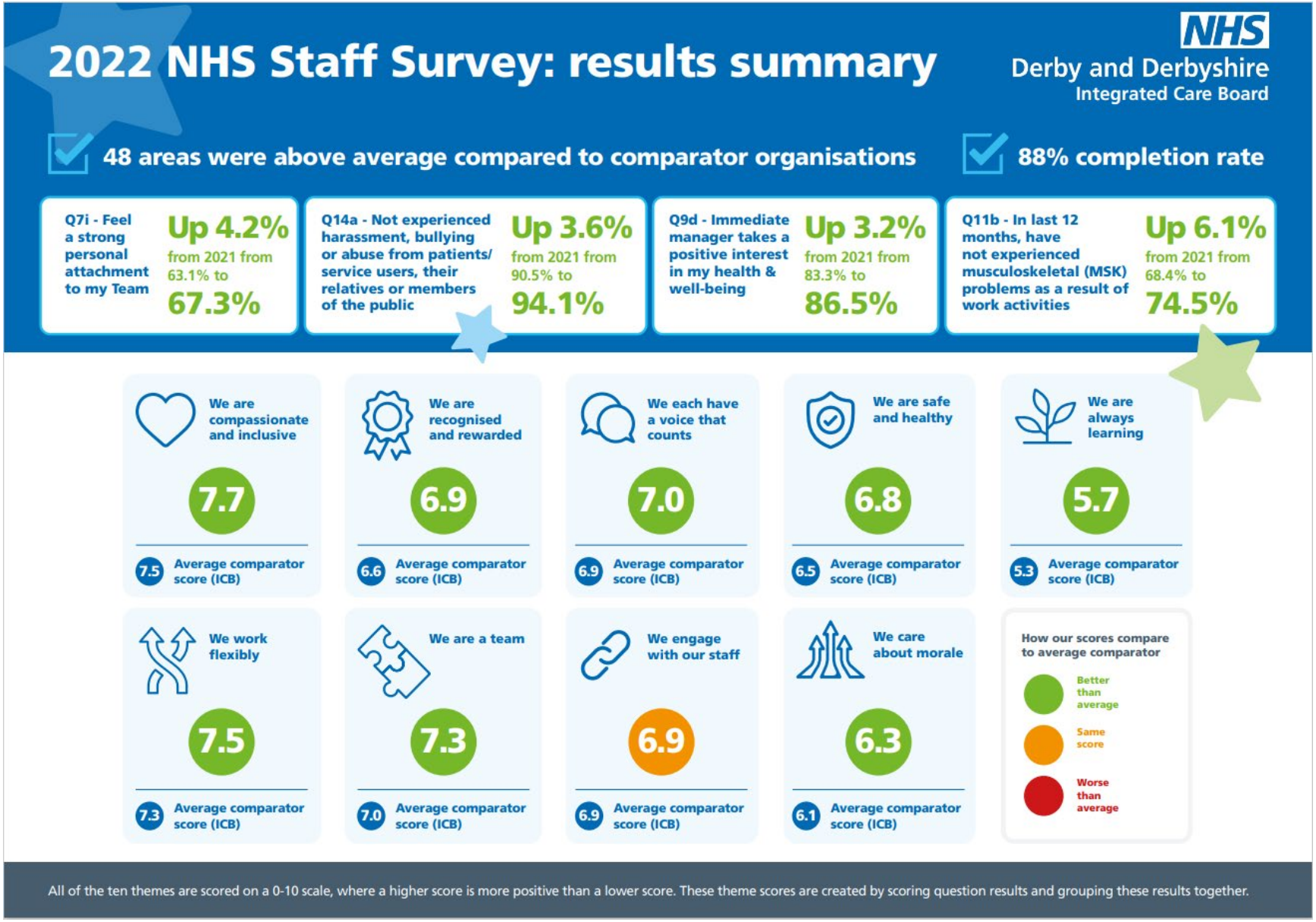
Better health outcomes	☐	Improved patient access and experience	☐
A representative and supported workforce	☒	Inclusive leadership	☒

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

As discussed above.

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

Appendix 1


2022 NHS Staff Survey: results summary
NHS
Derby and Derbyshire
Integrated Care Board
48 areas were above average compared to comparator organisations
88% completion rate
Q7i - Feel a strong personal attachment to my Team
Up 4.2%
from 2021 from 63.1% to
67.3%
Q14a - Not experienced harassment, bullying or abuse from patients/ service users, their relatives or members of the public
Up 3.6%
from 2021 from 90.5% to
94.1%
Q9d - Immediate manager takes a positive interest in my health & well-being
Up 3.2%
from 2021 from 83.3% to
86.5%
Q11b - In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities
Up 6.1%
from 2021 from 68.4% to
74.5%
We are compassionate and inclusive
7.7
7.5 Average comparator score (ICB)
We are recognised and rewarded
6.9
6.6 Average comparator score (ICB)
We each have a voice that counts
7.0
6.9 Average comparator score (ICB)
We are safe and healthy
6.8
6.5 Average comparator score (ICB)
We are always learning
5.7
5.3 Average comparator score (ICB)
We work flexibly
7.5
7.3 Average comparator score (ICB)
We are a team
7.3
7.0 Average comparator score (ICB)
We engage with our staff
6.9
6.9 Average comparator score (ICB)
We care about morale
6.3
6.1 Average comparator score (ICB)
How our scores compare to average comparator
Better than average
Same score
Worse than average
All of the ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

15th June 2023

Item: 032.2

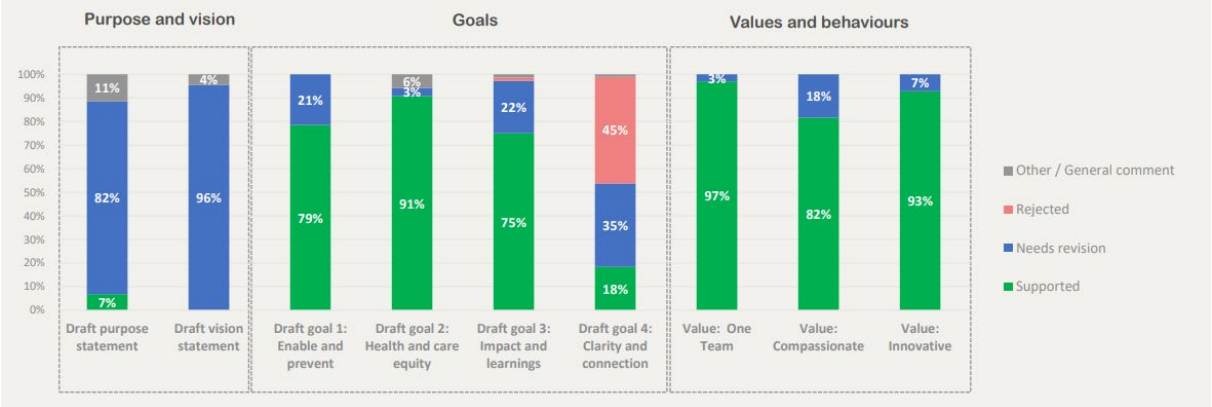
Report Title	Organisation Development and People - ICB Strategic Framework							
Author	Sean Thornton, Deputy Director Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Linda Garnett, Interim Chief People Officer							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 - Strategic Framework – Final 11th May 2023							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Board Development session – 18th April 2023							

Recommendations
The ICB Board is recommended to **DISCUSS** and **APPROVE** the ICB's Strategic Framework.
Purpose
This paper presents the final draft of the ICB's Strategic Framework, following a period of engagement with ICB and system partners.
Background
As a new NHS organisation, the ICB recognised it required a Strategic Framework to set purpose, vision and values. Partnering with Clever Together, the ICB sought to co-create a new Strategic Framework, to form the basis of a new detailed strategy and act as an inspiring leadership platform, owned and lived by everyone in the ICB and valued by the system's stakeholders more broadly. The mandate for the project outlined that the Board wished to create clarity on: • Destination - the things we want to achieve • Process - our approach to get there • Principles and characteristics - our behaviours and actions • What would it take - the risks and choices we take • Proposition - what we should do Engagement took place under the banner of 'Derby and Derbyshire Together', through a 24/7 conversation hosted on a dedicated digital platform. During November and December 2022, ICB

colleagues were invited to help shape the future of the ICB by sharing ideas and insights. Colleagues could also read, comment and vote on the ideas of others. This first phase of engagement generated a wealth of information and ideas, from which a draft purpose, vision, goals and values were obtained. These products were then shared again with the ICB in February 2023, along with a range of system partners, to test a final set of statements that would form the ICB's Strategic Framework.

Report Summary

Over 230 staff and partners joined the Derby and Derbyshire Together validation conversation and together they shared over 1,000 contributions in the form of written ideas and comments, as well as votes. We saw representatives from all ICB directorates, as well as invited partners from among NHS Provider Boards and leadership teams, GPs, VSCEs and the Local Authority. The outcome from the second engagement period is contained in the table below, with strong support for the drafted goals, values and behaviours, but with revisions required to the purpose and vision.



Based on this feedback, further work was undertaken to update the purpose statement to incorporate simpler, more inclusive language and reflect the role of other partners and health organisations, including social care. A Board Development session was held on 18th April 2023 to review these outputs to seek to agree a final draft. The draft is now included at Appendix 1 for review and approval by the Board for implementation.

Next Steps

Following Board approval, the final draft Strategic Framework will be shared with ICB colleagues and wider partners, with a series of recommended actions to begin to embed it into ICB business. These include:

- Use of this framework to shape personal, team, divisional and ICB-wide plans, whilst also re-thinking organisational and people development practices.
- Identify the strategic and longer-term commitments and what needs to be owned and driven by the Executive Team and what can be delegated to others to lead.
- Consider the appropriate governance arrangements and how and when progress will be reported back to maintain oversight and momentum.
- Celebrate the co-created solutions and action taken in response to colleagues' ideas, celebrate what has been learned and achieved and the value in operating this way.
- Embed this approach to engagement so that everyone feels they have a voice in how the organisation develops and the co-creation of insights and solutions becomes a new normal for the ICB.

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

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

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

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

None identified.

Project Dependencies

Completion of Impact Assessments

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

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

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

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

Yes ☐	No☐	N/A☒	**Summary:**

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

Better health outcomes	☒	Improved patient access and experience	☐

A representative and supported workforce	☒	Inclusive leadership	☒
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?			
Not applicable.			
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?			
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Not applicable.			

Derby & Derbyshire Together

NHS
Derby and Derbyshire
Integrated Care Board

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

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

15th June 2023

Item: 033

Report Title	Draft Joined Up Care Derbyshire Joint Forward Plan							
Author	Craig Cook, Director of Strategy & Planning							
Sponsor (Executive Director)	Zara Jones, Executive Director of Strategy and Planning							
Presenter	Zara Jones, Executive Director of Strategy and Planning							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☐
Appendices	Appendix 1 - Draft Joint Forward Plan (slide deck)							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Population Health & Strategic Commissioning Committee							

Recommendations
The Board is requested to **NOTE** the update provided through this paper on the development of the Joint Forward Plan (JFP).
Purpose
To confirm that the JFP will be published by 30th June 2023, and that work is taking place to finalise the content in collaboration with partner Foundation Trusts and through discussions with other system bodies, including the Health and Wellbeing Boards. A short, public-friendly version of the JFP is also being produced and will be published shortly after 30th June 2023. A further document is also being prepared for supporting engagement with citizens and staff, post publication of the JFP. The Board meeting in public will receive the final documentation in July.
Background
The ICB is accountable for the JFP, working jointly with the four Foundation Trusts to agree content, and for consulting with the Derby and Derbyshire Health and Wellbeing Boards to ensure the JFP takes proper account of the joint local health and wellbeing strategies.
Report Summary
The JFP is an NHS plan that seeks to convey how the Joined Up Care Derbyshire (JUCD) Integrated Care System (ICS) will meet the health needs of the Derby and Derbyshire populations

over the next five years, aligned with national policy requirements and the strategic aims and priorities of the ICS.

The JFP document will describe how the ICB is proposing to take forward engagement activities with NHS staff and the public to support the further development and agreement of priority improvement aims and enabling actions and seek feedback on the difficult decisions that will have to be taken in agreeing these. The document being prepared for 30th June reflects views of citizens and staff by using the outputs of previous and recent public engagement exercises.

The JFP must be reviewed and either updated or confirmed annually before the start of each financial year. This version is therefore the starting point for the Plan, and further development of the content will continue throughout 2023/24 to inform the annual update in March 2024.

Identification of Key Risks

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

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

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒

Details/Findings	**Has this been signed off by a finance team member?**
The JFP describes financial challenges for the system over the 5-year period and beyond. Specific financial related impacts and decisions form part of the ongoing work.	*N/A*

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

N/A

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings** N/A at this stage
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings** N/A at this stage

Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
				N/A at this stage

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

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

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

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

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

Details/Findings
Please see Section 4.6

Appendix 1

Development of the Joint Forward Plan

ICB Board – Public Session

15 June 2023

Joint Forward Plan – Purpose and Approach

- The Joint Forward Plan (JFP) is an NHS plan that will demonstrate how Joined up Care Derbyshire (JUCD) intends to arrange and/or provide NHS services to meet the physical and mental needs of its population over the next 5 years.

- This will include the delivery of universal NHS commitments, addressing Integrated Care System (ICS) core purposes and meeting legal requirements

- The production and publication of a JFP by Integrated Care Boards (ICBs) and their partner trusts is a statutory requirement

- For 2023-24 the deadline for publication is 30 June 2023

- The 2023-24 JUCD Operational Plan is effectively the first year of the JFP, and Operational Plans for 24-25 to 27-28 will be developed following an annual review of the JFP content

Joint Forward Plan – Purpose and Approach

- ICBs and their partner trusts must involve relevant Heath and Wellbeing Boards (HWBs) in preparing or revising the JFP. This includes sharing a draft with each relevant HWB, and consulting relevant HWB's on whether the JFP takes proper account of each relevant joint local health and wellbeing strategy

- The content will also align with the Derby and Derbyshire Integrated Care Strategy, and with other JUCD plans, including those from Place and Provider Collaboratives.

- The JFP must be reviewed and either updated or confirmed annually before the start of each financial year. This version is therefore the starting point for the Plan, and further development of the content will continue throughout 2023/24 to inform the annual update in March 2024.

Case for Change and Improvement Aims

- In developing the case for change and in collating the improvement aims for the JFP we will build out from commitments and requirements identified in existing JUCD strategies and plans, including priority improvements identified in our 23/24 Operational Plan – access, prevention and productivity are key themes to support managing our urgent and emergency care risks & recovering our elective care waiting time position.

- We will seek to build on what we do well – our JUCD strengths, but also examine where there are is unwarranted variation between JUCD and the rest of the country, and agree opportunities to address this variation

- We will structure the improvement aims under the four core purposes of an ICS

Four Core Purposes of an ICS

- 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

Case for Change and Improvement Aims

- The content will provide high level, tangible requirements that all subsequent NHS plans will need to align with

- We expect that at least some of these requirements will require significant and strategic changes to how JUCD services are commissioned and provided

- We have asked organisation/ programme/ policy leads to support the compilation of the JFP by:
  - Providing high level SWOT (strengths, weaknesses, opportunities, threats) assessments that reflect evidence and benchmarking
  - Identifying key, tactical decisions that are needed to build on the strengths, address the weaknesses and threats, and capitalise on the opportunities, by asking them :
    - *What do you think the Health and Care System needs to do and what decisions it needs to take in what is commissioned, funded, organised and delivered over the next 5 years - so that the ICB can achieve it's goals?*

Engagement

Our approach to System engagement includes:

- Engagement with local partners through JFP working group
- Consultation on content with partner Foundation Trusts & formal review with HWBs to ensure alignment with our joint local health and wellbeing strategies
- NHS England – support and feedback from regional NHSE colleagues

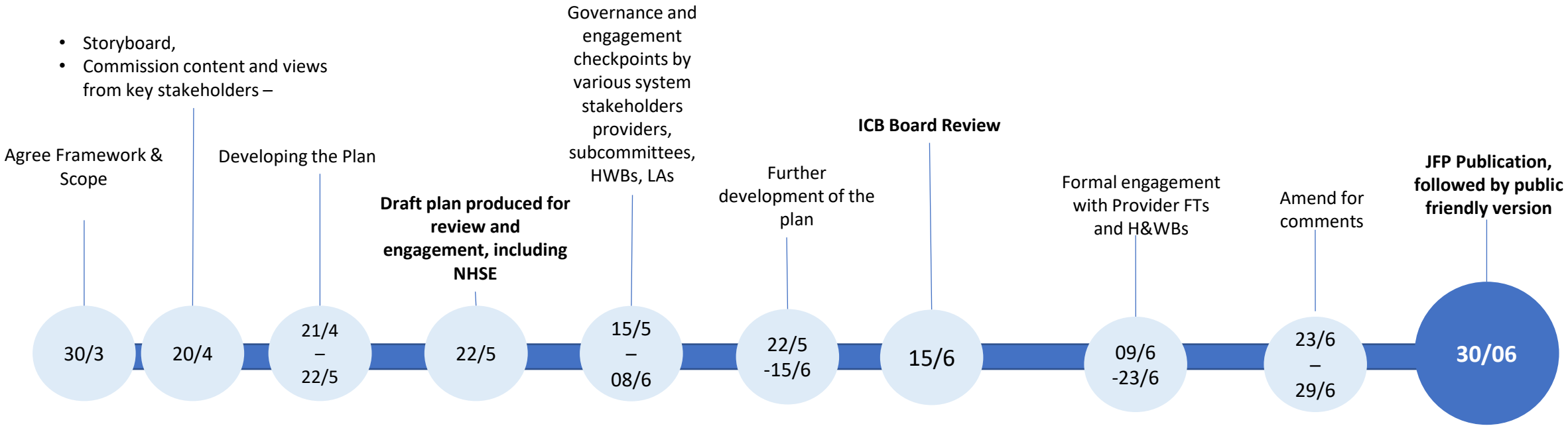
Our approach to Public engagement includes

- For the first iteration of the plan, we have:
  - Drawn together and themed insights soured from our Patient and Public Insight Library, a recent engagement exercise relating to NHS@75, and from our system partners. This has been referenced in the plan

- Following the publication of the first iteration we will;
  - Using public-friendly (‘what this means to me’) content to engage with the public and staff on the 'case for change’

- Then in the longer term;
  - We will utilise the outcomes of our developing Insight Framework to support the continuous conversation that needs to take place around the plan

Key milestones for producing the JFP - Timeline



NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

15th June 2023

Item: 034

Report Title	Digital Development							
Author	Jim Austin, ICB Chief Digital Information Officer							
Sponsor (Executive Director)	Jim Austin, ICB Chief Digital Information Officer							
Presenter	Jim Austin, ICB Chief Digital Information Officer							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☒
Appendices	Appendix 1 - Presentation on digital development							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	The content has been previously discussed at the ICB Finance and Estates Committees and has been summarised to this Board previously							

Recommendations

The ICB Board is recommended to **DISCUSS** and **NOTE** the following update on the Digital programme.

Purpose

The purpose of the paper is to update the ICB Board on progress being made to implement the ICS Digital and Data Strategy and support being delivered to JUCD Delivery Boards. A short presentation will guide the Board through the highlights of the work in progress – attached at Appendix 1.

Background

The Digital Health Strategy in Derbyshire is a plan to use technology to improve the health and care of people in the city and county. The strategy was developed by Joined Up Care Derbyshire, an Integrated Care System (ICS) that brings together health and care organisations across Derbyshire.

A copy of the Joined Up Care Digital and Data Strategy can be found here:

The use of data is explicitly excluded from this Board paper. Executive accountability for the use of data resides with the ICB Chief Medical Officer although there are clear links and dependencies between data, digital and technology. The use of data should be covered at a later session.

Report Summary

The Joined Up Care Derbyshire Digital and Data strategy has three main goals:

- To improve the patient experience by making it easier for people to access information and services, and by providing them with more control over their care.
- To improve the quality of care by using technology to support clinicians in making better decisions, and by providing them with access to the latest evidence-based information.
- To reduce the cost of care by using technology to make care more efficient and effective.

The strategy outlines a number of specific actions that will be taken to achieve these goals, including:

- Developing a single digital patient record that will be accessible to all healthcare professionals involved in a patient's care.
- Investing in new technologies, such as telehealth and remote monitoring, to support people to manage their own health conditions.
- Working with partners in the community to provide digital health services, such as online health information and advice.

The Digital Health Strategy is a key part of Joined Up Care Derbyshire's plan to transform the health and care system in Derbyshire. The strategy is ambitious, but it is essential if the ICS is to achieve its goal of providing high-quality, person-centred care that is both affordable and sustainable.

In addition to the specific actions outlined in the strategy, Joined Up Care Derbyshire is also committed to embedding a culture of digital innovation across the health and care system. This means creating an environment where staff are encouraged to use technology to improve their work, and where patients are supported to use digital services to manage their own health. This culture and commitment is underpinned by ensuring as safe an operating environment as possible through the use of up-to-date digital infrastructure and a tight, distributed team approach to cyber protection and awareness.

The Digital Health Strategy is a significant step forward for the health and care system in Derbyshire. It has the potential to transform the way people access and receive care, and to improve the quality of care for everyone. It has a costed and partially budget plan which is being developed in conjunction with the Joint Forward (5 year) Plan.

Some of the benefits of the Digital Health Strategy in Derbyshire are:

- Improved patient experience: The Digital Health Strategy will make it easier for people to access information and services and will provide them with more control over their care. For example, people will be able to book appointments online, view their medical records, and communicate with their healthcare providers through secure messaging. An example is the GetUBetter (MSK) App which supports the Elective Recovery Programme has now been installed within 71 GP practices in Derby and Derbyshire. This app has evidenced improvement in patient access, engagement and compliance with treatment plans. The roll out of the App to Community Physio and Secondary care settings has now commenced and plans have been drawn up for further roll out into care homes and the per-operative care pathway.
- Improved quality of care: The Digital Health Strategy will use technology to support clinicians in making better decisions and will provide them with access to the latest evidence-based information. For example, clinicians will be able to use electronic health records from all health and social care providers, to track a patient's progress over time, and to identify potential risks and better interventions. A live example of this is the response to the White Paper “People at the Heart of Care” – DDICB has already helped 40

care providers in Derby City and Derbyshire to move on to a digital record from a list of assured suppliers - and we plan to support **another 80** in 2023/24

- Reduced cost of care: The Digital Health Strategy will use technology to make care more efficient and effective. For example, telehealth and remote monitoring can be used to provide care to people in their homes, which can reduce the need for hospital admissions. An example in delivery at the moment is the deployment of "**OPTICA"** - Optimised Patient Tracking and Intelligent Choices Application. This is a patient tracking solution (developed by North East Commissioning Support Unit - NECSU) which provides real-time tracking of patients to improve management of discharge through the acute hospitals in Derbyshire. The ambition and expectation is to expand implementation to include community services beds and surfacing of local authority data during the summer of 2023.

JUCD has a Technical Design Authority (TDA) in place to agree requirements, architecture, design and the roadmap for the continual development of technical and digital capabilities that we deploy across the JUCD health and care system. The TDA is overseen by the Derbyshire Digital and Data Board (D3B), which then feeds into the ICB Finance and Estates Committee for assurance purposes and the Provider Collaborative Leadership Board for assurance and prioritisation. The Digital Health Strategy is a long-term plan, and it will take time to achieve all its goals. However, Joined Up Care Derbyshire is committed to making the strategy a success, and the small digital team is confident that it will have a positive impact on the health and care of people in Derbyshire.

Identification of Key Risks

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

Not applicable.

Financial impact on the ICB or wider Integrated Care System

Yes ☒	No☐	N/A☐
Details/Findings A digital budget has been provided with effect from 1 April 2023. Additionally, there is a shared and distributed approach to digital funding across the NHS providers, reflecting the fact that most digital activity is in the provider landscape. GP IT funding is separately and nationally determined. In most cases, digital costs are linked to RPI inflationary pressures, while ICB digital budgets are subject to the 30% RCA reductions and efficiency measures in line with all NHS budget lines. As an ICB and in conjunction with the provider trusts, we regularly and successfully bid for additional national funding for significant programmes (eg NHS Frontline digitisation programme).		**Has this been signed off by a finance team member?** Budget approved through ICB DoF

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

Not applicable in this update

Project Dependencies				
Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☒	No☐	N/A☐	**Details/Findings – All digital and data projects are operationally led and DPIAs completed as required**
Quality Impact Assessment	Yes ☒	No☐	N/A☐	**Details/Findings– All digital and data projects are operationally led and QIAs completed as required**
Equality Impact Assessment	Yes ☒	No☐	N/A☐	**Details/Findings– All digital and data projects are operationally led and EQIAs completed as required**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary: Not a project**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☒	No☐	N/A☐	**Summary: Digital and Data Strategy was developed with public representation and validated in 2022 through a public engagement process. Key stakeholders involved including voluntary sector**

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

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

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

Details/Findings

Digital (and data) interventions can positively impact all of the above measures. This can be as simple as continuing to exploit remote (MSTeams) meetings and avoiding unnecessary journeys through to carbon reduction as a consideration in the procurement of digital services to ensure providers use renewable energy sources and have a low carbon footprint. Reduction in on premise digital platforms, with a strategic shift to software as a service hosted on the cloud is central to the ICB Digital and Data strategy.

Derby and Derbyshire ICB Update
Digital and Data strategy

Jim Austin
Chief Digital Information Officer,
Derby and Derbyshire ICB

June 2023

Digital
Joined Up Care Derbyshire

Planning Guidance 22/23: The Digital Asks…

MARCH 2022

MARCH 2025

<u>March 2022:</u> ICSs to ensure GPs promote NHS App/ NHS.uk to reach **50% registration** among adults & 70% over next FY.

<u>April 2022:</u> ICSs must have a **digital and data transformation plan** in place, setting out priorities for 22/23.

<u>April 2022:</u> **Standards to be finalised** on medicines, discharge and booking & referrals and on interoperable medicines by April 2023. Information Governance Framework 'Part 2' also to be published.

<u>June 2022:</u> ICSs to have produced a **finalised costed Digital Investment Plan**, incl details on building cyber security capabilities.

Centre also to provide ICSs with clear set of **technical requirements for population health management** and **procure common data platform** to enable a federated data architecture. Also make available several patterns for existing ICS data infrastructure to integrate with common platform. ICSs to map themselves to these patterns by **June 2022.**

<u>Oct 2022:</u> Every ICS aim to have virtual beds. To increase to 40-50 per 100k population by October 2023.

<u>April 2023:</u> ICSs to have in place **technical capability required for population health management**, with longitudinal linked data.

<u>March 2023:</u> All ICSs within a **ShCR collaborative** to exchange information across collaborative, with a view to exchange nationally by March 2024. LAs with social service responsibilities should also be connected to local ShCR by this date.

<u>March 2024:</u> ICS Partnership to support LAs ensure 80% of CQC registered adult social care provider locations have access to a **digital social care record that can interoperate with a local shared record.**

<u>March 2025:</u> Acute, Community, Mental Health and Ambulance providers required to have met a **core level of digitisation** (NHS Long Term Plan).

Joined Up Care Derbyshire - Principles

- We will place the citizen / user needs and experience at the heart of any services we implement or transformation programmes we embark on
- We will adopt a "Digital By Default - Digitally Included" position for our programmes
- Data driven operational, tactical and strategic decision making that is: person-centred, reasonable and transparent
- We will ensure the **safety and security** of our digital / data services by ensuring all capabilities comply with current regulatory, legislative and industry standards.
- We will ensure our technologies adopt open standards and are interopable across our system and the wider health and care system
- Support our citizens and staff in the adoption of technology and exploitation of data for decision-making whilst transforming service delivery
- We will seek to reduce duplication, inefficent processes through the introduction of automation and machine learning

Digital and Data Strategy….refresh

- JUCD Digital and Data Strategy published November 2021
- Provide assurance the strategy remained in line with National and local direction
  - What Good Looks Like
  - Digital Maturity Assessment criteria
  - JUCD Integrated Care Strategy

- Key themes and delivery priorities were updated in 2022 with engagement from LA's. Voluntary Sector, Citizens and NHS providers
- Priorities have been aligned to the quadruple aims maintaining consistency with the original strategy

What good looks like (WGLL)

- National standards that create a common vision for good digital practice across health and care
- Empower frontline leaders, so a CEO can see whether their organisation is doing everything it should be doing
- Create a framework digital maturity
- Generate local & national insights
- Understand and be able to customise the right support offer
- Create a vibrant community for sharing good practice to accelerate digital transformation across health and care

Digital Maturity Assessment (DMA)

- DMA assessment measures how well secondary care providers are making use of **digital technology to achieve a health and care system** that is paper-free at the point of care. Primary Care DMA will be completed during 2023.
- DMA should help individual organisations identify **key strengths and gaps in provision of digital services**
- **Provider** DMA submission was peer reviewed (28.4.23). **ICB peer reviewed** (16.5.23). Anticipated that reviews will be published in Summer 2023.
- Key findings:
  - Governance and system maturity (Well Led) is strong
  - Empower Citizens and Healthy populations are areas that require significant focus
  - Ensure Smart Foundations scored highly except EPR at CRH & UHDB (priority investment)
  - Reporting capabilities within smart foundations is an area for development
  - Support People - Real time workforce planning and asset management tracking are immature

D3B Key programme delivery in 2023 Quadruple aim alignment

Improving the health of the population	Improving the experience of care	Improving staff experience	Reducing the per capita cost of healthcare

Electronic Patient Record @ acutes

Data access and business intelligence function

Derbyshire Shared Care Record across all partners and cross ICB border

+++ Delivery Plan for Recovering Access to Primary Care.

Project Derbyshire: Electronic Staff Record

Digitising in Social Care (including falls technology)

+++ Bed management System /Control Centre

Care Co-ordination Solution

Technically enabled care – virtual wards

+++Patient Experience Portal (book appoints)

Digital and technical infrastructure review

Technical design: support, delivery and assurance

Digital Inclusion

Patient Digital Front Door – NHS App – spread and adopt

Digital Maturity Assessment – outputs and levelling up

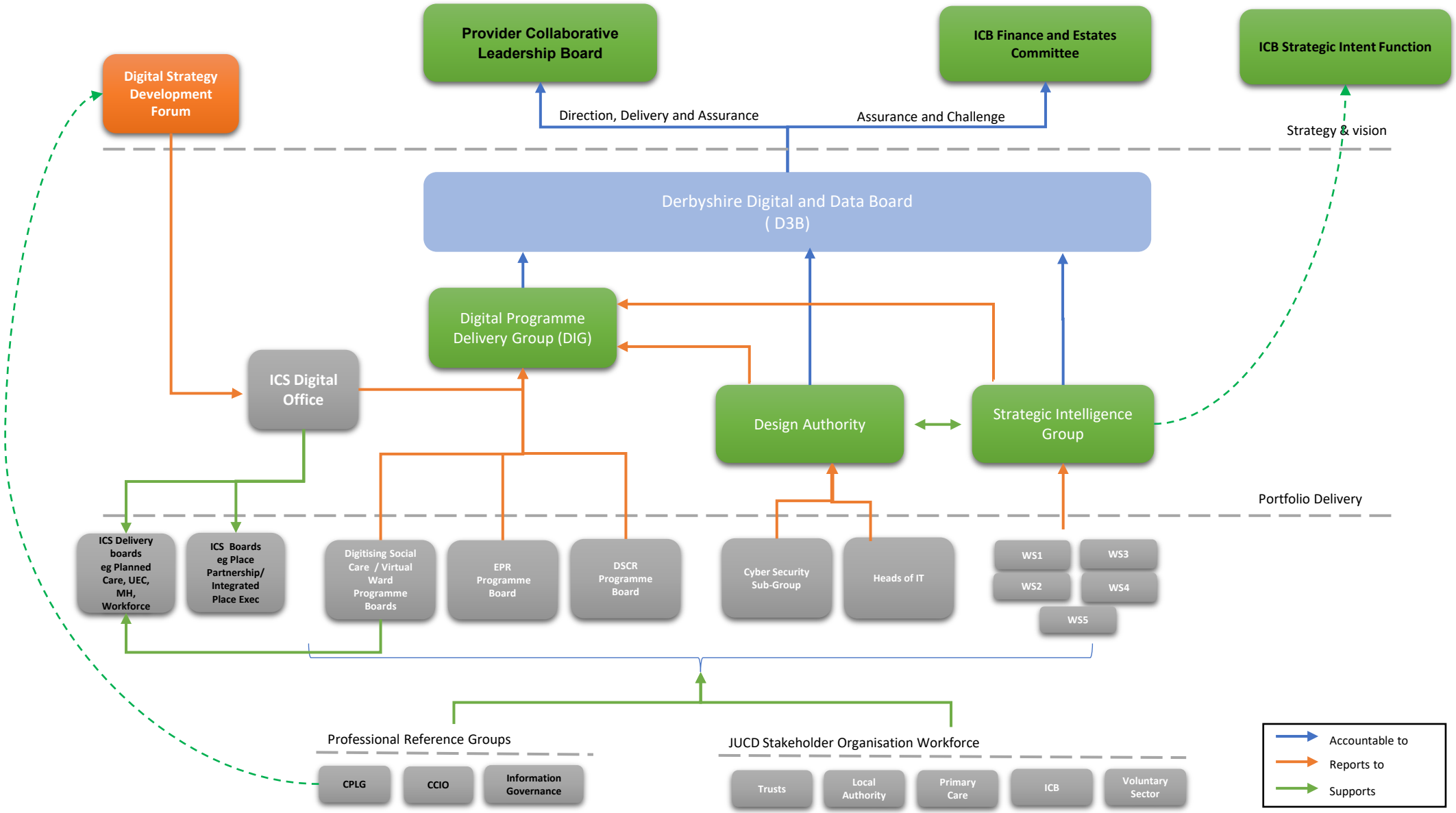
Key
In flight
New demand
Yet to start

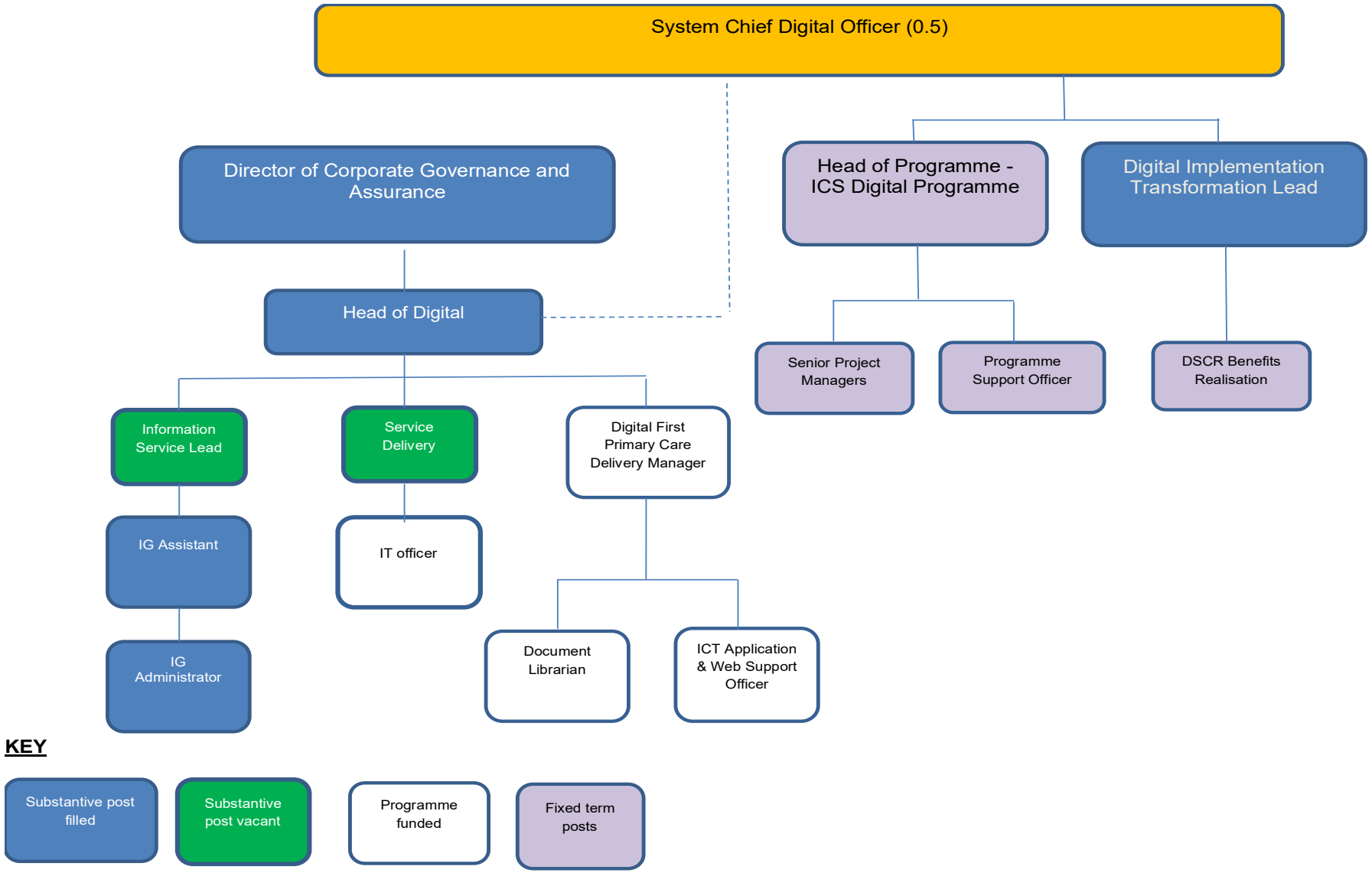
Supporting Information

Priority Deliverables	Activity bundle
Electronic Patient Record	• ePR procurement process, tender evaluation award • Full business case development and approval • Commence implementation
Data access and business intelligence function	• Population Health Management - Axym • Implementation of Optica in acute settings, community deployment • Develop and agree approach to strategic and operational analytics • Facilitate ICS Integrated Care Diagnostic (Newton)
Derbyshire Shared Care Record (DSCR)	• Continued implementation of DSCR • Refresh roadmap and delivery priorities • Benefits realisation
Electronic Staff Record (ESR)	• Project Derbyshire project plan digital deliverables • Digital People systems contract review and consolidation • Support current ESR usage stocktake and recommendations for optimisation
Digitising in Social Care (DiSC)	• Year 2 digital social care record adoption and implementation • Testing and deployment of technology to support falls management • Interoperability plan developed
Care Co-ordination Solution	• Support the exploration and implementation of solutions to realise elective recovery

Priority Deliverables	Activity bundle
Technically enabled care - Virtual Wards, Team Up and Place development	• Support the development and implementation of virtual wards
Digital and technical support infrastructure review - contract review	• Review of ICS (excluding local authority) digital and technology system contracts • Creation of a database to support on-going review, management and recommendations for retirement/consolidation and efficiencies
Technical design: support, delivery & assurance	• Technical Design Authority programme of work to support system 'business as usual', service delivery and assurance - Cyber Security strategy, Seamless Access , advice and guidance
Digital Maturity Assessment (DMA)	• DMA assessment and peer review outcome levelling up delivery plan to be confirmed
Digital Inclusion	• Development of guidance/best practice approach to digital inclusion in service change processes • Maximise opportunities of support and delivery from the voluntary services sector • Development of approaches to citizen and staff digital literacy training/awareness
Patient Digital Front door - NHS App	• Alignment of patient services, advice and guidance access via NHS App

Joined Up Care Derbyshire Digital and Data programme governance structure.





Joined Up Care Derbyshire Digital and Data Strategy

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

15th June 2023

Item: 035

Report Title	Board Assurance Framework – Quarter 1 2023/24							
Author	Suzanne Pickering, Head of Governance Frances Palmer, Corporate Governance Manager Rosalie Whitehead, Risk Management & Legal Assurance Manager							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Helen Dillistone, Executive Director of Corporate Affairs							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Quarter 1 2023/24 BAF strategic risks 1 to 9.							
Assurance Report Signed off by Chair	Not applicable.							
Which committee has the subject matter been through?	Finance and Estates Committee Population Health and Strategic Commissioning Committee Quality and Performance Committee People and Culture Committee Public Partnership Committee							

Recommendations

The ICB Board are recommended to **APPROVE** the Quarter 1 2023/24 Board Assurance Framework strategic risks 1 to 9.

Purpose

The purpose of this report is to present to the Board the Quarter 1 2023/24 Board Assurance Framework.

Background

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

The Board Assurance Framework (BAF) is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's aims and objectives. The BAF provides the Board with a framework to support identification of key areas of focus for the system and updates as to how those key areas are being addressed.

Nine Strategic Risks were identified at the ICB Board's BAF development workshops to determine the strategic risks to achieving the ICB's three core aims. These were agreed at the ICB Board

on the 17th November 2022 and these have been used as the basis for developing the full Board Assurance Framework.

The strategic risks are the risks that face the system, including the ICB. The ICB however will take a system coordination role to develop the framework that underpins the delivery and will require system partners input to mitigate complex risks. It will require strong alignment with system partner BAFs and assurance will be drawn from a range of internal and external sources.

System organisations have a duty to support the ICB in the management of the BAF and the achievement of the ICB's objectives.

Report Summary

Following previous feedback from the ICB Board and Internal Audit, further development and strengthening of the risks has been undertaken and is reflected in the Quarter 1 BAF.

During Quarter 1 of 2023/24, the BAF has been developed further to include the cross referencing of gaps in control and assurance to the relevant actions. Action plans are to be updated to clearly articulate the planned actions and associated progress. Updates to the strategic risks are highlighted in blue.

There has been no movement in risk scores during Quarter 1, this is reflective of the position of the risks and the management of the risk in line with the long term 5 year plan. Responsible Committees consider the risk scores to remain the same.

As a significant amount of detailed information is provided in the strategic risk templates, a summary sheet has been provided at page 1 of Appendix 1 to enable an overview of the current position in terms of the risk scores and owners.

Each responsible Committee reviewed and approved their final Quarter 1 2023/24 strategic risks at the Committee meetings in May prior to this report being presented to the ICB Board.

Identification of Key Risks

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

The report covers each strategic risk.

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

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

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

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

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

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

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

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

The key elements of the BAF are:

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

Key to lead committee assurance ratings:

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

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

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

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

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

Risk scoring = Probability x Impact (P x I)

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

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

Reference	Strategic risk	Responsible committee	Executive lead	Initial date of assessment	Last reviewed	Target risk score	Previous risk score	Current risk score	Risk appetite risk score	Overall Assurance rating
SR1	There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to delivery consistently safe services with appropriate levels of care.	Quality & Performance	Brigid Stacey	17.11.2022	11.05.2023	10	20	20	12	Partially assured
SR2	There is a risk that short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	Quality & Performance	Brigid Stacey	17.11.2022	11.05.2023	10	20	20	12	Partially assured
SR3	There is a risk that the population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	Public Partnership Committee	Helen Dillistone	17.11.2022	10.05.2023	9	16	16	12	Partially assured

Reference	Strategic risk	Responsible committee	Executive lead	Initial date of assessment	Last reviewed	Target risk score	Previous risk score	Current risk score	Risk appetite risk score	Overall Assurance rating
SR4	There is a risk that the NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	Finance & Estates Committee	Keith Griffiths	17.11.2022	15.05.2023	9	16	16	12	Partially assured
SR5	There is a risk that the system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	People & Culture Committee	Linda Garnett	17.11.2022	10.05.2023	16	20	20	16	Partially assured
SR6	There is a risk that the system does not create and enable One Workforce to facilitate integrated care.	People & Culture Committee	Linda Garnett	17.11.2022	10.05.2023	9	12	12	9	Partially assured
SR7	There is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	Population Health & Strategic Commissioning Committee	Zara Jones	17.11.2022	15.05.2023	9	12	12	12	Partially assured
SR8	There is a risk that the system does not: A. establish intelligence and analytical solutions to support effective decision making: and B. deliver digital transformation.	Finance & Estates Committee	Jim Austin	17.11.2022	10.05.2023	8	12	12	12	Partially assured
SR9	There is a risk that the gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	Population Health & Strategic Commissioning Committee	Zara Jones	17.11.2022	15.05.2023	12	16	16	12	Partially assured

Strategic Risk SR1 – Quality and Performance Committee

Strategic Aim – To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Brigid Stacey, Chief Nursing Officer **ICB Chair** :Adedeji Okubadejo, Chair of Quality & Performance Committee	**System lead:** Brigid Stacey, Chief Nursing Officer, Dr Robyn Dewis **System forum:** System Quality Group	**Date of identification:** 17.11.2022 **Date of last review:** 11.05.2023

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

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

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

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	digital management. This reports to the PHSCC. • Agreed ICB Quality Risk Escalation Policy. • Risk Escalations from System Quality Group to Quality and Performance Committee. • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023. • ICB and ICS Exec Teams in place.					
Threat 2 Lack of system ownership and capacity by the Integrated Care Partnership (ICP) and County and City Councils	• Agreed System Quality infrastructure in place across Derbyshire • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023. • Agreed System Quality and Performance Dashboard to include inequality measures • Agreed NHSE Core20PLUS5 Improvement approach to support the reduction of health inequalities. • ICB Board and Derbyshire Trusts approved and committed to the delivery of the Derbyshire ICS Green Plan. • Agreed Derby and Derby City Air Quality Strategy.	1T2.1C 1T2.2C	Derbyshire ICS Health Inequalities Strategy has been developed and requires approval form the ICP and ICB Board. Integrated Care Strategy is in place and requires sign off from Local Authority Cabinets	• Dr Robyn Dewis, Director of Public Health Derby City is the Chair of Health Inequalities Group across the System • Approved Integrated Care Partnership (ICP) Terms of Reference by the ICP and ICB Board. • ICP is now formally meeting in Public from February 2023. • County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Agreed Core20PLUS5 approach across Derbyshire.	1T2.1AS	Derbyshire ICS Health Inequalities Strategy has been developed and requires approval from the ICP and ICB Board.
Threat 3 Ineffective Commissioning of services across Derby and Derbyshire	• Derbyshire Cost Improvement Programme (CIP) in progress and Service Benefit Reviews challenge process is in place to support efficiencies. • Agreed Prioritisation tool is in place. • Population Health Strategic Commissioning Committee providing clinical oversight of commissioning and decommissioning decisions. • Robust system QEIA process for commissioning/ decommissioning schemes • Agreed targeted Engagement Strategy – to implement engagement element of Comms & Engagement strategy. • Robust Citizen engagement across Derbyshire and reported through Public Partnerships Committee.	1T3.1C 1T3.2C 1T3.3C 1T3.4C	Commissioning to focus on patient cohorts, with measures around services to be put in place to support reduction of inequalities. Increase Patient Experience feedback and engagement. CIP programme requires further development. Integrated Care Strategy is in place requires sign off from Local Authority Cabinets	• Agreed ICS 5 Year Strategy in place • Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • Population Health Strategic Commissioning Committee assurance to the ICB Board via the Assurance Report. • System Quality Group assurance to the Quality and Performance Committee and ICB Board. • System Quality Group assurance on System risks and ICB Risks • Public Partnerships Committee Public assurance to ICB Board. • NHSE Assurance Reviews and Assurance Letters provide evidence of compliance and any areas of concern.	1T3.1AS 1T3.2AS 1T3.3AS	2023/24 Operational Plan in place and submitted to NHSE Integrated Care Strategy is in place requires sign off from Local Authority Cabinets Draft Joint Forward Plan in place and will be published by 30th June 2023

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1 -	1T1.1A	Development of Intelligence and dashboard to evidence Core20PLUS5 principles	1T1.1C 1T1.2C 1T1.3C 1T1.4C	Dr Robyn Dewis	Quarter 2 2023/24	Commenced	Population Health and Strategic Commissioning Committee	Partially assured
	1T1.2A	Development of Integrated Care Strategy and sign-off by Local Cabinets	1T1.1C 1T2.2C 1T3.3C 1T3.4C 1T3.2AS 2T2.1AS 6T1.1AS 7T1.5AS 7T2.4AS 7T3.3AS 7T4.2AS	Zara Jones	Quarter 2 2023/24	Commenced	ICB Board/ Integrated Care Partnership/ Population Health and Strategic Commissioning Committee	Partially assured
	1T1.3A	Triangulation with Provider System BAF	1T1.5C	Chrissy Tucker	Quarter 2 2023/24	Commenced	ICB Board/Corporate Committees	Partially assured
Threat 2	1T2.1A	Development of a system Health Inequalities strategy as part of the wider Integrated Care Partnership strategy	1T2.1C 1T2.1AS	Dr Robyn Dewis	Quarter 2 2023/24	Commenced	Population Health and Strategic Commissioning Committee	Partially assured
Threat 3	1T3.1A	Development of Patient Experience Plan	1T3.2C	Letitia Harris	30/06/2023	Commenced	System Quality Group	Partially assured
	1T3.2A	Development of Operational Plan	1T3.1C IT3.1AS 4T3.1AS 7T1.4AS 7T2.3AS 7T3.2AS 7T3.3AS 7T4.1AS	Executive Team	Quarter 1 2023/24	Commenced	ICB Board	Partially assured
	1T3.3A	Development of Joint Forward Plan	1T3.3AS 7T1.6AS 7T2.5AS 7T3.4AS 7T4.3AS	Zara Jones	Quarter 1 2023/24	Commenced	ICB Board	Partially assured

Strategic Risk SR2 – Quality and Performance Committee

Strategic Aim – To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Brigid Stacey, Chief Nursing Officer **ICB Chair** :Adedeji Okubadejo, Chair of Quality & Performance Committee	**System lead:** Brigid Stacey, Chief Nursing Officer, Dr Robyn Dewis **System forum:** System Quality Group	**Date of identification:** 17.11.2022 **Date of last review:** 11.05.2023

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

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

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

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	Performance Dashboard to include inequality measures.					
Threat 2 The ICS short term needs are not clearly determined	• Agreed ICS 5 Year Strategy sets out the short-term priorities • Agreed ICB Strategic Objectives • Integrated Care Strategy approved ICB Board and ICP and requires sign off from Local Authority Cabinets • Integrated Care Partnership (ICP) was established in shadow form and met in formally Public from February 2023. • System planning & co-ordination group managing overall approach to planning • Agreed Commissioning Intentions in place	2T2.1C 2T2.2C	Commissioning to focus on patient cohorts, with measures around services to be put in place to support reduction of inequalities. Increase Patient Experience feedback and engagement.	• The ICB Board Development Sessions provide dedicated time to agree ICB/ ICS Priorities. • ICB Board agreement of Strategic Objectives	2T2.1AS	Integrated Care Strategy is in place requires sign off from Local Authority Cabinets
Threat 3 Lack of coordination across Derbyshire results in health outcomes and life expectancy improvements not being achieved	• Agreed NHSE Core20PLUS5 Improvement approach to support the reduction of health inequalities • Agreed System Quality & Performance dashboard to include inequality measures • County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Integrated Care Partnership (ICP) was established in shadow form and met in formally Public from February 2023. • Robust Citizen engagement across Derbyshire and reported through Public Partnerships Committee4	2T3.1C 2T3.2C 2T3.3C	Derbyshire ICS Health Inequalities Strategy has been developed and requires approval form the ICP and ICB Board. Ensuring prevention is embedded in all Care pathways. Alignment between the ICS and the City and County Health and Wellbeing Boards	• County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Public Partnerships Committee Public assurance to ICB Board.	2T3.1AS	Derbyshire ICS Health Inequalities Strategy has been developed and requires approval from the ICP and ICB Board.

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	2T1.1A	Develop the Intelligence and evidence to understand health inequalities	2T1.1C	Dr Robyn Dewis	Quarter 2 2023/24	Commenced	Population Health & Strategic Commissioning Committee	Partially assured
	2T1.2A	Clarification of the scope and Terms of References of Provider Collaborative Leadership Board and System Delivery Boards	2T1.2C 2T1.3C 7T1.3C 7T2.5C 7T4.6C	Tamsin Hooton	Quarter 2 2023/24	Commenced	Provider Collaborative Leadership Board/ System Delivery Boards	Partially assured
	2T1.3A	ICB Board Development Session to discuss Provider Collaborative Leadership Board and System Delivery Boards	2T1.2C 2T1.3C 7T1.3C 7T2.5C 7T4.6C	Helen Dillistone	Quarter 3 2023/24	Commenced	ICB Board	Partially assured
	2T1.4A	Annual Review of the Integrated Care Partnership to determine alignment and	2T1.4C 2T1.3C	Helen Dillistone/ICP Chair	Quarter 4 2023/24	Not yet commenced	Integrated Care Partnership	Partially assured

		relationships between ICP, Health and Wellbeing Boards and the ICS						
Threat 2	2T2.1A	Develop Patient Experience Plan	2T2.1C 2T2.2C	Letitia Harris	30/06/2023	Commenced	System Quality Group	Partially assured
Threat 3	2T3.1A	Development of a system Health Inequalities strategy as part of the wider Integrated Care Partnership strategy	2T3.1C 2T3.1AS 2T3.2C	Dr Robyn Dewis	Quarter 2 2023/24	Commenced	Population Health & Strategic Commissioning Committee	Partially assured

Strategic Risk SR3 – Public Partnership Committee

Strategic Aim – To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	Committee overall assurance level	Partially assured	
	ICB Lead: Helen Dillistone, Executive Director of Corporate Affairs **ICB Chair:** Julian Corner, Chair of Public Partnership Committee	**System lead:** Helen Dillistone, Executive Director of Corporate Affairs **System forum:** Public Partnership Committee	**Date of identification:** 17.11.2022 **Date of last review:** 10.05.2023

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

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

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

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

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

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
Threat 1	**3T1.1A**	Secure attendance in NHS Joint Forward Plan development group.	3T1.1C 3T1.2C 3T1.1AS	Sean Thornton	31 March 2023	Complete	JFP Development Group	Partially assured
	3T1.2A	Ongoing implementation of Engagement Strategy frameworks	3T1.1C 3T1.3C 3T1.1AS	Karen Lloyd	31 March 2024+	Commenced	Public Partnership Committee	Partially assured
	3T1.3A	Ongoing implementation of Insight Framework approach	3T1.1C 3T1.4C 3T1.1AS	Karen Lloyd	31 March 2024+	Commenced	Public Partnership Committee	Partially assured
	3T1.4A	Programme of work to roll out PPI Guide with system partners, including general practice	3T1.1C 3T1.5C 3T1.1AS 3T1.2AS	Karen Lloyd	31 March 2023+	Commenced	Public Partnership Committee	Partially assured
	3T1.5A	Assess current team skills in cultural engagement and communications, including channel assessment, and devise action plan to close gaps/implement training and development.	3T1.1C 3T1.6C 3T1.1AS 3T1.3AS	Sean Thornton	31 December 2023	Commenced	Communications and Engagement Team	Partially assured
	3T1.6A	Completion of ICB self-assessment and submission to NHSE	3T1.4AS 3T2.1AS 3T3.1AS	Helen Dillistone	End of Quarter 2/ Quarter 3	Commenced	Corporate Delivery Team/Public Partnership Committee/Audit and Governance Committee	Partially assured
Threat 2	**3T2.1A**	Delivery of Communications and Engagement Strategy Stakeholder chapter to scope processes on relationship managing and stakeholder perceptions, resulting in business case.	3T2.1C	Andy Kemp	31 March 2024+	Commenced	Public Partnership Committee	Partially assured
	3T2.2A	Meet with ePMO colleagues to understand change model approach to system transformation, including financial context for 23/24.	3T2.1C 3T2.2C 3T2.4C	Sean Thornton	30 June 2023	Commenced	Communications and Engagement Team	Partially assured

	3T2.3A	Delivery of Communications and Engagement Strategy Internal Communications chapter to create platform for engagement with ICB and system staff, building on existing mechanisms.	3T2.1C 3T2.3C	David Lilley-Brown	31 March 2024	Commenced	Communications and Engagement Team	Partially assured
	3T2.4A	Develop proposal and business case for UEC behaviour/insight programme following social marketing principles.	3T1.1C	Donna Broughton	31 July 2023	Commenced	Communications and Engagement Team	Partially assured
	3T2.5A	Completion of ICB self-assessment and submission to NHSE	3T2.1AS	Helen Dillistone	End of Quarter 2/ Quarter 3	Commenced	Corporate Delivery Team/Public Partnership Committee/Audit and Governance Committee	Partially assured
Threat 3	**3T3.1A**	Allied to ePMO programme review, implement scoping exercise across system/ICB delivery boards and other groups to establish baseline of work	3T3.1C	Sean Thornton	31 July 2023	Commenced	Communications and Engagement Team	Partially assured
	3T3.2A	Programme of work to roll out PPI Guide with system partners, including general practice	3T3.2A	Karen Lloyd	31 March 2024+	Commenced	Public Partnership Committee	Partially assured
	3T3.3A	Completion of ICB self-assessment and submission to NHSE	3T3.1AS	Helen Dillistone	End of Quarter 2/ Quarter 3	Commenced	Corporate Delivery Team/Public Partnership Committee/Audit and Governance Committee	Partially assured
Threat 4	**3T4.1A**	Allied to ePMO programme review, implement scoping exercise across system/ICB delivery boards and other groups to establish baseline of work	3T4.1C	Sean Thornton	31 March 2023	Commenced	Communications and Engagement Team	Partially assured
	3T4.2A	Confer with regional ICB leads on appetite for potential benchmarking approach to understand approaches, team roles, capacity.	3T4.1C 3T4.2C 3T4.1AS	Sean Thornton	31 March 2024	Commenced	Communications and Engagement Team	Partially assured
	3T4.3A	Implement remaining elements of Communications and Engagement Strategy chapters	3T4.1C 3T4.3C	Sean Thornton & team	31 March 2024+	Commenced	Public Partnership Committee	Partially assured

Strategic Risk SR4 – Finance and Estates Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Keith Griffiths, Chief Finance Officer **ICB Chair:** Richard Wright, Finance and Estates Committee Chair	**System lead:** Keith Griffiths, Chief Finance Officer **System forum:** Finance and Estates Committee	**Date of identification:** 17.11.2022 **Date of last review**: 15.5.2023

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

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

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

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
		4T1.6C	and level of productivity / efficiency required. The integrated assurance and performance report needs to be developed further to triangulate areas of activity, workforce, and finance.			
Threat 2 Shortage of out of hospital provision across health and care impacts on productivity levels	• Not aware of effective controls now, and the solution requires integrated changes across social care and the NHS • Collaborative escalation arrangements in place across health and care to ensure maximum cover out of hospital and flow in hospital is improved. • Programme delivery boards for urgent and elective care review	4T2.1C 4T2.2C 4T2.3C 4T2.4C 4T2.5C	National shortage in supply of out of hospital beds and services for medically fit for discharge patients prevents full mitigation. New Workforce strategy and Clinical Model required, alongside clear priorities for improving population health. Triangulated activity, workforce, and financial plan. Do not fully understand the low productivity levels and the opportunities to improve via the clinical workforce. Benchmark against pre Covid data and activity as a starting point to get to sustainable levels.	• Integrated assurance and performance report and tactical responses agreed at Board level. Assurances for permanent, long-term resolution not available. • National productivity assessment tool now available to assist all systems across the country, which will be used to influence 23/24 planning and delivery.	4T2.1AS	The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board.
Threat 3 The scale of the challenge means break even can only be achieved by structural change and real transformation. failure to deliver against plan and/or to transform services	• The CIP and Transformation Programme is not owned by leads, managed, implemented, and reported on for Finance to build into the system financial plan. • EPMO system has been established and is led by Transformation Director. • EPMO has list of efficiency projects only that are not developed to a level where the financial impact can be assured. • Long term national funding levels are insufficient and uncertain, meaning despite radical improvements in efficiency and structural, transformational change, a financial gap to breakeven will remain.	4T3.1C 4T3.2C 4T3.3C 4T3.4C 4T3.5C	Need to embed and cascade ICB savings target / CIP plan – staff at all levels to understand imperative and role in identification of savings / innovation. Ownership of system resources held appropriately. The EPMO System is not fully developed, owned, and managed to make the savings required. Programme delivery boards need to refocus on delivering cash savings as well as pathway change. The provider collaborative needs to drive speed and scope through the programme delivery boards	• Reconciliation of financial ledger to EPMO System. • SLT monthly finance updates provided – including recalibration of programme in response to emerging issues. • Finance and Estates Committee oversight. • Weekly system wide FD meetings focussed on long term financial stability, with real evidence of effective distributive leadership and collegiate decision making.	4T3.1AS	2023/24 Operational Plan in place and submitted to NHSE, awaiting approval

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

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	**4T1.1A**	Development of Triangulated Demand, Workforce and Financial plan	4T1.1C 4T1.2C 4T1.6C	Zara Jones	Awaiting national guidance – estimated 31/03/2023	Commenced	TBC	Partial assurance given the transparency and debate at Board level, recognising the socio-economic environment the health and care sectors are currently navigating and the scale of the tasks that lie ahead – both operationally and culturally.
	4T1.2A	Benchmark exercise and Report against pre covid levels of activity	4T1.1C 4T1.4C	Linda Garnett, Keith Griffiths		Commenced	TBC	
	4T1.3A	Develop management processes to deliver plans and level of productivity required	4T1.1C 4T1.3C 4T1.5C	Executive Team		Commenced	TBC	
	4T1.4A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met	4T1.1C 4T1.1AS 1T1.1AS 2T1.1AS 5T1.1AS 5T2.1AS 5T3.1AS 6T1.2AS 6T2.1AS 7T1.1AS 7T2.1AS 7T3.1AS	Executive Team	End of Quarter 2 2023/24	Commenced	ICB Board	
Threat 2	**4T2.1A**	Development of new Workforce and Clinical Models Plan	4T1.2C 4T2.2C 4T2.4C	Linda Garnett/ Chris Weiner	End of Quarter 3 2023/24	Commenced	TBC	Partial assurance given the transparency and debate at board level, recognising the socio-

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
	4T2.2A **4T2.3A**	Development of Triangulated Demand, Workforce and Financial plan Benchmark exercise and report against pre covid levels of activity	4T2.1C 4T2.3C 4T2.1C 4T2.5C	Executive Team Executive Team	End of Quarter 3 2023/24 End of Quarter 3 2023/24	Commenced Commenced	TBC TBC	economic environment the health and care sectors are currently navigating and the scale of the tasks that lie ahead – both operationally and culturally
Threat 3	**4T3.1A** **4T3.2A**	Develop and embed EPMO System CIP Engagement Plan being implemented	4T3.3C 4T3.1C	Tamsin Hooton Tamsin Hooton	End of Quarter 1 2023 End of Quarter 1 2023	Commenced Commenced	TBC TBC	Partial assurance through evidence of improving reporting and accountability, although real delivery is yet to be seen
Threat 4	**4T4.1A**	National Allocations unclear	4T4.1C 4T4.1AS	Executive Directors / NEMs	Ongoing		TBC	Not assured
Threat 5	**4T5.1A**	The ICB will continue to lobby the Regional and National teams	4T5.1C 4T5.1AS	Keith Griffiths	Ongoing		TBC	A significant change in allocation policy at National level will need to take place to rectify this issue.

Strategic Risk SR5 – People and Culture Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Linda Garnett, Interim Chief People Officer **ICB Chair:** Margaret Gildea, Chair of People and Culture Committee	**System lead:** Linda Garnett, Interim Chief People Officer **System forum:** People and Culture Committee	**Date of identification:** 17.11.2022 **Date of last review:** 10.05.2023

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

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

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

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

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	5T1.1A	Refresh of 22/23 workforce plan	5T1.2C	Sukhi Mahil	Quarter 1 2023/24	Commenced	People & Culture Committee	Partially assured
	5T1.2A	Design approach for 23/24 plan, agree common assumptions and ensure plan is workforce and activity lead.	5T1.1C	Sukhi Mahil	Quarter 1 2023/24	Commenced	People & Culture Committee	Partially assured

Threat 2	5T2.1A	Continue to spread and embed well-being offer	5T2.3C 5T2.2AS	Nicola Bullen	Review 30.06.2023	Commenced	TBC	Partially assured
	5T2.2A	Review Occupational Health Services to ensure they are focused on promoting health and wellbeing	5T2.2AS	Nicola Bullen	Quarter 1 2023/24	Commenced	TBC	Partially assured
Threat 3	5T3.1A	Continue to develop system wide recruitment campaigns to meet demand for health and care across Derbyshire	5T3.1C 5T3.2C 5T3.3C	Susan Spray	System Recruitment campaigns planned until 31.12.2023	Commenced	People & Culture Committee	Partially assured

Strategic Risk SR6 – People and Culture Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	Committee overall assurance level	Partially assured	
	ICB Lead: Linda Garnett, Interim Chief People Officer **ICB Chair:** Margaret Gildea, Chair of People and Culture Committee	**System lead:** Linda Garnett, Interim Chief People Officer **System forum:** People and Culture Committee	**Date of identification:** 17.11.2022 **Date of last review:** 10.05.2023

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

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

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

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

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	6T1.1A	Develop One Workforce Strategy in response to the Integrated Care Strategy, JFP and anticipated People plan	6T1.1C	Sukhi Mahil	Initial draft by 30.6.23	Commenced	TBC – June 2023	Partially assured
Threat 2	6T2.1A	System Wide TNA process to be developed and implemented	6T2.1C	Faith Sango	Quarter 1 2023/24	Commenced	TBC – June 2023	Partially assured
Threat 3	6T3.1A	Develop One Workforce Strategy in response to the Integrated Care Strategy, JFP and anticipated People plan	6T3.1C 6T3.1AS	Sukhi Mahil	Initial draft by 30.6.23	Commenced	TBC – June 2023	Partially assured

Strategic Risk SR7 – Population Health and Strategic Commissioning Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Zara Jones, Executive Director of Strategy and Planning **ICB Chair:** Julian Corner, Chair of PHSCC	**System lead:** Zara Jones, Executive Director of Strategy and Planning **System forum:** Population Health and Strategic Commissioning Committee	**Date of identification:** 17.11.2022 **Date of last review:** 15.05.2023

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

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

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control Ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 Lack of joint understanding of strategic aims and requirements of all system partners.	• Strategic objectives agreed at ICB Board; dissemination will occur via Board members who represent system partners. • ICB and ICS Exec Teams in place • JUCD Transformation Co-ordinating Group in place with responsibility for delivery of transformation plans across system. • System Delivery Boards in place - providing a mechanism to share decisions and challenge actions enhancing transparency and shared understanding of impact • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis • Delivery Boards engagement with	7T1.1C 7T1.2C 7T1.3C 7T1.4C	Lack of a systematic approach/framework to guide the prioritisation of allocating resources to advance population health. In some cases, the 'scope' of System Delivery Board focus is not sufficiently broad enough to tackle the root cause of problems and thus there is an issue that system partners are crowded out from influencing the business of the Board. Level of maturity of Delivery Boards Values based approach to creating shared vision and strong relationships across partners in line with population needs	• Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE • PHSCC assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • Audit and Governance committee oversight and scrutiny • BAFs • Internal and external audit of plans • HOSC • ICB Strategic objectives and strategic risks • System Delivery Board agendas and minutes • Provider Collaborative Leadership Board minutes • Health and Well Being Board minutes • ICB Scheme of Reservation and	7T1.1AS 7T1.2AS 7T1.3AS 7T1.4AS 7T1.5AS	The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. Consistent management reporting across the system to be agreed Implement routine mechanism for shared reporting of risks and risk management across the system Integrated Care Strategy to be signed off by Local Authority Cabinets Joint Forward Plan to be published by end June 2023

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	JUCD Transformation Board. • Provider Collaborative Leadership Board in place overseeing Delivery Boards and other delivery groups. • System planning & co-ordination group managing overall approach to planning • Formal risk sharing arrangements in place across organisations (via Section 75s/ Pooled Budgets) • HOSCs/ Health and Wellbeing Boards are in place with an active scrutinising role • Dispute resolution protocols jointly agreed in key areas e.g. CYP joint funded packages – reducing disputes • Currently the system part funds the GP Provider Board (GPPB) which provides a collective voice for GP practices in the system at a strategic and operational level • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023.	7T1.5C 7T1.6C 7T1.7C 7T1.8C 7T1.9C 7T1.10C 7T1.11C 7T1.12C 7T1.13C 7T1.14C 7T1.15C	Potential lack of clarity until the roles and responsibilities of new structures fully embed. Potential gap from 01/04/23: the GP Provider Board is only funded until 31/03/23. Without the GPPB there would be a gap in the development, dissemination and co-ordination of response to strategic objectives. Potential structural gap in that General Practice largely works to a nationally set contract which may not always totally align with locally set strategy No agreed process to measure system understanding and implementation of strategic aims. Process to ensure consistent approach is adopted to share outputs from ICS and ICB Exec team meetings. Lack of process to measure impact of agreed actions across the system. System PMO not in place. Scoping, baselining, strategic overview, and solution choice to be carried out to ensure right solution is adopted to fit the business problem Understand impact of changes, how they support operational models, how best value can be delivered, and prioritised. Further development of the strategy to bring greater efficiencies to staff and patients Establish a robust governance structure to programme, agree and prioritise change with operational leadership	Delegation • Agreed process for establishing and monitoring financial and operational benefits • GPPB proposal for future operating model and funding planned for ICB Board discussion in April 23. • 2023/24 Operational Plan in place • Integrated Care Strategy approved by the ICB Board and ICP. • Production of Joint Forward Plan		

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 2 Demand on organisations due to system pressures/restoration may impact ability to focus on strategic aims.	**As above and:** • System performance reports received at Quality & Performance Committee will highlight areas of concern. • ICB involvement in NOF process and oversight arrangements with NHSE. • As above – GPPB and LMC both provide some resourced 'headspace' giving GP leaders time and opportunity to focus on strategic aims. • PCN funding gives GP Clinical Directors some time to focus on the development of their Primary Care Networks • System Planning and Co-ordination Group ensuring strategic focus alongside operational planning	7T2.1C 7T2.2C 7T2.3C 7T2.4C 7T2.5C	Prolonged operational pressures ahead of winter and expected pressures to continue / increase. Individual GP practices have little time or incentive to participate in delivering the strategic aims of the system unless they are aligned with the national contract or are specifically locally commissioned. Inconsistent planning and performance management systems in place across the system Implement routine mechanism for shared reporting of risks and risk management across the system Level of maturity of Delivery Boards	• NHSEI oversight and reporting • Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • System Quality Group assurance to the Quality and Performance Committee and ICB Board. • System Quality and Performance Report • Monthly reports provided to ICB/ ICS Executive Team/ ICB Board and NHSE • Measurement of relationship in the system: embedding culture of partnership across partners • Coproduction • Workforce resilience • Demand in the system • Audit and Governance Committee oversight and scrutiny • BAFs • 2023/24 Operational Plan in place • Integrated Care Strategy approved by the ICB Board and ICP. • Production of Joint Forward Plan	7T2.1AS 7T2.2AS 7T2.3AS 7T2.4AS	The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. Consistent management reporting across the system to be agreed Integrated Care Strategy to be signed off by Local Authority Cabinets Joint Forward Plan to be published by end June 2023
Threat 3 Time for system to move more significantly into "system think".	• SOC/ICC processes – ICCs supporting ICB to collate and submit information • As above – GPPB and LMC both provide some resourced 'headspace' giving GP leaders time to focus on system working • Development and delivery of Integrated Care System Strategy • Embedded Place Based approaches that focus partners together around community / population aims not sovereign priorities	7T3.1C 7T3.2C 7T3.3C 7T3.4C 7T3.5C 7T3.6C 7T3.7C	As above, extent of operational pressures and time required to focus on reactive management. Individual practices may not see system working as a priority unless it delivers the requirements of their national contract Routine reporting not yet in place that is recognised by the system to enact real time change management. Recruitment of workforce not complete – lack of resilience. Lack of real time data collection. Embed reporting Complete recruitment of staff for posts	• Daily reporting of performance and breach analysis – identification of learning or areas for improvement • Measurement of relationship in the system: embedding culture of partnership across partners • Resilience of OCC in operational delivery including clinical leadership • Coproduction • Workforce resilience • Demand in the system • NHSE oversight and daily reporting • 2023/24 Operational Plan in place • Integrated Care Strategy approved by the ICB Board and ICP. • Production of Joint Forward Plan	7T3.1AS 7T3.2AS 7T3.3AS	The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. Integrated Care Strategy to be signed off by Local Authority Cabinets Joint Forward Plan to be published by end June 2023
Threat 4 Statutory requirements on individual organisations may conflict with system aims.	• Strategic objectives agreed at ICB Board; dissemination will occur via Board members who represent system partners. • ICB and ICS Exec Teams in place • JUCD Transformation Co-ordinating Group in place with responsibility for delivery of transformation plans across system.	7T4.1C 7T4.2C	Process to ensure consistent approach is adopted to share outputs from ICS and ICB Exec team meetings. Lack of process to measure impact of agreed actions across the system.	• Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE • Audit and Governance committee oversight and scrutiny • ICB Strategic objectives and strategic risks • System Delivery Board agendas and minutes • Provider Collaborative Leadership Board minutes	7T4.1AS 7T4.2AS	Integrated Care Strategy to be signed off by Local Authority Cabinets Joint Forward Plan to be published by end June 2023

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	• System Delivery Boards in place - providing a mechanism to share decisions and challenge actions enhancing transparency and shared understanding of impact • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis • Delivery Boards engagement with JUCD Transformation Board. • Provider Collaborative Leadership Board in place overseeing Delivery Boards and other delivery groups. • GPPB and LMC both provide some resourced 'headspace' giving GP leaders time and opportunity to focus on strategic aims. • PCN funding gives GP Clinical Directors some time to focus on the development of their Primary Care Networks • System Planning and Co-ordination Group ensuring strategic focus alongside operational planning	7T4.3C 7T4.4C 7T4.5C 7T4.6C 7T4.7C	Prolonged operational pressures ahead of winter and expected pressures to continue / increase. Individual GP practices have little time or incentive to participate in delivering the strategic aims of the system unless they are aligned with the national contract or are specifically locally commissioned. Inconsistent planning and performance management systems in place across the system. Level of maturity of Delivery Boards System Oversight of Individual boards decisions which may be against system aims.	• Health and Well Being Board minutes • Measurement of relationship in the system: embedding culture of partnership across partners • Coproduction • 2023/24 Operational Plan in place • Integrated Care Strategy approved by the ICB Board and ICP. • Production of Joint Forward Plan		

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	7T1.1A	Agree long term plan for resourcing GPPB	7T1.1C 7T1.6C	GPPB/ CN	Quarter 1 2023/24	Complete	Primary Care Sub Group/GPPB	Partially assured
	7T1.2A	Produce and embed the use of a universal prioritisation framework to guide resource allocation decisions.	7T1.1C 7T1.2C 7T1.12C 7T1.13C	ZJ	Quarter 3 – Quarter 4 2023/24	Commenced	PHSCC	Partially assured
	7T1.3A	Complete 23/24 planning round and deliver robust system plan	7T1.1C	ZJ	Quarter 1 2023/24	Complete	PHSCC	Partially assured
	7T1.4A	Development and ICB approval of the ICB Strategic Framework	7T1.4C	HD/ZJ	Quarter 2 2023/24	Commenced	ICB Board	Partially assured
	4T1.4A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met.	7T1.1AS	Executive Officers	End Quarter 2 2023/24	Commenced	ICB Board	Partially assured
	4T4.2A	Establishment System Focus ICB Board Meetings	7T1.2AS	HD	End Quarter 2 2023/24	Commenced	ICB Board	Partially assured
	1T1.2A	Integrated Care Strategy is in place requires sign off from Local Authority Cabinets	7T2.3AS	ZJ	End Quarter 2 2023/24	Commenced	ICB Board	Partially assured

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
	1T3.3A	Development of Joint Forward Plan to be published by 30 June 2023	7T2.4AS	ZJ	End Quarter 1 2023/24	Commenced	ICB Board	Partially assured
Threat 2	7T2.1A	Surge planning process established / all year-round planning approach – this does not prevent operational pressures but helps to predict and plan better the response	7T2.1C	UECC Board / UECC SRO / ZJ	End of Quarter 2 2023/24	Commenced	UECC Board	Partially assured
	4T1.4A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met.	7T2.1AS	Executive Officers	End Quarter 2 2023/24	Commenced	ICB Board	Partially assured
	4T4.2A	Establishment System Focus ICB Board Meetings	7T2.2AS	HD	End Quarter 2 2023/24	Commenced	ICB Board	Partially assured
	1T1.2A	Integrated Care Strategy is in place requires sign off from Local Authority Cabinets	7T2.3AS	ZJ	End Quarter 2 2023/24	Commenced	ICB Board	Partially assured
	1T3.3A	Development of Joint Forward Plan to be published by 30 June 2023	7T2.4AS	ZJ	End Quarter 1 2023/24	Commenced	ICB Board	Partially assured
Threat 3	7T3.1A	Prioritisation process agreed in the system to better manage our time and use of resource	7T3.1C	ICB / ICP	Quarter 3 – Quarter 4 2023/24	Commenced	PHSCC	Partially assured
	4T1.4A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met.	7T3.1AS	Executive Officers	End Quarter 2 2023/24	Commenced	ICB Board	Partially assured
	1T1.2A	Integrated Care Strategy is in place requires sign off from Local Authority Cabinets	7T3.2AS	ZJ	End Quarter 2 2023/24	Commenced	ICB Board	Partially assured
	1T3.3A	Development of Joint Forward Plan to be published by 30 June 2023	7T3.3AS	ZJ	End quarter 1 2023/24	Commenced	ICB Board	Partially assured
Threat 4	7T4.1A	Development of log System Board decisions	7T4.1C 7T4.2C 7T4.5C 7T4.7C 1T1.1AS 2T1.1AS	HD	Quarter 2 2023/24	Commenced	ICB Board	Partially assured
	7T4.2A	Establishment System ICB Board Meetings	7T4.1C 7T4.2C 7T4.5C 7T4.7C 1T1.1AS 1T1.2AS 2T1.1AS 5T1.2AS 6T2.2AS	HD	Quarter 1 2023/24	Completed	ICB Board	Partially assured

Actions to treat threat								
Threat	**Action ref no**	**Action**	**Control/ Assurance Ref No**	**Action Owner**	**Due Date**	**Has work started?**	**Committee level of assurance** (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	**Committee level of assurance**
	7T4.3A	Surge planning process established / all year-round planning approach – this does not prevent operational pressures but helps to predict and plan better the response	7T4.3C	UECC Board / UECC SRO / ZJ	End of Quarter 2 2023/24	Commenced	UECC Board	Partially assured
	1T1.2A	Integrated Care Strategy is in place requires sign off from Local Authority Cabinets	7T4.1AS	ZJ	End of Quarter 2 2023/24	Commenced	ICB Board	Partially assured
	1T3.3A	Development of Joint Forward Plan to be published by 30 June 2023	7T4.2AS	ZJ	End of Quarter 2 2023/24	Commenced	ICB Board	Partially assured

Strategic Risk SR8 – Finance and Estates Committee

Strategic Aim – To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Jim Austin, Chief Digital Information Officer **ICB Chair:** Richard Wright, Chair of Finance and Estates Committee	**System lead:** Keith Griffiths, Executive Director of Finance **System forum:** Finance and Estates Committee Data and Digital Board	**Date of identification:** 17.11.2022 **Date of last review:** 10.05.2023

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

Strategic threats (what might cause this risk to materialise)	**Impact** (what are the impacts of each of the strategic threats)
1. Agreement across the ICB on prioritisation of analytical and BI activity is not realised and therefore funding and associated resources are not identified to deliver the analytical capacity 2. Agreement across the ICB on prioritisation of digital and technology activity may not be realised and therefore budget allocation and reconciliation process across ICB for digital and technology are not agreed. 3. Digital improvements and substitutions to clinical pathways are not delivered through either a lack of citizen engagement and/or clinical engagement	<u>Threat 1</u> As a result of incomplete and non-timely data provision/analysis, the ICB will be hampered in the making optimal strategic commissioning decisions and it will require complex and inefficient people structures to ensure system oversight of daily operations. This will result in a: • reduced ability to effectively support strategic commissioning and service improvement work • failure to meet national requirements on population health management, • reduced ability to analyse how effectively resources are being used within the ICB • failure to deliver the required contribution to regional research initiatives • continued paucity of analytical talent development and recruitment resulting in inflated costs <u>Threats 2 and 3</u> • Failure to secure patient, workforce and financial benefits from digitally enabled care and implementation of alternative care pathways highlighted in ICB plan; e.g. limited adoption of alternative (digital) clinical solutions (e.g. PIFU, Virtual Ward, self-serve on line) • Failure to meet the national Digital and Data strategy key priorities (eg attain HIMMS level 5; cyber resilience)

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 Agreement across the ICB on prioritisation of analytical and BI activity is not realised and therefore funding and associated resources are not identified to deliver the analytical capacity	• Agreed and publicly published Digital and Data Strategy • Digital and Data Board (D3B) in place. This provides board support and governance for the delivery of the agreed Digital and Data strategy. • D3B responsible for reporting assurance to ICB Finance and Estates Committee and assurance and direction from the Provider Collaborative Leadership Board. • Strategic Intelligence Group established with oversight of system wide data and intelligence capability and driving organisational improvement to optimise available workforce and ways of working • Analytics and business intelligence identified as a key system enabler and priority for strategic planning and operationally delivery in the Digital and Data strategy • NHSE priorities and operational planning guidance 23/24 requires the right data architecture in place for population health management • Digital and Data identified as a key enabler in the Integrated Care Partnership strategy	8T1.1C 8T1.2C 8T1.3C 8T1.4C	Prioritisation and investment decision making process is required to fully implement the data and intelligence priorities Permanent, funded structure for analytical team demonstrating: ○ recruitment of a permanent Chief Data Analyst, Temporary appointment in place. ○ allocation of analytical resource from within current workforce; ○ development of analytical workforce in line with investment plan Strategic Intelligence Group needs formalising and structured reporting through to D3B and direct link to ICB Strategic Intent function and ICB planning cell. SIG being reconstituted and reset. JUCD Information Governance Group needs formalisation and work required on using data for planning purposes. SIG being reconstituted and re-set.	• Data and Digital Strategy • CMO and CDIO from ICB executive team are vice chairs of the D3B. • Regional NHSE and AHSN representation at D3B provide independent input. • D3B minutes demonstrating challenge and assurance levels • Provider Collaborative Leadership Board Minutes demonstrating challenge and assurance levels • Monthly Reporting to Finance and Estates Committee, ICB Board, NHSE and NHS Executive Team • Evidence of compliance with the ICB Scheme of Reservation and Delegation • A staffed, budgeted establishment for ICB analytics (workforce BAF link required) • Data Sharing Agreements in place across all NHS providers, ICB, hospices and local authorities for direct care purposes.	8T1.1AS	The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board.
Threat 2 Agreement across the ICB on prioritisation of digital and technology activity may not be realised and therefore budget allocation and reconciliation process across ICB for digital and technology are not agreed.	• Agreed and publicly published Digital and Data Strategy • Digital and Data Board (D3B) in place. This provides board support and governance for the delivery of the agreed Digital and Data strategy. • D3B responsible for reporting assurance to ICB Finance and Estates Committee and assurance and direction from the Provider Collaborative Leadership Board. • Representation from Clinical Professional Leadership Group on D3B • Digital programme team leading and supporting key work in collaboration with system wide Delivery Boards e.g., Urgent and Emergency Care, Elective to embed digital enablement in care delivery • Digital and Data identified as a key enabler in the Integrated Care Partnership strategy • NHSE priorities and operational planning guidance 23/24 requires the right data architecture in place for population health management	8T2.1C 8T2.2C 8T2.3C 8T2.4C	ICB prioritisation and investment decision making process is required to fully implement the digital and data strategy priorities. Digital literacy programme to support staff build confidence and competency in using technology to deliver care. Linked to Project Derbyshire (Digital HR) – no resource allocated / prioritised at this time. Clear prioritisation of clinical pathway transformation opportunities needs formalising through Provider Collaborative and ICB 5 year plan. Digital land data has contributed to ICB 5 year plan and will continue to update Stronger links / formalisation required to link the GP IT governance and activity to the wider ICB digital and technology strategy. CDIO joining GPIT discussions where possible. GP presence on Derbyshire Digital and Data Board under discussion.	• Data and Digital Strategy approved by ICB and NHSE • CMO and CDIO from ICB executive team are vice chairs of the D3B. • Regional NHSE and AHSN representation at D3B provide independent input. • D3B minutes demonstrating challenge and assurance levels • Provider Collaborative Leadership Board Minutes demonstrating challenge and assurance levels • Clinical Professional Leadership Board Minutes demonstrating challenge and assurance levels • Evidence of compliance with the ICB Scheme of Reservation and Delegation • exploitation of Derbyshire Shared Care Record capabilities; demonstrated through usage data • Acceptance and adoption of digital improvements by operational teams (COO, primary care and comms support needed – links to digital people plan and Delivery Board outcomes) • A staffed, budgeted establishment for ICB digital and technology (workforce BAF link required)	8T2.1AS	2023/24 Operational Plan in place and submitted to NHSE

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 3 Digital improvements and substitutions to clinical pathways are not delivered through either a lack of citizen engagement and/or clinical engagement	• Digital and Data Board (D3B) enabling delivery board and support governance established and responsible for the delivery of the agreed Digital and Data strategy • D3B responsible for reporting assurance to ICB Finance and Estates Committee and assurance and direction from the Provider Collaborative Leadership Board • Citizen's Engagement forums have a digital and data element • ICB and provider communications team engaged with messaging (e.g. Derbyshire Shared Care Record)	8T3.1C 8T3.2C 8T3.3C 8T3.4C	Data and Digital communication and engagement strategy required to increase awareness of digital technology and solutions available to support care delivery. Some engagement now delivered Development of a 'use case' library to help promote the benefits of digitally enabled care and now under construction for Shared care Record Improved information and understanding of Citizen and Community forums that could be accessed to discuss digitally enabled care delivery Increased collaboration with the Voluntary Sector across Derby and Derbyshire to harness capacity and expertise. Meetings with Rural Action Derbyshire completed and joined engagement strategy being developed	• ICB and provider communications plans with evidence of delivery • Staff surveys showing ability to adopt and influence change • Patient surveys and D7F results • D3B minutes demonstrating challenge and assurance levels • Provider Collaborative Leadership Board Minutes demonstrating challenge and assurance levels • Clinical Professional Leadership Board Minutes demonstrating challenge and assurance levels • Evidence of compliance with the ICB Scheme of Reservation and Delegation • Data and Digital Strategy adoption reviewed through Internal Audit • ICB Board Finance and Estates Committee Assurance Report to escalate concerns and issues. • Public Partnerships Committee minutes demonstrating challenge and assurance levels	8T3.1AS	The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board.

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	8T1.1A	Secure agreement on data resource funding - budget being formalised		Jim Austin / Darran Green	June 2023	Commenced	TBC	Partially assured
	8T1.2A	Agree structure of ICB analytics team and role of Chief Data Analyst	8T1.2C	Chris Weiner	June 2023		TBC	Partially assured
	8T1.3A	Recruitment of analytics team		Chris Weiner	September 2023		TBC	Partially assured
	8T1.4A	Formalisation of Strategic Intelligence Group governance	8T1.2C	Chris Weiner (CDA once appointed)	June 2023		TBC	Partially assured
	8T1.5A	Execution of planned investment in analytical skills development in line with ICB plan		Chris Weiner (CDA once appointed)	April 2024		TBC	Partially assured
	8T1.6A	Formalise JUCD IG group and draft data sharing agreements for using data for purposes other than direct care	8T1.4C	Chris Weiner (CDA once appointed)/ Chrissy Tucker	June 2023	Commenced	TBC	Partially assured

Threat 2	8T2.1A	Secure agreement on digital and technology resource funding - budget being formalised		Jim Austin / Darran Green	June 2023	Commenced	TBC	Partially assured
	8T2.2A	Develop and roll out staff digital literacy programme	8T2.2C	Jim Austin / Workforce lead/AR	October 2023		TBC	Partially assured
	8T3.3A	Adopt ICB prioritisation tool to enable correct resource allocation		Jim Austin / Zara Jones	TBC – requires prioritisation tool		TBC	Partially assured
	8T3.4A	Formally incorporate Primary Care digital and technology governance within D3B	8T2.4C	Jim Austin / Chrissy Tucker	June 2023		TBC	Partially assured
Threat 3	8T3.1A	Formalise link to Public Partnership Committee, delayed until budgets resolved		Jim Austin /Sean Thornton	June 2023	Commenced	TBC	Partially assured
	8T3.2A	Work with ICB communications team and Provider communications teams to integrate digital strategy messaging into current engagement programme	8T3.1C	Jim Austin /Sean Thornton	June 2023		TBC	Partially assured
	8T3.3A	Deliver digital (and data) messaging through ICB communications plan		Jim Austin /Sean Thornton	June 2023+		TBC	Partially assured

Strategic Risk SR9 – Population Health and Strategic Commissioning Committee

Strategic Aim – Reduce inequalities in health and be an active partner in addressing the wider determinants of health.	**Committee overall assurance level**	**Partially assured**	
	ICB Lead: Zara Jones, Executive Director of Strategy and Planning **ICB Chair:** Julian Corner, Chair of PHSCC	**System lead:** Dr Robyn Dewis **System forum:** Population Health and Strategic Commissioning Committee	**Date of identification:** 17.11.2022 **Date of last review:** 15.05.2023

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.**	**Risk appetite: target, tolerance and current score** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **12**		**Initial** **16**	**Current** **16**	**Target** **12**

Strategic threats (what might cause this risk to materialise)	**Impact** (what are the impacts of each of the strategic threats)
1. Resource required for restoration of services post-Covid impacts progress of health inequalities programme. 2. The cost of living crisis worsens health inequalities. 3. The population may not engage with prevention programmes. 4. The ICS aim to achieve too much in too many areas with limited resources	1. Delay or non-delivery of the health inequalities programme. 2. Fuel/food poverty exacerbates or accelerates health conditions or diverts individuals from activities to support their health. 3. The population are not able to access support to improve health. 4. The ICS fails to make any impact rather than focusing on a small number of priority areas where the ICS can make an impact

Threat status	**System Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Control Ref No**	**System Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**System Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	**Assurance Ref No**	**System Gaps in Assurance** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1 Resource required for restoration of services post-Covid impacts progress of health inequalities programme.	• Integrated Care Partnership Board in place with Terms of Reference agreed and work programme in place. • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023. • NHS and ICS Executive teams in place. • Core 20 Plus 5 work programme. • Delivery Boards remit to ensure work programme supports HI. • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis inclusive of access and inequality considerations • System-wide EQIA process supports identification of equalities risks and mitigations and reduces risk of projects/ programmes operating in	9T1.1C 9T1.2C 9T1.3C 9T1.4C 9T1.5C 9T1.6C 9T1.7C	Financial position and requirement to break-even / lack of funds to invest or double-run whilst transforming. Clear ICP work programme The national formula for funding GP practices (Carr-Hill) probably provides insufficient weighting for deprivation Development of system needs assessment Infection Rates – impact on recovery Limited capital - impact on recovery Under performance against key national targets and standards	• Measurement of relationship in the system: embedding culture of partnership across partners • PHSCC assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • System Delivery Board agendas and minutes • Provider Collaborative Leadership Board minutes • Health and Well Being Board minutes • ICP Agenda and minutes • Coproduction • Workforce resilience • Demand in the system • Audit and Governance Committee oversight and scrutiny • HOSC • EDI Committee reporting	9T1.1AS 9T1.2AS 9T1.3AS	The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. Integrated Care Strategy to be signed off by Local Authority Cabinets Joint Forward Plan to be published by end June 2023

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	isolation – and specifically decommissioning decisions • Ambulance handover action plan developed – improvement trajectory agreed with NHSI – monthly improvement trajectories monitored at Boards • Derbyshire ICS Green Plan and action plan approved by Derbyshire Trusts and adopted by the ICB Board July 2022	9T1.8C 9T1.9C 9T1.10C 9T1.11C 9T1.12C 9T1.13C 9T1.14C 9T1.15C	Single integrated improvement plans being developed with regular monitoring Relationships between various operating tiers of the ICS, in particular what a delegation and governance arrangements might be across the ICS (e.g. provider collaborative) in relation to place based delegation and governance arrangements. Development of clear narrative for provider collaborative, and participation in ICS and place-based discussions Establish a robust governance structure to programme, agree and prioritise change with operational leadership Further development of the strategy to bring greater efficiencies to staff and patients Consistent management reporting across the system to be agreed Implement routine mechanism for shared reporting of risks and risk management across the system Capacity in Primary Care to deliver increased target Annual Health Checks for high risk groups (ie LD/ SMI)	• Derbyshire ICS Greener Delivery Group and minutes • 2023/24 Operational Plan in place • Integrated Care Strategy approved by the ICB Board and ICP. • Production of Joint Forward Plan • Development of health inequalities Group Provider facing for Mental Health • Performance Data from MHSDB		

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 2 The cost of living crisis worsens health inequalities.	• The 22/23 winter plan includes additional funding for practices serving the most deprived populations in DDICB	9T2.1C 9T2.2C 9T2.3C 9T2.4C 9T2.5C 9T2.6C 9T2.7C 9T2.8C	Scale of the challenge and areas we cannot directly influence which impact on health, Place Based Plans not in place Development of system needs assessment No impact analysis System governance arrangements that describe approach to delivery of the system transformation programme Variation across the ICS of patient and wider involvement in the planning and delivery of services Patient experience data collated at Trust wide level Wider population input into service development and population health developments	• PHSCC assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • ICB Board Development sessions • 2022/23 Winter Plan • Alignment between the ICS and the City and County Health and Wellbeing Boards • NHSEI oversight and reporting • Production of Joint Forward Plan	9T2.1AS 9T2.2AS 9T2.3AS	Derbyshire ICS Health Inequalities Strategy has been developed and requires approval from the ICP and ICB Board. The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. Joint Forward Plan to be published by end June 2023
Threat 3 The population may not engage with prevention programmes.	• Prevention work - winter plan and evidence base of where impact can be delivered • General Practice is still trusted by the vast majority of people and has a proven track record of helping people engage with prevention programmes • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023 and has approved a draft ICP Strategy which will support improving health outcomes and reducing health inequalities.	9T3.1C 9T3.2C	Core 20 plus 5 work - This programme forms a focus of the Health Inequalities requirement for the NHS but does not cover the entire opportunity for the system to tackle Health Inequalities. Time and resource for meaningful engagement	• Alignment between the ICS and the City and County Health and Wellbeing Boards • Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • Population Health Strategic Commissioning Committee assurance to the ICB Board via the Assurance Report. • ICB Board and minutes • ICP and minutes	9T3.3AS	Derbyshire ICS Health Inequalities Strategy has been developed and requires approval from the ICP and ICB Board.
Threat 4 The ICS aim to achieve too much in too many areas with limited resources	• NHS and ICS Executive teams in place. • Core 20 Plus 5 work programme. • Delivery Boards remit to ensure work programme supports HI. • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis inclusive of access and inequality considerations • System-wide EQIA process supports identification of equalities risks and mitigations and reduces risk of projects/ programmes operating in isolation – and specifically decommissioning decisions.	9T4.1C 9T4.2C 9T4.3C 9T4.4C 9T4.5C	Financial position and requirement to break-even / lack of funds to invest or double-run whilst transforming. Clear ICP work programme The national formula for funding GP practices (Carr-Hill) probably provides insufficient weighting for deprivation Development of system needs assessment Variation across the ICS of patient and wider involvement in the planning and delivery of services	• Measurement of relationship in the system: embedding culture of partnership across partners • System Delivery Board agendas and minutes • Provider Collaborative Leadership Board minutes • Health and Well Being Board minutes • ICP Agenda and minutes • Coproduction • 2022/23 Winter Plan • Alignment between the ICS and the City and County Health and Wellbeing Boards • Production of Joint Forward Plan	9T4.1AS 9T4.2AS	Derbyshire ICS Health Inequalities Strategy has been developed and requires approval from the ICP and ICB Board. Joint Forward Plan to be published by end June 2023

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Control Ref No	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – management, risk and compliance, external)	Assurance Ref No	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	• The 22/23 winter plan includes additional funding for practices serving the most deprived populations in DDICB. • Prevention work - winter plan and evidence base of where impact can be delivered.	9T4.6C	Wider population input into service development and population health developments			

Actions to treat threat

Threat	Action ref no	Action	Control/ Assurance Ref No	Action Owner	Due Date	Has work started?	Committee level of assurance (eg assured, partially assured, not assured)	
							Committee/Sub Group Assurance	Committee level of assurance
Threat 1	9T1.1A	Review alternative funding formula to Carr Hill – scope cost and logistics	9T1.3C	GPPB/CN/ Finance	01/04/2024	Commenced	GPPB	Partially assured
	4T1.4A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met.	9T1.1AS	Executive Officers	End Quarter 2 2023/24	Commenced	ICB Board	Partially assured
	1T1.2A	Integrated Care Strategy is in place requires sign off from Local Authority Cabinets	9T1.3AS	ZJ	Quarter 1 2023/24	Commenced	ICB Board	Partially assured
	1T3.3A	Development of Joint Forward Plan to be published by 30 June 2023	9T1.4AS	ZJ	Quarter 1 2023/24	Commenced	ICB Board	Partially assured
Threat 2	9T2.1A	Development of priorities for the ICP and delivery commences	9T2.1C	ICP/ZJ/KB	Quarter 1 2023/24	Commenced	ICP/PHSCC	Partially assured
	4T1.4A	Development of Integrated Assurance and Performance Report to ensure Board expectations are met.	9T2.1AS	Executive Officers	End Quarter 2 2023/24	Commenced	ICB Board	Partially assured
	1T1.2A	Integrated Care Strategy is in place requires sign off from Local Authority Cabinets	9T2.2AS	ZJ	Quarter 1 2023/24	Commenced	ICB Board	Partially assured
	1T3.3A	Development of Joint Forward Plan to be published by 30 June 2023	9T2.3AS	ZJ	Quarter 1 2023/24	Commenced	ICB Board	Partially assured
Threat 3	9T3.1A	Discuss approach with Public Partnership Committee	9T3.1C 9T3.2C	Julian Corner/ Sean Thornton	30/04/2023	Commenced	Public Partnership Committee	Partially assured
	1T1.2A	Integrated Care Strategy is in place requires sign off from Local Authority Cabinets	9T3.3AS	ZJ	Quarter 1 2023/24	Commenced	ICB Board	Partially assured
Threat 4	9T4.1A	Development of priorities for the ICB/ ICP and delivery of metrics	9T4.2C	ICB/ZJ/CW/CCo	Quarter 1 2023/24	Commenced	ICP/PHSCC	Partially assured
	1T1.2A	Integrated Care Strategy is in place requires sign off from Local Authority Cabinets	9T4.1AS	ZJ	Quarter 1 2023/24	Commenced	ICB Board	Partially assured
	1T3.3A	Development of Joint Forward Plan to be published by 30 June 2023	9T4.2AS	ZJ	Quarter 1 2023/24	Commenced	ICB Board	Partially assured

Time Commenced: 13:00pm
Time Finished: 14.45pm

Health and Wellbeing Board
19 January 2023

Present:

Statutory Members Chair: Councillor Webb (Chair), Sue Cowlishaw (Derby Healthwatch), Buk Dhadda (Vice Chair), Andy Smith Strategic Director of Peoples Services, Alison Wynn, Assistant Director Public Health

Elected members: Councillors Martin

Appointees of other organisations: Amjad Ashraf & Nosheen Ali (Community Action Derby), Paul Brookhouse (Derby Poverty Commission), Chris Clayton (CEO Derby & Derbyshire ICB), Lucy Cocker (Derbyshire Community Healthcare Services), Gino Distefano (University Hospitals Derby & Burton), Ian Fullagar, (Head of Strategic Housing, City Development and Growth DCC), Fran Fuller (Derby University), James Joyce, (Head of Housing Options and Homelessness) Michael Kay (Head of Environment Protection, Housing Standards, Licensing and Emergency Planning DCC), Claire Mehrbani (Director of Housing Services, Derby Homes Ltd), Rachel North (Strategic Director of Communities and Place), Bridget Stacey (Derby & Derbyshire ICB), Clive Stanbrook (Derbyshire Fire and Rescue Service)

Non board members in attendance: Kirsty McMillan, Director Integration and Direct Services Adults, Simon Harvey (GP)

36/22 Apologies for Absence

Apologies were received from: Councillors Poulter and Whitby, Steve Bateman (CEX DHU Healthcare), David Cox (Derbyshire Constabulary), Robyn Dewis, (Director of Public Health), Stephen Posey (Chief Executive University Hospitals of Derby and Burton)

37/22 Late Items

There were none.

38/22 Declarations of Interest

There were none.

39/22 Minutes of the meeting held on 10 November 2022

The minutes of the meeting on 10 November 2022 were proposed, seconded and agreed.

40A/22 Health Impacts Arising from Poor Housing Conditions

The Board received a report and presentation from the Strategic Director of Communities and Place. The presentation was provided by the Head of Strategic Housing and the Head of Environment Protection and Housing Standards. The report and presentation gave an overview of two reports by the Council about the poor conditions existing within the worst of Derby's private sector homes and the impact that poor quality private sector housing has on the health of Derby's residents.

The officer explained the methodology used which included desktop modellng based on the results of the English Housing Survey and physical surveys of privately rented homes across central wards of Derby. The results of the desktop modelling were updated to reflect the findings of the physical survey.

Private Renting in Derby - A chart showed the areas of Derby within each deprivation group. The highest percentage (46.5%) of Derby's private rented sector homes are in wards with more deprivation, Normanton, Arboretum, Abbey and Mackworth.

Condition of Private Rented Homes in Derby – In England the proportion of private sector rented homes which would fail the decent homes standard was 24.8%, in Derby the percentage was 30.9%. The local physical survey showed the proportion of housing which failed the standard were in the central wards of Derby, at least 8,500 privately rented homes failed the Decent Homes Standard.

Housing Health and Safety Rating System (HHSRS) Category 1 Hazards (Hazards which pose a serious risk to the health and wellbeing of occupants) in Derby 23.7% of private rented sector (PRS) homes in Derby have an HHSRS Category 1 hazard compared to 14.4% of PRS homes in England. Category 1 hazards include falls on stairs, excess cold, damp and mould and fire and electrics.

Housing and Health Impact Assessment – it was highlighted that it was not just private rented accommodation affected but also privately owned houses that were of a low standard. The Board heard that life expectancy had stalled and was now decreasing. In Derby life expectancy was falling more significantly that the national average In Derby the life expectancy for men was 77.7 years and for women it was 81.5 years. There was also a inequality gap in life expectancy for those born in the most and least deprived areas of Derby of 10.9 years for women and 11.1 years for men.

Cold and Damp Homes – 2,899 PRS homes had a Category 1 hazard for excess cold, there was a strong link to poor health including respirotary diseases caused by damp or mould people living in Derwent ward were 6 – 5 times more likely to be admitted to hospital for COPD. Trips and Falls occur everywhere across the City, 95% of pelvic fractures are caused by falls. The costs to the Local Health Services of poor housing were highlighted.

The officers described the next steps which included strategic leadership that sees the local provision of health, care and housing services as a coherent system which seeks to deliver the best possible outcomes for the community. It was noted that the Council Cabinet had resolved to consult on the introduction of Selective Licensing /or Additional Licensing to help address issues in private accommodation. A government white paper proposing a decent homes standard could be introduced across the private sector. However, the officers suggested there was a need to take action now. Could Board members as a group of leaders start to work together to address issues ?

The Board considered the presentation and made the following comments. These surveys were important and the results were shocking. There are good private landlords who work with the services provided by DCC from the Decent Safe Homes Team, Healthy Homes Hub and that grants provided by Government had been accessed. Landlords that don't comply are being targeted and offered advice, help and assistance where possible. However, if they are not prepared to engage then the enforcement route should be considered for them.

It was good to see this report at the HWB, it was a wider approach on the determinants of health, taking this forward it would be good to see wider information on how Derby does compare with other cities, was this a general city issue or was this a specific Derby challenge. If managed there would be a saving to the NHS for example in respiratory issues but funding could not be taken out as there would be other health issues.

This was about what was happening in the housing market over last 20 to 30 years. The poor standards in social housing used to be seen until legislation was put in place. There was a complete change in where affordable housing sits, as there was now a restricted supply of houses. The private rented sector has grown due to the unaffordability of buying houses, this has become a national issue.

There has been a lot of discussion recently about the need to get rid of no fault eviction. Landlords currently do not have to provide a reason for eviction of tenants, so families living in poor housing conditions risk losing accommodation if they complain about their rented property, this could lead to losing their tenancy and homelessness. Urban areas have a lot of poor quality landlords who rent out one or two properties without improvements and with no regulatory framework in place to guide them, the condition of properties was poor and the horrific reduction in life expectancy could be seen as a result. The regulatory regime was too weak to tackle problems. In Derby environmental health was a small team in the Council with a lack of funding. The problem was getting worse which was why it was important to work collectively to find solutions.

The information provided gave an insight and the data was hugely sobering and shocking. However, over the next 18, 24 to 36 months the situation could worsen due to the cost of living and energy crisis, lack of regulation and the increasing challenges to council finances. The dip in life expectancy, which was sharper in Derby, was likely to get worse before levelling of and recovering. What strategic recommentations can come to HWB on how to work as a system going forward what are the opportunities, how do we use what works well, there are examples of services across the system such as the using the BCF creatively around the Healthy Housing Hub, a direct link in reduction in falls and hospital admissions can be seen. There may be different ways of using resources more preventatively in the medium to long term.

The Board resolved:

1. **to note the findings of this report, together with the presentation delivered at the meeting**

2. **to consider how health, social care and housing may be better aligned and commissioned to deliver improved and preventative and responsive services**

40B/22 Single Homeless Adults in Derby: A Health Needs Assessment

The Board received a report and presentation from the Director of Public Health which was presented by a Speciality Registrar in Public Health. The report presented the findings of the health needs assessment of single homeless adults in Derby, with was conducted in 2021 and 2022 to the Health and Wellbeing Board.

The health needs assessment of single homeless adults gave an overview of their health needs and the gaps that exist in terms of health with the general population. The health needs of single homeless adults and the inequalities that exist between them and the general population are extreme, there was a life expectancy gap of 30 years. They often have complex health and social needs which are not served well by mainstream health and care service. When they access health services it is often in emergency situations. There was also a strong association with homelessness in adulthood and early childhood trauma. A lot of homeless people will have been involved with social care and criminal justice agencies in earlier life.

The aims and objectives of the health needs assessment were to identify the health needs of single people aged 16 to 65 who were currently homeless or living in temporary, supported accommodation in Derby, to identify gaps in current service provision and make recommendations for changes to meet their needs, improve health and reduce health inequalities.

The key findings were:

- 825 homeless single adults, approximately 150 on edge of rough sleeping
- Population was younger than the general population and predominantly male
- Health worse than the general population – large health inequalities
- Health was poorest where the acuity of housing need was greatest
- More likely to have multiple and complex health and care needs, multi-morbidity and long-term conditions
- More likely to have concurrent substance or alcohol dependency and mental ill health.
- Many also required support with social care and end of life care.
- Adverse childhood experiences of abuse and neglect were associated with a higher risk of homelessness in adult life.
- Women were more likely to have experienced domestic and sexual violence and to have more complex support needs.
- 43 extremely complex single homeless adults in Derby, 20 of whom are in the most insecure accommodation.
- The homeless population was part of wider inclusion health population, many of whom are at a high risk of homelessness at some point in their life and who have complex needs that require more specialised and personalised approaches to care.
- Need the right approach to care as well as clinical expertise and evidence-based interventions
- Paramedic role is critical in Derby: navigating health services, single point of contact, expertise by experience, trusted personal relationships with people who experienced homelessness
- Routine housing data to characterise health need of those who are homeless and

those at risk of homelessness
- Learning from people who experienced homelessness and support services about challenges and opportunities to improve care and support.

The Board considered the presentation in relation to housing. It was stated that Housing Authorities and local providers should ensure they support peoples needs including those relating to Health and Social Care. It was not just those homeless people seen on the street affected but also people with complex needs.

A member of the board suggested recommending that this goes to the Housing Sub Group and that group comes back to the Board with some recommendations as to how the Board can take this further. It was highlighted that work with landlords, health colleagues also with Mental Health Support services has been ongoing since this report was put together. A “Just Giving” service was created so instead of giving to people on the streets people can donate using a QR code.

Comments from the Board were made about the fear people had of speaking up about poor conditions in their rented property in case of eviction. There are people living in the same house through generations, there are issues of literacy. Tenants have rights but they also are in fear of losing homes through no fault evictions. The issue of chronic respiratory disease was discussed. The Board understood the point about tenants rights but felt whilst Section 21 and no fault evictions are in place, tenants have the rights but also they fear losing home if they upset their landlords.

To pull together the discussion, two specific recommendations were suggested for the Board to consider.

Strategic Support and prioritisation was asked for regarding attendance at the sub group of HWB in relation to Housing Health and Homelessness, the multi agency board was set up to discuss these issues but they were struggling in terms of attendance from all sectors, there was strong attendance from social care, public health and housing but the group struggled to get sufficient attendance at a strategic level so any strategic support and priority to attend would be welcomed. Also a sense check was asked for to see if the right people had been invited. It was difficult for housing to navigate across health services and know they were in the right place talking to right people at the right level.

The second recommendation concerned whether that sub group of HWB (housing health and homelessness group) might also get more power in terms of being able to report jointly into the ICP. This might strengthen attendance and also help embed the Health housing and homeless discussion. It was suggested that the Health, Housing and Homelessness Group could be the pivotal group to look at NICE guidance and create an Action Plan for all partners to collectively and collaboratively own.

The Chair clarified whetherit was being asked for the ICP to join with HWB Housing sub group to make a targeted group across both organisations. Officers said they were looking for guidance in terms of which was the best route. It was recognised in order to get an equal playing field around recognising the value of health, housing and homeless in one multi agency forum they need to report to HWB but a more direct route into health and social care was also needed.

This committee could not resolve this issue, but suggested it could be looked at in the ICS executive forum. It was suggested that the ownership of this agenda should not be moved from the HWB. The ICP has a different role between NHS, Public Health and Social Care. However, there was a need to empower this sub group and to have an approach that takes it forward. It was suggested and agreed that it could be discussed at an ICS Executive Forum.

A Board member was interested in the statistics showing the contrast between life expectancy of the housed and homeless and asked how was the figure were arrived at, and if it included people who had been homeless for five years or just one year. The officer explained the figures were taken from mortality data, at the point when somebody dies who was homeless. The link between housing tenure and life expectancy was highlighted. There was a progression of steps, sofa surfing, bed and breakfast, other types of accommodation which would progressively become worse. The lack of secure housing was not good for health and life expectancy was likely to become worse.

The Board discussed the ways of looking at housing problems which was often unhelpful, for rough sleepers being homeless was the last part of a problem. There would be other problems experienced throughout their lives eventually leading to homelessness. There was a need to think about the problems people have, think about the person and the outcomes holistically and reflect around the issues and problems before people become labelled homeless. A councillor talked about having been tasked with targeting five of the most difficult cases for homelessness, a review had been undertaken and, it did reflect specifically the issues raised about problems prior to being street homeless, it was a downward spiral, people do not meet criteria for single services but if problems were looked at collectively they could be offered assistance.

The recommendation to give the issues discussed to the Housing Sub Group to look at and provide recommendations for the HWB to take forward, and for the ICS Executive to support getting better membership at that sub-group was agreed.

Resolved to

1. **adopt the findings of this health needs assessment report into Derby City's Joint Strategic Needs Assessment.**

2. **That the HWB and partner organisations commit to intersectoral and partnership action to address the needs of single homeless adults in Derby, and to reduce the inequality in access, experience and outcomes for health and social care that exist between this population and the general population of the City.**

3. **To ask the HWB Housing Sub Group to consider the issues discussed and provide the HWB with recommendations to take forward and that the Integrated Care System Executive promote and prioritise better membership of the Housing sub group.**

Items for Information

41/22 Health and Wellbeing Boards Guidance

The Board received a report from the Director of Public Health which gave an overview of the

guidance published by the Department of Health and Social Care (DHSC). The report was presented by the Assistant Director of Public Health.

The officer highlighted the points to note from the report. The published guidance was non-statutory and set out the roles and duties of HWBs and clarified their purpose within the new health and care system particularly the establishment of integrated care boards (ICBs) and integrated care partnerships (ICPs). The Board noted that HWBs continue to have a statutory role promoting joint working across health and care organisations and setting strategic direction to improve the health and wellbeing of local people.

HWBs retain their separate statutory duty to develop a pharmaceutical needs assessment (PNA) for their area. They remain a formal statutory committee of the local authority and continue to provide a forum where political, clinical, professional and community leaders from across the health and care system come together to improve the health and wellbeing of the local population and reduce health inequalities. The core statutory membership of HWBs was unchanged other than having a representative from ICBs rather than CCGs. HWBs are expected to continue to lead action at place level to improve peoples lives and they are still responsible for promoting increased integration and partnership between the NHS, public health and local government.

HWB and ICPs should work collaboratively in the preparation of a system-wide integrated care strategy that will tackle challenges best dealt with at a system level. The Derby Health and Wellbeing Strategy will be reviewed in light of the developing Integrated Care Strategy. The first meeting of the ICP Board will be in February 2023.

Resolved to note this report and the updated guidance on Health and Wellbeing Boards published by the Department of Health and Social Care

42/22 Joined Up Care Derbyshire Update – Integrated Care Partnership and Integrated Care Strategy

The Board received a report from the Director of Public Health which gave an update from JUCD Derby and Derbyshire's Integrated Care System. An update was provided on the progress to establish formally the Integrated Care Partnership and on its development of an Integrated Care Strategy. The report was presented by the Assistant Director of Public Health.

The Board heard that approval had been received from Derby City Council, Derbyshire County Council (DCC) and Derby and Derbyshire ICB to formally establish the ICP as a joint committee. DCC would host the ICP on behalf of the three constituent bodies and the ICP will follow DCC committee procedure rules. The first meeting of the ICP as a formally constituted joint committee will be in February 2023.

The officer explained that there are four strategic aims for the ICS which were:

- Prioritise prevention and early intervention to avoid ill health and improve outcomes
- Reduce inequalities in outcomes, experience and access
- Develop care that was 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

The report also detailed the key focus on the ICP in relation to working with the HWB. It was intended that a first draft of the Integrated Care Strategy would be considered by the ICP Board in February 2023 and a final version of would be produced for the approval of the ICP Board in April 2023.

The Board resolved to note the update from Joined Up Care Derbyshire (JUCD)

43/22 Better Care Fund 2022/23 – amendment relating to the Adult Social Care Discharge Fund

The Board received a report of the Stratgic Director of Peoples Services which gave a summary of the amendment to the proposed plan for the Derby Integration and Better Care Fund (BCF) 2022/23 particularly in relation to the Adult Social Care Discharge Fund. The report was presented by the Director, Integration and Direct Services.

The officer explained that in September 2022 the government announced its "Plan for Patients", which committed £500m for the remainder of the financial year to support discharge from hospital into the community by reducing the number of people delayed in hospital waiting for social care. This was an addendum to the 2022/23 Better Care Fund (BCF) policy framework. Guidance was issued to the health and social care sector on 18th November 2022 and updated on 5th January. The report summarised the addendum and guidance alongside the local plan for its use.

The funding will be distributed to both local authorities and ICBs to pool into the local BCF. The use of both elements must be agreed between local health and social care leaders. The national £500m funding will be distributed with 40% (£200m) distributed as a section 31 grant to local authorities and the remainder (£300m) to ICBs.

The initial completed planning template for Derby was attached in Appendix 1 of the report. The officer explained that the appendix lists the current proposed spending, it was planned to pass funding on to primary sector care agencies. A councillor highlighted that the Voluntary and Community Sector would receive a proportion of the funding to support discharges.

The Board resolved to note the report and the amendment to the BCF relating to the Adult Social Care Discharge Fund.

44/22 COVID Outbreak Engagement Board and Health Protection Board Update

The Board received a report of the Director of Public Health which provided an update and overview of the key discussions and messages from the COVID Outbreak Engagement Board and Derbyshire Health Protection Board.

The Board noted that after a period where meetings had been paused the Derby Outbreak Engagement Board met in December 2022. The meeting considered the Updated Local Outbreak Management Plan, COVID vaccination uptake and updates from partner organisations.

The Derby COVID-19 Outbreak Management Plan sets out the approach to prevent, manage and contain outbreaks of COVID 19. The Plan was in need of updating in relation to the current context of COVID and its response. Key changes include “Living with COVID”, testing data, National guidance with relaxation of measures. Re-emergence of other respiratory infections, the end of COVID Outbreak Management Funding and the reduction in UKHSA capacity.The Board noted that planning had not changed significantly.

The OEB approved the updated Local Outbreak Management Plan and its publication.

The Board resolved to note the report.

Private Items

None submitted.

MINUTES END

PUBLIC

MINUTES of a meeting of **HEALTH AND WELLBEING BOARD** held on Wednesday, 25 January 2023 at Committee Room 1, County Hall, Matlock, DE4 3AG.

PRESENT

Councillor C Hart (in the Chair)

In attendance was Councillor Froggatt, Councillor N Hoy, Councillor J Mannion-Brunt, Councillor A McKeown, Councillor J Patten, Councillor G Rhind, Councillor T Spencer, C Clayton, S Lee, J MacDonald, C Stanbrook and H Henderson.

Also in attendance was Councillor N Atkin, A Appleton, J Boyle, T Braund, C Durrant, E Houlston, H Jones, E Langton, I Little, K Monk, H Nicol, V Smyth, , and C Winder.

Apologies for absence were submitted for Councillors M Dooley and K Hanson, P Maginnis, and H McDougall, S Scott, and G Smith.

01/23 MINUTES

RESOLVED that the minutes of the meeting of the Board held on 06 October 2022 be confirmed as a correct record.

02/23 PUBLIC QUESTION

Question received from Mr Ingham:

I attended and asked two questions at the Improvement and Scrutiny Committee - Health on 16-01-23 regarding my concerns to the apparent 200 million being allocated to the NHS to secure care home places to support current hospital discharge pressures.

I'm therefore extremely interested in what is to be presented under Agenda Item 3 Looking After Our People - Derbyshire but understand this is a verbal update with no report to view.

In light of the concerning information contained in the report at Agenda Item 9 regarding Residential Care Workers in respect of pay, poverty, deprivation, group demographics and pressures (albeit based on information only up to 2020) how will the Committee factor that information against NHS plans to give those specific Council and PVI employees even more people to care for when considering Agenda Item 3 and also in the wider context and role of the Committee.

Mr Ingham would be provided with a written response to his question

as he was unable to attend the meeting.

03/23 LOOKING AFTER OUR PEOPLE - DERBYSHIRE

The Health and Wellbeing Board had been provided with an update on the work being produced on the Looking After Our People Mental Health & Wellbeing Hub.

Officers welcomed suggestions for further funding streams to the project and agreed to provide further detail to Board members in relation to occupational breakdowns and the numbers of individuals they had connected with. The Board offered their assistance in regard to making connections.

04/23 UPDATE ON WARM SPACES AND HOUSEHOLD SUPPORT FUND

The Health and Wellbeing Board had been provided with an update in regard to warm spaces within Derbyshire and the Household Support Fund.

Derbyshire County Council had asked the District and Borough Council's to provide data and insight on the health impacts of the cost of living pressures but were yet to receive the information.

The Board Members had been informed that the Household Support Fund was now in round 3 with another round of funding expected to be announced in 2024. Further information was given on the distribution of grocery and cost of living vouchers.

05/23 HEALTH AND WELLBEING BOARD DEVELOPMENT AND ICP UPDATE

The Health and Wellbeing Board had been asked to consider the resolutions as stated in the report.

RESOLVED to

1) Note the refreshed performance reporting arrangements for the Health and Wellbeing Board and the summary of the latest performance;

2) Note the proposed approach to developing a revised Joint Local Health and Wellbeing Strategy for Derbyshire throughout 2023 and agree nominees to the working group;

3) Note the latest update from the Integrated Care Partnership for Derby and Derbyshire;

4) Agree proposals to utilise the Derbyshire Place Partnership Board as a forum to coordinate work between the Integrated Care Partnership and the

Health and Wellbeing Board;

5) Agree nominees from the Health and Wellbeing Board to attend the Derbyshire Place Partnership Board from February 2023 onwards;

6) Provide comment and feedback on Health and Wellbeing Board role profiles which summarise the main responsibilities of Board members;

7) Agree that the Board participates in the development activity as proposed by the Local Government Association; and

8) Agree the format for development sessions for the Health and Wellbeing Board.

06/23 CARERS STRATEGY (2020 - 2025) REFRESH 2022

The Health and Wellbeing Board had been asked to endorse the Derbyshire Carers Strategy refresh 2022 and encourage all system partners to commit to the priorities and pledges of the strategy and to develop organisational delivery / action plans.

RESOLVED to

1) Endorse the Derbyshire Carers Strategy refresh 2022; and

2) Encourage all system partners to commit to the priorities and pledges of the strategy and to develop delivery / action plans.

07/23 HEALTH PROTECTION BOARD UPDATE

The Health and Wellbeing Board were provided with an update of the key messages arising from the Derbyshire Health Protection Board from its meeting on 16 December 2022.

RESOLVED to

1) Note the update report from the Health Protection Board.

08/23 HEALTHWATCH DERBYSHIRE UPDATE

The Health and Wellbeing Board were provided with an update from Healthwatch Derbyshire, including:

a) An introduction to Healthwatch Derbyshire;
b) An update on current work around GP Access;
c) Warm Space findings; and
d) To think about ways of working between Healthwatch Derbyshire and the Health and Wellbeing Board, and its partners.

RESOLVED to

1) Note and accept the report.

09/23 HEALTH AND WELLBEING ROUND UP

The Health and Wellbeing Board were provided with a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda.

RESOLVED to

1) Note the information contained in the round-up report.

10/23 HOUSING - STOCK CONDITION SURVEY UPDATE

The Health and Wellbeing Board had been provided with an update on Housing within the District and Boroughs of Derbyshire.

Board Members would conduct further conversations on actions that could be taken in regard to Housing; aligning with Derby City.

11/23 ANY OTHER BUSINESS

The Chairman paid tribute to Helen Jones, Executive Director Adult Social Care & Health at Derbyshire County Council, who was attending her final meeting of The Health and Wellbeing Board as she was leaving her position at the end of March 2023. Thanks were shared with Helen for her support and hard work.

PUBLIC

MINUTES of a meeting of **HEALTH AND WELLBEING BOARD** held on Wednesday, 29 March 2023 at Council Chamber, County Hall, Matlock, DE4 3AG.

PRESENT

Councillor C Hart (in the Chair)

Dr C Clayton, Dr J Corner, E Houlston, H Henderson.

Councillors N Hoy, J Patten J Mannion-Brunt, A McKeown, H Froggatt, T Spencer.

Also in attendance was T Braund, T Dunn, C Durrant, D Gould, M Hague, K Hanson, M Holford, E Langton, H Leason, S Lee, I Little, K Monk, G Smith, S Wallace.

Apologies for absence were submitted for Councillor G Rhind Councillor P Maginnis, C Cammiss, and S Scott.

12/23 MINUTES

RESOLVED that the minutes of the meeting of the Board held on 25 January 2023 be confirmed as a correct record.

13/23 HEALTH INEQUALITIES AND GYPSY/TRAVELLER COMMUNITIES

The Health and Wellbeing Board were provided with a presentation on health inequalities and Gypsy/Traveller communities.

The presentation gave detail on the Gypsy, Roma & Traveller Education and Awareness session that took place on Tuesday 26th October 2021 as well as gave background and statistics on Gypsy/Traveller communities.

There were a number of barriers for Gypsy/Traveller communities accessing NHS services. The presentation outlined practical solutions to these barriers.

14/23 INTEGRATED CARE STRATEGY

The Health and Wellbeing Board had been asked to note the contents of the Draft Derby and Derbyshire Integrated Care Strategy, propose any changes to the Integrated Care Partnership regarding the content of the Draft Strategy. As well as comment on the Board and its partners roles in mobilising the strategy and the work plans for the Start Well, Stay Well and Age /Die Well key areas of focus. And consider and discuss the implications of the Integrated Care Strategy on the development of the Joint Local Health and Wellbeing Strategy.

RESOLVED to

1) Consider any proposed changes to the content of the Draft Strategy;

2) Comment on the Board and its partners roles in mobilising the Strategy and the work plans for the Start Well, Stay Well, and Age/Die Well Key Areas of Focus; and

3) Consider and discuss the implications of the Integrated Care Strategy on the development of the Joint Local Health and Wellbeing Strategy.

15/23 ICB 5-YEAR PLAN UPDATE

The Health and Wellbeing Board had been provided with a report detailing the Derby and Derbyshire ICB Joint Forward Plan.

The plan had set out how the ICB intended to meet the physical and mental health needs of the population through the provision of NHS services. This included setting out how universal NHS commitments would be met and addressed the four core purposes of Integrated Care Systems.

RESOLVED to

1) Note the contents of the report; and

2) Offer guidance and feedback on questions posed to support the effective development and delivery of the Derby and Derbyshire ICB's Joint Forward Plan – 5 Year Plan.

16/23 ANNUAL SECTION 75 UPDATE FOR COMMISSIONED SEXUAL HEALTH SERVICES

The Health and Wellbeing Board had been provided with the annual update on the Section 75 Agreement for commissioned sexual health services.

RESOLVED to

1) note the report and the progress made within the section 75 agreement for sexual health commissioned services; and

2) endorse the Sexual Health Alliance as the strategic Forum to engender greater collaboration to improve sexual health outcomes and to strengthen membership of organisations in the Alliance where there may be gaps.

17/23 JSNA UPDATE

The Health and Wellbeing Board had been provided with an update on the ongoing JSNA transformation programme in Derbyshire.

RESOLVED to

1) Note the progress delivered in Phase One of the JSNA Transformation; and

2) Support the development and implementation of a jointly owned approach to the transformation of the JSNA.

18/23 UPDATE ON THE PROGRESS OF THE JOINT LOCAL HEALTH AND WELLBEING STRATEGY

The Health and Wellbeing Board had been provided with an update on the proposed approach to the development of a new Joint Local Health and Wellbeing Strategy.

RESOLVED to

1) Note the update on the proposed approach to the development of the new Joint Local Health and Wellbeing Board Strategy;

2) Agree to engage in the process of supporting the development of the strategy, along with representatives from the local health and wellbeing partnerships; and

3) Collate feedback from district and boroughs on community need to feed into the strategy and agree to present this at the development session on 11 May 2023.

19/23 UPDATE ON WARM SPACES AND HOUSEHOLD SUPPORT FUND

The Health and Wellbeing Board had been provided with a presentation giving an update on warm spaces and the Household Support Fund.

20/23 BETTER CARE FUND OUTTURN REPORT AND BETTER CARE FUND PLANNING SUBMISSION

The Health and Wellbeing Board had been provided with details on the Derbyshire Better Care Fund 2022-23 Plan.

RESOLVED to

1) Note the Better Care Fund Planning Requirements;

2) Sign off the Better Care Fund Plan as it forms part of the national

conditions for the programme; and

3) Note the correction to the reablement calculation for the previous year.

21/23 HEALTH PROTECTION BOARD UPDATE

The Health and Wellbeing Board had been provided with an update of the key messages that had arisen from the Derbyshire Health Protection Board from its meeting on 10 February 2023.

RESOLVED to

1) meet the purpose of the Derbyshire Health Protection Board in providing assurance to the Derbyshire Health and Wellbeing Board that adequate arrangements are in place to protect the health of the residents of Derbyshire County.

22/23 HEALTH AND WELLBEING ROUND UP

The Health and Wellbeing Board had been provided with a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda.

RESOLVED to

1) Note the information contained in the round-up report.

23/23 ANY OTHER BUSINESS

There was no other business.

NHS Derby and Derbyshire Integrated Care Board

Meeting in Public – System Focus

Forward Planner 2023/24

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

ICB Key Areas	2023/24											
	20 Apr	18 May	15 Jun	20 Jul	17 Aug	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Introductory Items												
Welcome/Apologies and Quoracy			X			X			X			X
Questions from Members of the Public			X			X			X			X
Declarations of Interests • Register of Interest • Summary register of interest declared during the meeting • Glossary			X			X			X			X
Minutes and Matters Arising												
Minutes of the previous meeting			X			X			X			X
Action Log			X			X			X			X

ICB Key Areas	2023/24											
	20 Apr	18 May	15 Jun	20 Jul	17 Aug	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
System Assurance												
Urgent & Emergency Care						X						
Planned Care			X									
Mental Health, Learning Disabilities and Autism									X			
System Focus												
Integrated Care Strategy									X			
Population Health & Inequalities						X						X
Place Alliance and Provider Collaborative update						X			X			
System Enabling Functions												
Innovation & Information • Digital Development • Research			X									X
Medium Term Financial Planning									X			
2023/24 Financial Plan Update			X									
2023/24 Operational Plan			X									
NHS Joint Forward Plan			X									

ICB Key Areas	2023/24											
	20 Apr	18 May	15 Jun	20 Jul	17 Aug	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
One Workforce Plan						X						
One Public Estate Strategy												X
Green NHS Progress						X						
Corporate Assurance												
System Board Assurance Framework			X			X			X			X
For Information												
Derby City Council Health & Wellbeing Board Minutes			X			X			X			X
Derbyshire County Council Health & Wellbeing Board Minutes			X			X			X			X
Closing Items												
Forward Planner			X			X			X			X
Any Other Business			X			X			X			X
Questions received from members of the public			X			X			X			X