NHS Derby and Derbyshire Joint Forward Plan 2023/24 to 2027/28

Joined Up Care Derbyshire

NHS Derby and Derbyshire Integrated Care Board

Progress on Delivery

Original Publication Date: 28th June 2024

Latest Publication Date: 28th June 2024

Version no. 1.1

Forward

The NHS in Derby and Derbyshire has real ambition to improve the overall health outcomes for the population it serves. Furthermore, that ambition is grounded in the knowledge that the NHS will need to work in full partnership with others to influence those improvements given the full and wide-ranging determinants of health that exist.

Therefore, this Joint Forward Plan (JFP) represents the contribution that the NHS will make into the broader Integrated Care System (ICS) strategy that is owned by the Integrated Care Partnership (ICP) between the NHS, Local Authority and Voluntary Sector partners. Lastly, The Integrated Care Strategy of the ICS is influenced by our two Health and Wellbeing Board strategies and the Joint Strategic Needs Assessments (JSNAs) that support them; thereby, creating the strategic links between the health needs of the population and the forward responses from the NHS and its partners.

We recognise that improvements of this nature will not be delivered overnight but will come from determined strategic effort over several years and through having clarity on priority areas of focus for the NHS itself and its intricate work with partners as referenced above.

Our Joint Forward Plan sets our ambition regarding increasing preventive approaches, moving care and control to local areas, developing better information and intelligence, and optimising daily operations while delivering large-scale complex change.

As this document summarises, working through 23/24 and now 24/25, we are gaining a greater sense of our roadmap to delivering the ambitions of the system over the coming years. We must remember that large-scale systems change is a complex and emergent process; the detail of our collective future as a system of care is often unknown at the beginning and is only now materialising through the discovery, design and delivery of new services. As a system leader, I recognise that we work in a dynamic environment, building from experience but also continually learning and developing as we move forward. Therefore, despite the inherent challenges, I am confident there is a navigable path to developing a sustainable health and care system and overall improved health outcomes for the population.

If I look back to when we published our Joint Forward Plan, I see that we have achieved much. Improvements in how we respond to those who need an urgent health and care response by both improving their outcomes and experience by being treated and cared for at the place they call home as evidenced by our "Team Up" model.

In terms of increasing the role of prevention in our care model, a total of 3400 people who have needed inpatient care (physical and mental health), as well as 590 maternity patients, have also accessed our Tobacco Dependency Treatment programme.

Our portfolio of large change initiatives signals our ongoing transition towards the destination set in our JFP and incrementally moves us towards a more sustainable health and care service. That said, we cannot afford to lose our focus on the priorities of today with improvements to the operational stability of NHS urgent and emergency care services and reducing our overall elective waiting list being clear current and interlinked priorities.

If we look to this year and our next contributions to delivering the JFP strategy, fully mobilising our Place approach will form a key priority. This will support our mission to build our primary and community care offer and take towards the ambition of increasing the quantity of care received closer to home. Improving the use and sharing of information will be a key enabling mechanism for doing this and support local population health management.

As detailed, this balance between managing today AND tomorrow remains our strategic intent. This JFP review illustrates both of these aspects giving further detail on our long-term plan but also reflecting against the progress that has been and will be made in each single year. Whilst this review has had a specific focus on delivery against the plan, we will also seek to refresh the JFP as a whole to make sure that our long term "guiding light" view remains relevant to our population's needs and remains aligned with the Integrated Care and Health and Wellbeing Boards strategies that inform it.

Chris Clayton,

Chief Executive

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1. Introduction

The purpose of the publication is to provide an update on the delivery progress of the NHS Derby and Derbyshire Joint Forward Plan. As the NHS constituent of the Joined-Up Care Derbyshire Integrated Care System (ICS), DDICB acts as convenor and facilitator for the NHS family in the delivery of this plan. The plan's purpose, published on the 1st of April 2023, set the NHS in Derby and Derbyshire on a course over five years to develop how it operates.

In doing so, it informed a set of guiding policies for action, which were informed by a detailed analysis of the challenges and opportunities the NHS and care system faced. It articulated a set of high-level goals we wanted to achieve, the emergent large-scale changes required, and the choices to make. The Joint Forward Plan is the NHS's contribution to the Joined-Up Care Derbyshire Integrated Care Strategy. This sets out the broader Integrated Care Partnership (ICP) ambitions to ensure all citizens start their lives well, live well, and age well, and the strategies produced by our two Health and Wellbeing Boards.

In line with national guidance, the NHS Derby and Derbyshire Integrated Care Board has reviewed the progress of the delivery for the first year of the plan. This review informs us of the achievement of planned milestones and signals where we might need to correct our course. As we implement the proposals outlined in this review, we will have evidence-based information on any definitive changes required to the JFP that must be made before 31 March 2025. We will aim to achieve this as soon as possible. We have consistently recognised that our journey will be complex and emergent in achieving our goals.

The report is divided into the following sections:

- A summary of what we achieved in the year,
- A summary of what and why we need to change,
- What is the Derby & Derbyshire Integrated Care System,
- What we have learnt on our emergent journey.
- Progress on our work plans:
    - How we provide care,
    - How we enable that care,
    - How we work as an Integrated Care Board (ICB).

2. A summary of what we achieved in the year

While we recognise that we have a significant amount of work to do, we have made progress since the publication of our Plan, which provides a solid foundation for the future.

What follows is a summary of several of our achievements:

1. Leadership Development & Talent Management
    - We have co-designed and deployed a consistent core offer for leadership development and induction for all new leaders anywhere in the system. This supports a culture of improvement, encouraging learning and promoting system working. We are creating an inclusive talent approach as the driver for recruitment and development. This includes unified approaches to Leadership Development, Talent Management Development, and organisational development (OD).

2. Local Place Alliances - Team Up
    - We have designed and delivered 12 locally led multi-disciplinary neighbourhood teams to better support those with frailty and complexity in the place they call home. If we look at last year, the team delivered:
        i. 5000+ home visiting appointments monthly.
        ii. Over 86% of GP practices reported freed-up GP appointments.
        iii. 70% of urgent community response referrals were responded to within 2 hours, with only 2% of patients going to more advanced urgent care settings.
        iv. Slower growth in A&E attendance and non-elective admissions for over 65 with frailty compared to growth in this age category.

3. Hypertension - going Further & Faster
    - As part of our cardiovascular disease (CVD) prevention plan, we have increased the number of Blood Pressure checks being carried out across Derbyshire to increase the detection of those with undiagnosed Hypertension. The Hypertension case finding project has achieved an increase of 4113 BPs monitored, 1228 of which (30%) were identified as high or very high.

4. Tobacco Dependency Treatment Services
    - Patients who are admitted to the acute providers, mental health units and maternity patients and their partners are offered NHS-funded tobacco treatment services. Services are run at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB), Chesterfield Royal Hospital NHS Foundation Trust (CRH), and Derbyshire Healthcare NHS Foundation Trust (DHFT) for maternity and mental health inpatients. A total of 3400 inpatient and mental health patients, as well as 590 maternity patients, accessed the programme on 23/24.

5. Dementia Diagnosis
    - Over 2023/24, we exceeded our target dementia diagnosis rate, achieving 68.2%, representing a 2% improvement on the March 2023 position.

6. Access to Specialist perinatal and maternal mental health services
    - We have increased the number of women accessing specialist perinatal and maternal mental health services by 80% over the 2023/24 and ended the year in the top 10 of ICBs nationally for best access levels.

7. Access to care services for Children and Young People (CYP)
    - We increased the number of children and young people accessing services by a third over 2023/23.

3. The highlights for this year ahead (2024-2025)

What follows is a summary of several of our projected achievements for the end of this year:

a) Care Transfer Hub
   i) The hub triages strength-based referrals, asking, ‘Why not home? Why not today?’ prescribes and sources the most appropriate pathway for citizens, with full oversight of system capacity, demand and delays. Once operational, our hospitals will save between 336 and 346 monthly bed days.
b) Central Navigation Hub
   i) The hub's purpose is to simplify and make consistent internal care navigation so that staff can deliver the right care the first time. We are projecting an additional 5,935 patients will be deflected from conveyance and Emergency Department attendance compared to 2023-24.
c) Derbyshire Shared Care Record (DSCR)
   i) We have already achieved interoperability with partner organisations: View data: · Ashgate Hospice - Treetops - Blythe House - DHU - Primary Care Networks - Derbyshire County Council Adults - East Midlands Ambulance Service (EMAS). We are looking to expand this to a wider portfolio of our partner organisations, such as EMAS, to support improved support to emergency crews and expand the local authority data set to include children’s services.
d) Electronic Patient Record
   i) Having secured our EPR supplier via the procurement process, NerveCentre will commence implementation across our acute hospitals.
e) Adult Mental Health & Learning Disabilities
   i) Building works will be completed at Kingsway Hospital in Derby, and a new 14-bed psychiatric intensive care unit (PICU) will open. Derbyshire does not currently have a PICU, and people who need this level of support currently need to travel outside the county to access an appropriate bed.
f) Financial Balance
   i) To increase future investments in primary, community, and social care to reduce health inequalities, we need the overall NHS system to be at breakeven by the end of 2025/26. Currently, we have an underlying £50m deficit, so our goal is to eradicate this and create some financial headroom to strengthen out-of-hospital physical and mental health services. Clearly, the wider context is one of continued pressure on access to urgent and elective secondary care services, so we must be ambitious and establish new ways of collaborating across organisations and genuinely transforming models of care. This should also improve the patient's experience as well as the finances, so by working seamlessly on these two agendas, we will have the opportunity to stabilise our underlying financial position and make material steps towards improving population health.'

4. A summary of what and why we need to change

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

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

As set out in the Plan, the course will see the NHS change its operating model to become more preventative, integrated, personalised for the citizen, and more intelligence-led. The clinical sectors/organisations will be integrated by design in how they interact with patients and citizens. By all partners committing to this course and taking the necessary action, we will be able to improve the quality of provision, reduce cost and maximise the NHS' contribution to the broader agenda of improving population health.

Primary and Community Care is the “cornerstone” of the NHS’s contribution to improving population health, and we are committed to prioritising and strengthening this offer.

The three critical issues that we are addressing with our plan are:

1. Our Model of Care
    - Re-designing how clinical teams work across different care settings to combine the specialist's collective power with the generalist's expertise.
    - Developing the capability of clinical teams to proactively target limited clinical resources to those most at risk of their health deteriorating.
    - Providing people with the means to engage and influence decisions about their care.

2. Finance
    - We are changing our policy on distributing financial resources – focusing on incorporating specific “weights” for social deprivation and health inequity at the sub-population level – so that more financial resources are allocated to these areas to fund care.

3. Workforce
    - We will reverse the trend where “general medical” acute-based nursing and doctoring has increased faster than general practice doctoring and nursing.

Our plan was informed by local and national research and data highlighting social and health equality gaps. It also includes a variety of targets, aims, and ambitions designed to reduce health inequalities and improve health in specific areas. Sources include National Priorities: Core20PLUS5, Fuller Report, Turning the Curve, NHS 10-year plan, and the NHS Mandate 2023.

Within the JFP, five enabling approaches/principles/ambitions were described as follows and universally supported across the system:

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

- Give the teams working in our localities the authority to determine the best ways to deliver improvements in health and care delivery for local people.
- Give people more control over their care.
- Identify and remove activities from the provision of care that result in expending time and cost but do not materially improve patient outcomes.
- Prioritise the improvement of the System's Intelligence Function and the capacity and capability of its research programme.

5. What is the Derby & Derbyshire Integrated Care System

Derby and Derbyshire Integrated Care System (ICS) is a local partnership that brings together the health and care organisations of Derby and Derbyshire to develop shared plans and joined-up services. It is formed by NHS organisations and upper-tier local councils. It also includes the voluntary sector, social care providers, and other partners who play a role in improving local health and wellbeing.

Our partnership constitutes.

- Chesterfield Royal Hospital NHS Foundation Trust (CRH)
- Derby and Derbyshire Integrated Care Board (DDICB)
- Derbyshire Community Health Services NHS Foundation Trust (DCHS)
- Derbyshire Healthcare NHS Foundation Trust (DHFT)
- East Midlands Ambulance Service NHS Trust (EMAS)
- University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)
- Derby City Council
- Derbyshire County Council
- 112 GP practices (reg. pop. ranges (2-25k) forming 15 Primary Care Networks, plus one Out of Hours provider
- Residential and care home providers
- Multiple voluntary and independent sector organisations

a) Derby and Derbyshire Integrated Care Board

The Derby and Derbyshire Integrated Care Board (DDICB) has numerous roles and function. Principally, it is a convenor for the NHS family in Derby & Derbyshire supporting the development of integrated care but also acts as a key partner in influencing the wider determinants of health. Furthermore, it has a role in supporting broader social and economic development in our area. It also has specific statutory duties and functions that it undertakes namely being a Strategic Commissioner of health and care services and also oversees and assures the NHS and its partners on the quality and performance of the services delivered.

DDICB's strategic commissioning role is focused on creating a systematic and proactive approach to planning, procuring, and delivering NHS services for all communities of the Derby and Derbyshire population. As a new organisation formed in 2022, the DDICB is evolving to achieve its ambition to be seen as a valued partner in the wider collective effort to improve population health and reduce inequity in healthcare provision.

As an NHS sovereign organisation, with staff seeking to understand healthcare needs, manage NHS finance and performance, ensure engagement with the local community in NHS care, and work with system partners to commission a sustainable healthcare landscape.

The board is responsible for delivering the Derby and Derbyshire Integrated Care Strategy and the contribution from the NHS through the Joint Forward Plan, which is currently deployed via the:

- Integrated Place Executive (IPE) & Local Place Alliances,
- Provider Collaborative,
- Several cross-cutting work programmes.

b) Integrated Place Executive (IPE)

The Integrated Place Executive (IPE) coordinates the agreed decisions and actions from two Place Partnership Boards (City & County), who draw priorities from and influence priorities in:

- Integrated Care Strategy
- Joint Health & Well-being Board Strategies
- NHS Integrated Care Board plan
- Joint Forward Plan

The IPE deploys its strategy and receives updates on place-based activities and change initiatives via the eight Local Place Alliances.

c) Local Place Alliances

Our eight place alliances, which are our city and county footprints, are coterminous with our local authority boundaries, and within these, our smaller alliance of partnerships at a local level.

The provider organisations/teams represented within each of our local places are as follows:

- Adult Social Care
- Children's Social Care
- Community Care (NHS)
- Community Mental Health Care (NHS)
- General Practice (NHS)
- Primary Care Network(s) (NHS)
- Public Health
- Voluntary care services

The purpose of our local place alliances is to understand the emergent care needs of our local community and join up to coordinate their services to meet these needs.

Illustration: 01

d) Provider Collaboration

The JUCD Provider Collaborative provides a single forum for all providers of NHS services to work together and take collective responsibility for delivering priorities within the NHS, enabling vertical and horizontal integration at scale. The collaborative includes the following organisations:

- Chesterfield Royal Hospital NHS Foundation Trust (CRH)
- Derbyshire Community Health Services NHS Foundation Trust (DCHS)
- Derbyshire Healthcare NHS Foundation Trust (DHFT)
- DHU Healthcare (DHU)
- East Midlands Ambulance Service NHS Foundation Trust (EMAS)
- University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)
- GP practices - represented by the GP Provider Board

e) DDICB cross-cutting work programmes.

These programmes aim to bring together and deliver system-wide large-scale changes, supporting our front-line care delivery teams. The following image illustrates how we deploy or work.

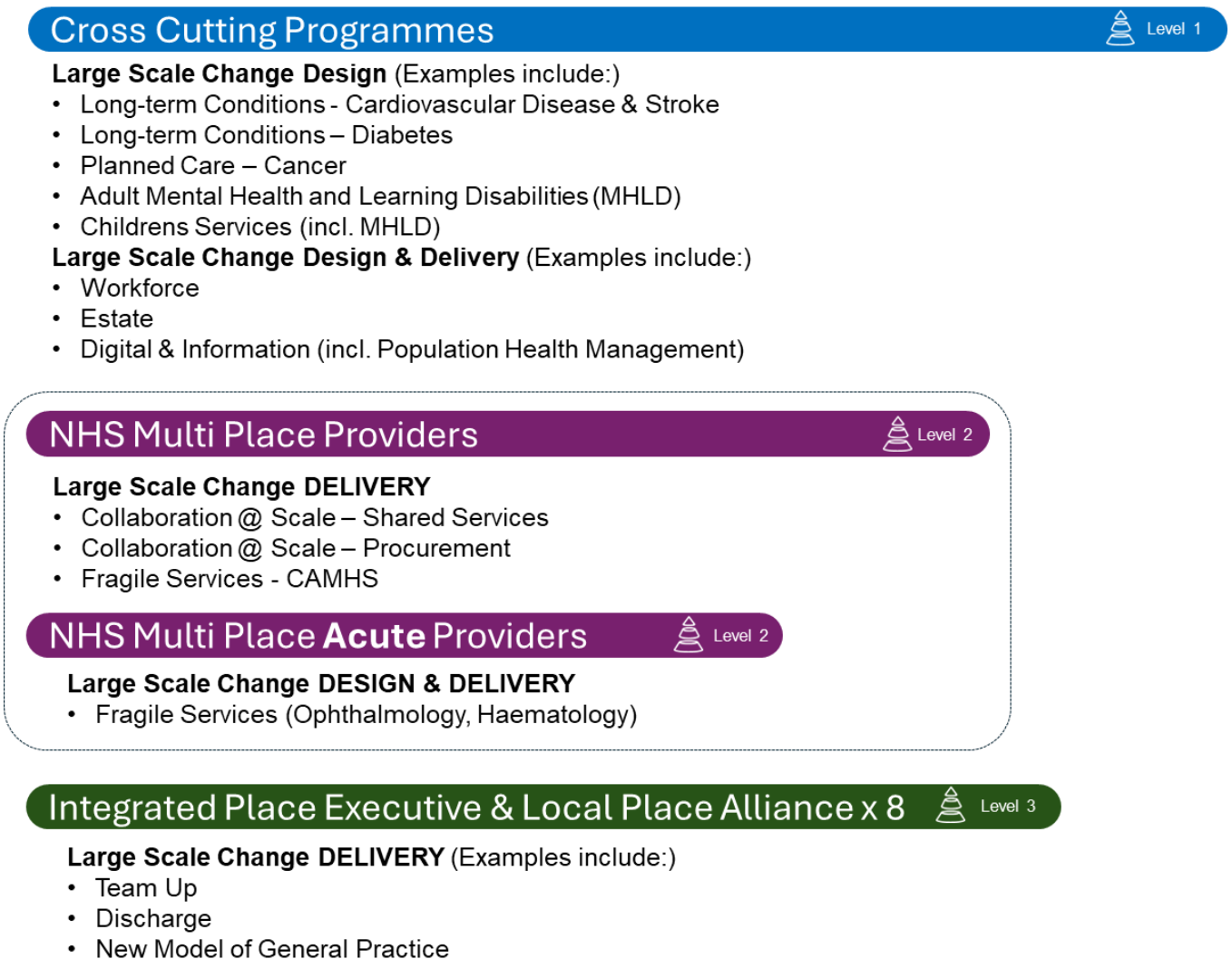

Illustration: 02

6. What we have learnt on our Emergent Journey

While we recognise there is much more to be done, we have improved the care we provide since the publication of the Joint Forward Plan in April 2023.

By working more closely together, we have better understood the services offered already, where gaps might be, what changes are needed to our models of care, how we spend the money entrusted to us, and our workforce. We want to become more preventative, integrated, personalised for the citizen, and be intelligence and information led.

This understanding, balanced alongside the commitments as described in the NHS long-term plan and progress on delivery of our five-year joint forward plan, has enabled us to challenge our assumptions about where we thought we were and recognise that some of our original goals and ways of working still need to evolve if we are to accelerate plans to deliver large-scale change.

While we have delivered real change, challenges emerge, and it is important that, as a system, we learn from these challenges and adapt as they will affect how we succeed in delivering our plan in the future. Critically, there are three areas of how we deliver large-scale change which require our immediate attention:

a) Our Approach to Large-Scale Change

The role of Derby and Derbyshire Integrated Care Board (DDICB) is to act as a steward on the delivery of large-scale change—to commission, coordinate, and provide assurance on delivery. We have a portfolio of large-scale, complex changes to deliver, and our current structure and processes mean we can't do that effectively. We don't have a common approach to change and change management. We have multiple work plans, and whilst they have oversight, we don't have a single view. We are using our existing operational governance frameworks to provide assurance of short-term immediate actions and medium to long-term, large-scale change; this is not working. The use of metrics to measure progress and impact is not consistent. Therefore, tracking progress and managing interdependencies is sub-optimal.

Whilst Programme Management Office (PMO) capability exists to support the collaboration at scale initiatives, we do not have this capability at a system level.

Therefore, we are setting up an integrated **Strategic Deployment and Portfolio Management Office** to align our system goals and change initiatives, engage and connect the stakeholders, support the development of the cases for change, measure the change, support the change, and prepare everybody to be the change. This office will provide a holistic view of all large-scale change progress across our geographical footprint. We will separate out the governance of our large-scale change but will actively manage the day-to-day operational management interdependencies. We will connect multidisciplinary teams, leveraging the ability of the tools, techniques, and methodologies from the professional practices of transformation and improvement, organisation development, programme

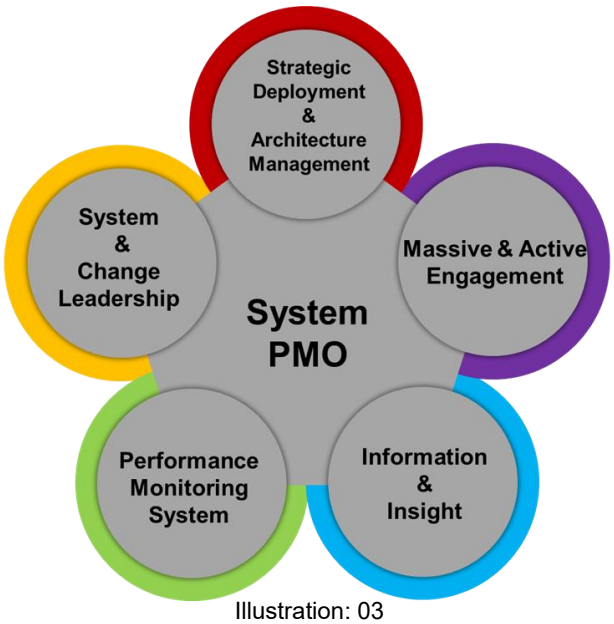

Illustration: 03

management, strategy & business planning, information & insight (incl. Finance) and communications to create a shared, collaborative and agile right-sized change function. The PMO will nurture a culture of collaboration, teamwork, and transparency to overcome inherent organisational and professional boundaries. It will facilitate the development of a sense of community and shared purpose and create communities by connecting the key people at all levels within the system.

The system PMO and the new large-scale change governance and assurance framework will enable us to carry out an independent review of our portfolio of complex programmes, identifying where we need to accelerate our plans, pause, or even stop initiatives that cannot demonstrate improved outcomes in quality, performance, and productivity. This will also enable us to map our existing change capability and where it is deployed.

b) Strategic Commissioning

Care is delivered along horizontal pathways that transcend different clinical and service intervention domains, often provided by multiple horizontal sovereign providers. An ideal intervention at the right time and place can, for example, stop hospital admission. The design and development work of our Integrated Partnership Executive and Local Place Alliances now means that horizontal independent community and primary care providers are working together and coordinating their services to prevent unwarranted hospital admissions.

To understand how this capability and our acute care need to evolve, we must start looking horizontally across our major condition pathways and understand how they need to change. This will inform our medium—to long-term workforce plan, as we will understand the skills and capacity required to deliver the emergent future models of care. These models can then be commissioned. The domains of prevent, detect, protect, treat & perfect can be used as a design guide to develop new models of care at the right stage in the patient's journey. The principles of the domains can be applied to any clinical specialities, as illustrated below:

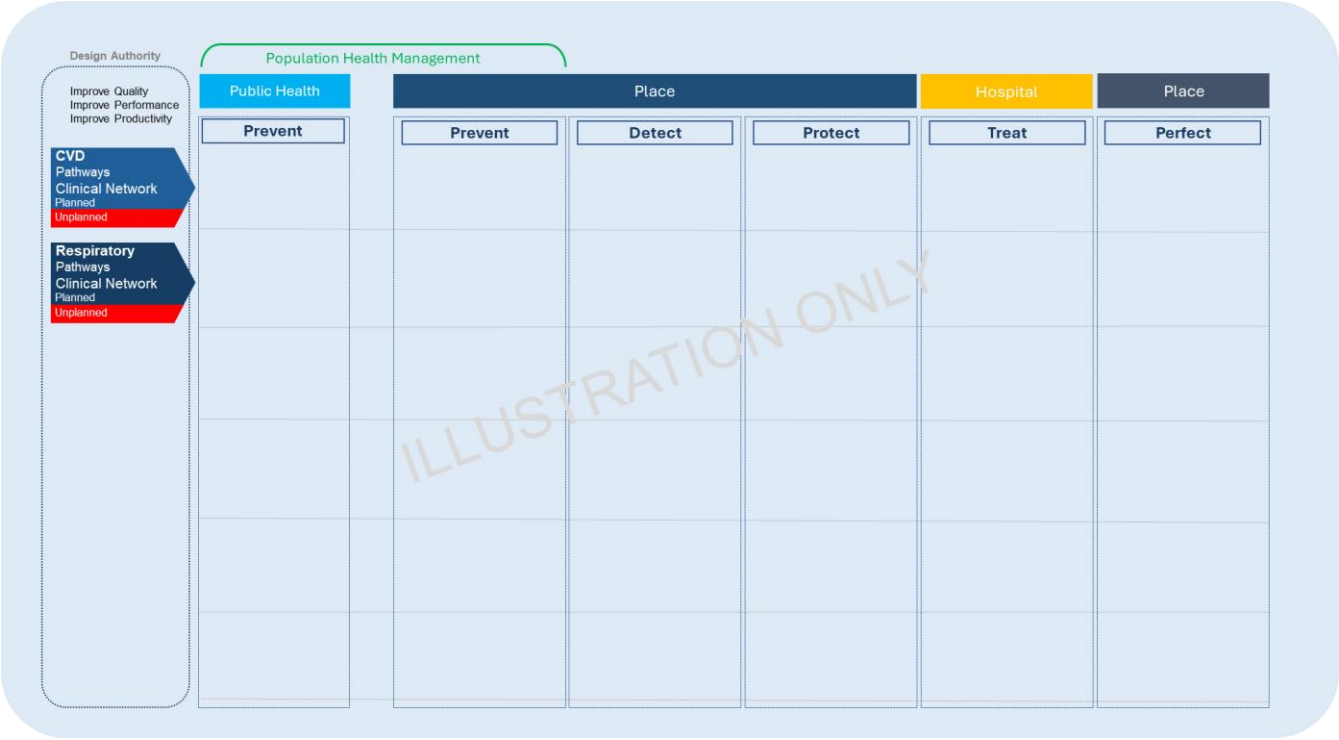

Illustration: 04

In the transition from CCG (Clinical Commissioning Groups) to ICB, it was widely accepted that the DDICB's commissioning function needed to transition from the tactical level of commissioning (based principally on care pathway development and inter-provider/organisational facilitation) to a strategic level (based principally on understanding the population's health and health needs and commissioning in line with these needs).

We are clear that the ICB is not yet fully fulfilling this role and remains in a transition period; next year will see a further evolution towards this. However, with finite resources, this shift is constrained by all elements of the system being able to fulfil their new duties (such as provider collaboration at Place and at Scale (see later)) and the operational position of the health and care system.

Image 04 is an illustration only; we will look to design and deploy a framework for Derbyshire Derby.

c) Integrated Place Executive and our Place Alliances

i) Integrated Place Executive

We cannot lose the momentum we have built in our local place alliances, the cornerstone of population health improvement. For this reason, we will enhance the connectivity between the Integrated Care Partnership (ICP) and the Integrated Care Board (ICB), with an Executive Member of the ICB joining the Integrated Place Executive (IPE). We will also strengthen the connection between the IPE and our Local Place Alliances regarding process and information flow. The differential operating frameworks within our Local Place Alliances are barriers to integrated care. We will work together to bring consistency to those frameworks.

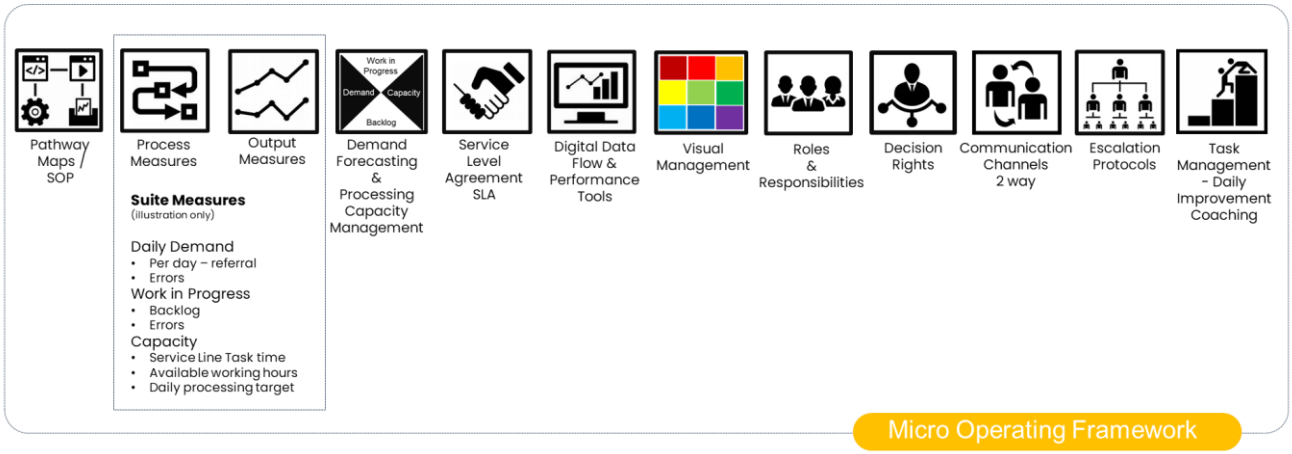

Illustration: 05

Primary and Community Care is the “cornerstone” of our contribution to improving population health, and we have developed prevention and integration improvement strategies for both. Our goal is to enhance the interface between primary and community care. Therefore, the delivery of our Primary Care Improvement strategy will come under the umbrella of the Community Care Improvement programme. We believe all these actions will enhance how the teams in each locality determine the best ways to deliver improvements in health and care delivery for local people.

ii) Collaboration at Scale

We recognise the collaboration at scale work delivered by our provider colleagues, especially around fragile services (e.g., Ophthalmology and Haematology) and procurement. We are aware that large-scale change that cuts across our Local Place Alliance and hospital providers brings added complexity, especially in terms of interdependency management, and therefore, as an ICB, we are seeking to bring a greater level of transparency to this work and, in turn, help our provider colleagues to bring further momentum to discovering the opportunity for greater collaboration.

In addition to the three areas of how we deliver large-scale change, we recognise that it can be difficult for our teams to find the line of sight from their contribution to our goals as an organisation.

d) Strategic Deployment – Line of Sight

Even the NHS family of organisations within Joined Up Care Derby has developed various goals, aims, objectives, and priorities. This is partly because we are a partnership of sovereign organisations and because of the multiple drivers for improvement and change that our regulatory frameworks require us to deliver. These frameworks are not all yet aligned.

All our teams must see how their contribution relates to our shared purpose and long-term goals. The more complicated we make this, the less relatable it becomes. People can struggle to make sense of their work and contribution, so their connection to the organisation is lessened.

We will work with our partners over the summer to simplify our various goals, aims & objectives.

However, we cannot lose the various priorities, associate targets, and measures we are asked to deliver. Our new Strategic Deployment and Portfolio Management Office will map, monitor, and maintain a register with our Informatics and Corporate Affairs Teams.

We will also look to integrate these goals, aims, objectives, and priorities into our decision-making and strategic commissioning service design frameworks (see image 06 for an illustration). We mustn't default to creating new and often siloed change initiatives for every new priority; design principles and decision frameworks can depend upon the ask, be just as effective, and be powerful tools for mainstreaming and sustaining change. The team leading our green and sustainability agenda is developing a Net Zero / Green Quality.

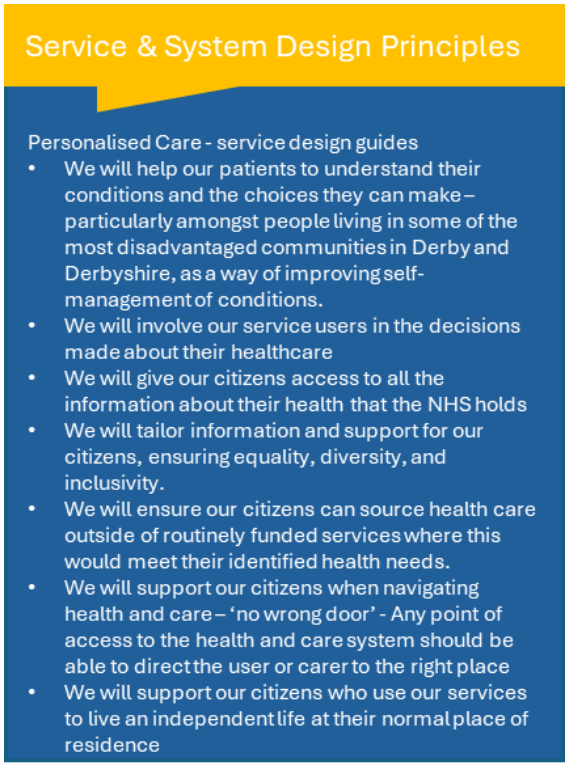

Illustration: 06

7. Next steps

Our collective focus over the next three months and beyond is to enhance our functionality to deliver large-scale change and strategic commissioning. We aim to accelerate our plans while ensuring we don't lose momentum on the progress we have made. Our work plan, coorindated by ICB, is as follows:

1. Setting up an integrated Strategic Deployment and Portfolio Management Office to align our system goals and change initiatives.
2. Transition to a new large-scale change governance and assurance framework, which may result in existing projects and programmes being absorbed into others.
3. The Strategic Deployment and Portfolio Management Office will conduct a deep-dive review of our portfolio of complex programmes, identifying where we need to accelerate our plans, pause, or recommend the stopping of initiatives that cannot demonstrate improved outcomes in quality, performance, and productivity.
4. Map our existing change capability and where it is deployed.
5. Continue our evolution towards being a strategic commissioner.
6. Enhance the connectivity between the Integrated Care Partnership (ICP) and the Integrated Care Board (ICB) and more directly with the Integrated Place Executive (IPE).
7. Strengthen the connection between the IPE and our Local Place Alliances regarding process and information flow.
8. Co-design harmonising the differential operating frameworks within our Local Place Alliances.
9. The delivery of our Primary Care Improvement strategy will be part of the Community Care Improvement programme.
10. Bring greater transparency and momentum to the programmes and projects that constitute Collaboration at Scale.
11. We will work with our partners over the summer to simplify our various goals, aims & objectives.
12. Our new Strategic Deployment and Portfolio Management Office and our Informatics and Corporate Affairs Teams will map, monitor, and maintain a register of priorities, associate targets, and measures.
13. Integrate goals, aims, objectives, and priorities into our decision-making and strategic commissioning service design frameworks.

Our Work Plans

Progress on Delivery

8. Our Work Plans - Progress on Delivery

This section of the document summarises the delivery work plan of the Joint Forward Plan. It is divided into 16 sections reflecting the following themes:

1. Prevention
2. Health Inequalities
3. Primary Care Programme
4. Community Transformation Programme
5. Urgent and Emergency Improvement Programme
6. Long-term conditions
7. Planned Care
8. Children's & Young Peoples Services
9. Adult Mental Health and Learning Disabilities
10. Fragile Services (Collaboration at scale) (C@S)
11. Estate Programme (Collaboration at scale) (C@S)
12. Procurement Programme (Collaboration at scale) (C@S)
13. Shared Services (Collaboration at scale) (C@S)
14. Integrated Pharmacy & Medicines Optimisation (IPMO)
15. Workforce
16. Digital
17. Population Health Management
18. Green Agenda & Net Zero
19. Estates
20. ICB

The themes are represented via a simple table; for the purposes of this report, the change initiatives are categorised as projects. The project's purpose, 2023-24 summary of the impact to date and 2024-25 forecast impact are described. If the cluster of projects forms a programme, then this is described. A summary of the national and/or local drivers for change is described. For the purposes of this document, we have limited this list to three. Where a cell is light grey, the designates that no further explanatory information is available or required at publication.

Productivity
The project title box's light blue background indicates where a project or theme contributes to or has been designated as driving productivity improvements.

Prevention			Driving our work	
			• Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • Prevention and health inequalities - Achieve 80% of those with hypertension to be treated by March 2025.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
1	Tobacco Dependency Treatment Services (Prevention)	Patients who are admitted to the acute providers, mental health units and maternity patients and their partners are offered NHS-funded tobacco treatment services.	• Services are running at UHDB, CRH and DHFT for maternity and mental health inpatients. A total of 3400 inpatient and MH patients, as well as 590 maternity patients, accessed the programme on 23/24.	• Increase access to services for maternity and mental health patients.
2	Cardiovascular disease (CVD) prevention plan	To identify and optimise treatment for undiagnosed hypertension, Arterial Fibrillation (AF) and Elevated Cholesterol in adults living in most deprived areas through a Place-based model of delivery.	• Designed a five-year phased CVD prevention plan.	• Awaiting decision as part of the 24/25 planning round related to the funding allocation to support delivery.
3	Obesity Digital Weight Management	To provide targeted support and access to weight management services for people living with obesity plus either diabetes, hypertension, or both.	• On 23/24, 44% of 112 General Practices referred to the programme. 378 eligible referrals have been made against a target of 1000 per annum (38%). Derbyshire is an outlier. A refreshed communications plan was implemented to include targeted practices not referred to.	• The target for Derby and Derbyshire ICB is 750 eligible referrals. The national target is to reach at least 90% eligible referral rate.

Health Inequalities

The Five (plus) Priorities for Healthcare Inequality Improvements

#	Driving our Work	2024-25 Summary of Progress
4	Restoring NHS services inclusively: Performance reports will be broken down by patient ethnicity and IMD quintile, focusing on unwarranted variation in referral rates and waiting lists for assessment, diagnostic and treatment pathways, immunisation, screening, and late cancer presentations.	• Our portfolio of providers is in various stages of discovery, design and delivery of changes to data collection, data monitoring, and performance reporting to inform action.
5	Mitigating against 'digital exclusion': ensuring providers offer face-to-face care to patients who cannot use remote services and complete data collection to identify who is accessing face-to-face/telephone/video consultations is broken down by patient age, ethnicity, IMD, disability status, etc.	• Our goal will be to introduce these requirements into our decision-making and strategic commissioning, large-scale change and service design frameworks.
6	Ensuring datasets are complete and timely: Continue to improve data collection on ethnicity across primary care/outpatients/A&E/mental health/community services, specialised commissioning and secondary care Waiting List Minimum Dataset (WLMDS).	• Our portfolio of providers is in various stages of discovery, design and delivery of changes to data collection, data monitoring, and performance reporting to inform action.
7	Accelerating preventative programmes: • Covering flu. • Covid-19 vaccinations. • Annual health checks for people with severe mental illness (SMI) and people with a learning disability. • Supporting the midwifery continuity of maternity carers targeting long-term condition diagnosis and management.	• No update was available at the point of publication. • No update was available at the point of publication. • SMI – please refer to section – Adult Mental Health & Learning Disabilities. • Our providers have plans to focus care on those most in need of continuity of carer in 24/25 and develop teams to support those in place to provide enhanced care in identified areas of deprivation.
8	Strengthening leadership and accountability: Supporting PCN, ICS, and Provider health inequalities SROs in accessing training and a wider support offer. • Increase the capacity and capability of the workforce to understand their role in reducing healthcare and wider inequalities. • Ensure that governance, accountability, and assurance mechanisms facilitate a clear focus on reducing health inequalities.	We have established a Prevention & Health Equalities board. • We have trained 8 Core Plus 2- Ambassadors. • Our goal will be to introduce these requirements into our decision-making and strategic commissioning, large-scale change and service design frameworks.
9	Inclusive recovery plans are in place to implement the inclusion health framework.	• No update was available at the point of publication.
10	Ensuring all A&E departments have access to an intense user service.	• Please refer to the Urgent and Emergency Improvement Programme.

Primary Care Programme			Driving our work	
A new Primary Care Model and delivery strategy will facilitate (1) streamlining access to care, (2) providing more personalised, proactive care, and (3) ensuring a far more ambitious and joined-up approach to prevention.			• Support primary care practices to ensure appointments within 2 weeks and urgent assessment the same or the next day. • Improve access to NHS dental services. • Ensure the ongoing sustainability and integration of other Primary Care Providers (Pharmacy, Optometrists and Dentists).	
#	**Projects**	**Purpose**	**2023-24 Impact to date**	**2024-25 Forecast Impact**
11	Strategy Development	Development of a new Primary Care Model and delivery strategy.	• The GP Provider Board set out its clinical model for General Practice, incorporating the GP response to Fuller, which was signed off by the ICB board. • GP estates strategy implementation continued. • PCNs continue to recruit additional roles. • The PCN development programme is ongoing and supported by the GP Provider Board. Place team overseeing the development of integrated neighbourhood teams – supporting Team up.	• Clear approach and plan for implementing the model. • Stratified population enabling tailored services to meet population needs, improve patient experience and maximise value for money. • Consistent approach to digital triage across primary care. • PCNs and Local Place Alliances begin implementing changes to the primary/ community care model on a local place alliance footprint.
12	Population stratification	Use population stratification tools to identify cohorts of patients and then tailor GP services for those cohorts at scale.		
13	Digital triage	Triage and direct patients to the appropriate cohort using a consistent and nationally recognised triage tool to get the right services.		
14		Work with PCNs/ Local Place Alliances to reorganise how General Practice works around cohorts of patients.		
15	PCN development in line with national priorities	Commission the PCN Directed Enhanced Services and develop Primary Care Networks. (Commissioning)	• Access to General Practice improved. • Primary Care Access Recovery Plan delivered. • PCN Directed Enhanced Services provided. • PCN development to mature, integrated system partners.	• ARRS roles are in place; PCNs are delivering directed enhanced services (enhanced access, care home support, etc.); PCNs are maturing and integrating. • Year 1 targets completed. Plan on target. •
16	Improved GP access through the delivery of the Primary Care Access Recovery Plan	Deliver the national Primary Care Access Recovery Plan to improve GP access.\ (Commissioning plan)		
17	Delivery of Dental Recovery Plan	Improve access to NHS dentistry and deliver the national dental recovery plan. (Commissioning plan)	• Commenced national dental recovery plan delivery and developed additional local dental plans to improve access.	• Delivery of year 1 of the national dental recovery plan and local work to improve dental access.
18	Pharmacy, Optometry and Dental (POD) Commissioning	Commission PODS to integrate and expand their role and ensure their sustainability (Commissioning plan)	• ICB has commissioning responsibility for pharmacy, optometry, and dental (POD) contractors, has established appropriate governance and oversight, and has launched Pharmacy First.	• POD commissioning plans in development.

Community Transformation Programme			Driving our work	
A comprehensive system diagnostic undertaken in 2023 identified three priority areas for system transformation and sustainability: • Home-based pathways • Complex discharges and bedded care • Population health management			• National requirements of Urgent Community Response - providing urgent care to people in their homes, helping avoid admission and enabling people to live independently for longer. • National mandate of Enhanced Health in Care Homes programme - aiming to improve care for Care Home residents. • Supporting more proactive, personalised care from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions. [Fuller Stocktake Report – 2022].	
#	**Projects**	**Purpose**	**2023-24 Impact to date**	**2024-25 Forecast Impact**
19	Team Up	To build and integrate multi-disciplinary neighbourhood teams to better support those with frailty and complexity in the place they call home. Delivered via the following workstreams: • Urgent community response • Home Visiting • Enhanced health in care homes • Navigating our system of care • Enhanced fall response at home • Improving management of falls in care homes	• 12 locally led integrated teams delivering 5000+ home visiting appointments a month. • Over 86% of GP practices reported freed-up GP appointments. • 70% of urgent community response referrals were responded to within 2 hours, with only 2% of patients going onto more advanced urgent care settings. • Slower growth in A&E attendances and non-elective admissions for over 65's with frailty compared to growth in these age categories. • A step change in how the ICB benchmarks nationally for A&E attendance for 65 years +, which coincides with the launch of this programme.	• Reduction of 900 A&E attends for those with moderate/severe frailty. • Reduction of non-elective admissions NELs for those with moderate/severe frailty.
20	Care Transfer Hub	The hub triages strength-based referrals, asking, 'Why not home? Why not today?' prescribes and sources the most appropriate pathway for citizens, with full oversight of system capacity, demand and delays.	• 15% reduction in number of people in P1 delay (patients with 7+ days LOS). • County relaunch of re-enablement service with increased capacity started in Jan 2024	• Care transfer hub to be developed with the potential to save between 336- 346 bed days per month. • Potential to save 333-660 bed days per month from 1–2-day reduction in P1 delay • Review of the P2/3 bedded offer has the potential to save 512 bed days per month through a 2-day reduction in P2 sourcing. • Dementia palliative care service will support 54 patients per month – earlier discharge from acute care.
21	Pathway 1 redesign	A multidisciplinary team is responsible for all Derbyshire Pathway 1-3 referrals, including step-up, step-down, and out-of-area referrals. Improve the hospital discharge arrangements across JUCD for individuals who cannot immediately return to the place they call home and who will benefit from accessing Pathway 2 or 3.		
22	Pathway 2 redesign			
23	Discharge database	To provide system-level oversight of capacity, demand and flow and support operational decision-making with real-time data.		

Urgent and Emergency Improvement Programme			Driving our work	
			• Urgent and emergency care - Improve A&E wait times with a minimum of 78% of patients seen within 4 hours in March 2025. • Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25. • Reduce High-Intensity Users (where safe and appropriate).	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
24	Central Navigation Hub	To design, implement and deliver an SPoA ICC to improve care navigation. Simplify and make consistent internal care navigation so that staff can deliver the right care the first time.	• 22,488 patients (83.9%) found appropriate alternative pathways to A&E. Including an increase in Hear, Treat and Discharge to over 13%, 10% received care through community services including UCR, 9% seen by primary care, 58% booked into or referred to UTCs. • CAT3&4 Telephone ambulance deflection has significantly increased to 73%, and CAT3 & 4 online has increased to more than 94% deflected from 999/111 to alternative pathways. • More than 1000 patients per month consistently continue to be found alternative pathways than conveyance to A&E across Derby and Derbyshire.	• An additional 5,935 patients deflected from conveyance and Emergency Department attendance compared to 2023-24.
25	Urgent Treatment Centre (UTC) Model Review	To review and implement change to the Derby and Derbyshire Community UTC model in the context of same-day urgent care offers to prevent inappropriate attendances at ED and see, hear and treat patients closer to home.	• Across the system, Community UTCs combined have seen an average of 11,455 patients per month or 373 per day. All sites remain above the 85% waiting target set for A&Es.	• Increase in patients attending all UTC settings - impact of new integrated UTC model yet to be modelled.
26	Virtual Ward	To implement change to maximise the capacity of virtual wards to support both step-up and step-down care and provide care in a home setting.	• Virtual Ward onboarded over 1,000 patients onto the digital platform. Successfully monitored 10,000 active patient days using the DOCCLA platform. CRH Cardiology increased daily capacity to 15 beds per day • April – monthly average 64 patients (40%), highest day 81 patients (51%).	• Work continues increasing utilisation
27	High-Intensity Users	Discover high-intensity users' demand patterns and capacity impact on our care system. To co-design the right care for the first time to reduce touchpoints and admissions where safe and appropriate.		• Discovery work commenced.

Long-term Conditions – cardiovascular disease (1)			Driving our work	
			• Prevention and health inequalities - Achieve 80% of those with hypertension to be treated by March 2025. • The percentage of patients aged 18 or over with GP recorded hypertension who had a blood pressure reading in the preceding 12 months – Derby and Derbyshire at 87.86, above the national average.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
28	Cardiovascular disease (CVD) prevention plan	To identify and optimise treatment for undiagnosed hypertension, Arterial Fibrillation (AF) and Elevated Cholesterol in adults living in most deprived areas through a Place-based model of delivery.	• Designed a five-year phased CVD prevention plan.	• Awaiting decision as part of the 24/25 planning round related to the funding allocation to support delivery.
29	Stroke Rehabilitation Services review (Fragile Service)	Review of Stroke Rehabilitation services to develop a service model to comply with the National Integrated Community Stroke Specification model.	• Stroke service benchmarked against the NHSE Integrated Community Stroke Service specification has been undertaken to identify gaps in provision	• Completed Case for Change to identify key challenges and public/patient engagement to commence in the summer of 2024.
30	Stroke - Critical Service Review (HASU) (Fragile Service)	Medical workforce recruitment and retainment risk impacts the sustainability of hyperacute and Acute Stroke Units across the region. A service review and options appraisal across Derbyshire, Nottinghamshire and South Yorkshire has been approved to identify cross-border service improvements.	• Identified key workforce risks across all trusts in the Critical Service Review.	• Derbyshire trusts to agree on workforce and recruitment strategy in partnership with tertiary centres.

Long-term Conditions – respiratory disease (2)			Driving our work	
			• Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • NHS Major Conditions Strategy.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
31	Respiratory Pathway Review	Variance in services across the county leads to health inequalities. Utilising an evidence-based approach, deliver a gap analysis to understand pathway improvement opportunities.	• Service review of UHDB Impact+ Specialist Community Respiratory service. Agreed on a new contract, KPIS, and implementation of service improvements in targeted areas (Smoking Cessation, Emergency Department case finding).	• Awaiting approval to commence countywide service review.

Long-term Conditions – diabetes (3)			Driving our work	
			• Reduce health inequalities and improve outcomes for young people with early onset type 2 Diabetes. • Improve patient care and reduce hospital admissions and length of stays.	
#	Projects	Purpose	2023-24 Summary of impact to date	2024-25 Progress & Impact
32	T2Day	Type 2 Diabetes in the Young programme – an initiative for people with Early Onset Type 2 Diabetes. An incentive scheme in General Practice to improve outcomes for people with Early Onset Diabetes (18-39) and reduce health inequalities downstream activity and healthcare costs. To increase 8 care process delivery.	• 71 practices signed up, and 63% increased the number of people receiving 8 Care process reviews within the 18 - 39 age group.	• If funding is agreed upon, expect an increase in the baseline of 8 care processes compared to 23/24.
33	Diabetes-Specific Health Psychology Pilot	Establish a system-wide clinical lead role to develop and deliver psychological interventions for people living with diabetes to improve patient care and reduce hospital admissions and length of stay. The service will also upskill clinicians at all levels, including NHS Talking Therapies, to better support category 1 - 3 patients. To develop a diabetes-specific pathway with NHS Talking Therapies to enable patients to access higher-level psychological services.	• Pathway design completed and recruitment undertaken.	• Reduce non-elective admissions by 10%. • Reduce LoS by 10% • Improved quality of life for 70% of patients. • Improved treatment and medication compliance by 80% • (patients seen by service) • 8 NHS Talking Therapies practitioners upskilled (2 per organisation).
34	Continuous Glucose Monitoring	• To give CGM access to patients with type 1 Diabetes who are not accessing secondary care. • To give CGM access to patients with type 2 Diabetes in line with NICE Guidance	• Business case created and approved.	• Quantitative forecast impact – ongoing development.

Long-term Conditions – Long Covid			Driving our work
			• Prevention & LTC Bundling 2024/25
#	Projects	Purpose	2024-25 Progress & Impact
	CVD-R – Long Covid	• Children and young people service funding into targeted SDF bundle. • Adult Service Funding into the core baseline.	• The service was reviewed on 23/24 and included an option appraisal process and public engagement. The review recommended continuing the service into 24/25 in line with national guidance but with the reduced resources (staffing and funding) aligned to current demand.

Planned Care (1)			**Driving our work**	
			• Eliminate 65-week waits by September 2024 at the latest. • Cancer - Improve performance against 28-day Faster Diagnosis Standards to 77% by March 2025. • Cancer - Increase stage 1 and 2 cancer diagnosis to achieve 75% early diagnosis ambition by 2028.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
35	Elective Care Community productivity	Increase efficiency of pathways into acute trusts.		• Further referral optimisation schemes, e.g. tele, dermatology, advice and guidance, offer the potential to reduce referrals to secondary care –reducing reliance on insourcing/outsourcing to manage waiting times. • Better patient experience / reduced waits.
36	Elective Care Cancer Primary Care Pathways	Increase efficiency of pathways into acute trusts • LGI Pathway. • Headache Pathway. • Non-Site-Specific Pathway (NSS). • Gyna DA Ultrasound.	• FIT pathway agreed 2023. Partially in place at UHDB (with LGI triage). • Headache/Brain MRI pathway clinically agreed. • NSS pathway in place across DDICB practices. • DA TV Pathway in place. Monitoring to confirm impact and further opportunities.	• Information was not available at the point of publication. • Pathway agreed. • Roll out across Joined up Care Derby. Limited uptake. • Pathway implemented.
37	Elective Care Outpatients Optimisation	Acute internal outpatient workstreams are connected to internal 24/25 planning. To increase productivity via A&G, RAS/CAS, Virtual consultation, PIFU, and VWA.		• Plan to bring under revised governance structure to include ICB oversight of system opportunities and GIRFT/FF Agenda. • Provider impact not currently quantified.

Planned Care (2)			**Driving our work**	
			• Eliminate 65-week waits by September 2024 at the latest. • Cancer – Increase stage 1 and 2 cancer diagnosis to achieve 75% early diagnosis ambition by 2028. • Cancer - Improve performance against 28-day Faster Diagnosis Standards to 77% by March 2025.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
38	Elective Care Optimise theatres/estate	Maximise Acute theatre capacity across our hospital providers (Delivered via Acute Provider Productivity programmes).	• Theatre utilisation improved CRH by 78% and UHDB by 82% • High volume, low complexity Ophthalmology lists in place at both acute sites • Largely provider-led work to maximise productivity and value. Some opportunities for shared work HVLC and day care facilities.	• Expected efficiency is already included in provider planning assumptions • Potential to increase VWA, ERF income and RTT delivery, workforce productivity • Supports provider CIPs and ERF income, supports elective recovery.
39	Elective Care Ophthalmology	Maximise community capacity.	• Implementation of Ophthalmology triage service across Derbyshire demonstrated that 42% of referrals could be avoided.	• Ophthalmology plan refresh to address IS choice/contractual sustainability. • Impact data was not available at the point of publication.
40	Elective Care Cancer Faster Diagnosis	Increase efficiency of pathways into acute trusts to expedite diagnosis/ruling out of cancer through faster diagnosis.	• Pathways implemented both trusts.	• Full implementation has a greater impact on performance.
41	Elective Care Cancer Prostate Case Finding	Increase efficiency of pathways into acute trusts to expedite diagnosis/ruling out of cancer through early Diagnosis: Prostate Case Finding Pilot.	• Prostate Case Finding Pilot has engaged up to 1000 men – evaluation complete.	• Evaluation impact was not available at the point of publication.
42	Elective Care Cancer prevention/case finding	Increase efficiency of pathways into acute trusts to expedite diagnosis/ruling out cancer through early Diagnosis: prevention/case finding.	• Early Diagnosis opportunities recommended by the cancer alliance with the system lead to agreeing on targeted opportunities for 2024/20255.	• To be scoped - the impact of early diagnosis on primary/community care pressures.
43	Elective Care Cancer Tele dermatology	Increase efficiency of pathways into acute trusts to expedite diagnosis/ruling out of cancer through Tele dermatology.	• Skin: The region has mandated the implementation of teledermatology. Options appraisal is underway for a system approach to managing skin cancer activity.	• To be scoped - the impact of early diagnosis on primary/community care pressures.

Planned Care (3)			**Driving our work**	
			• Cancer - Improve performance against 28-day Faster Diagnosis Standards to 77% by March 2025. • Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • Increase the proportion of diagnostic tests within 6 weeks to 95% by March 2025. • Eliminate 65-week waits by September 2024 at the latest.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
44	Elective Care Cancer – Lung Health Check	Increase the efficiency of pathways into acute trusts to expedite the diagnosis/ruling out of cancer through Targeted Lung Health Check (TLHC).	• TLHC: a mandate from the region to implement targeted health lung checks- recruitment delays to develop JUCD infrastructure to develop implementation plan/options appraisal.	• Opportunities being scoped.
45	Cancer Alliance Personalised care Prehabilitation	Prehabilitation is a way to prepare the patient's body and mind for surgery, chemotherapy, or other cancer treatments. It involves a structured program that includes exercise, eating well, psychological or emotional support, and other helpful activities.	• Discovery Phase: pending regional sign-off on cancer prehab model and development of business case to pilot in systems.	• Information was not available at the point of publication.
46	Elective Care Diagnostics	Improve access to diagnostics/ maximise care in the community.	• Diagnostic performance complies with the operational plan targets for diagnostic tests within 6 weeks.	• Evaluation impact was not available at the point of publication. • The initiative will be reviewed post-impact evaluation. • Impact of CDC and link to UEC and Planned care pathway improvement. • Supports referral optimisation initiatives. • Potential for lower-cost pathways, although not CRE in the first instance.
47	Elective Care Community Diagnostic Centre	Improve access to diagnostics/ maximise care in the community.	• Diagnostic performance complies with the operational plan targets for diagnostic tests within 6 weeks.	• Implementation of CDC ongoing. • Impact of CDC and link to UEC and Planned care pathway improvement. • Supports referral optimisation initiatives • Potential for lower-cost pathways, although not CRE in the first instance.

Planned Care (4)			**Driving our work**	
			• Cancer - Improve performance against 28-day Faster Diagnosis Standards to 77% by March 2025. • Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • Increase the proportion of diagnostic tests within 6 weeks to 95% by March 2025. • Eliminate 65-week waits by September 2024 at the latest.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
48	Elective Care Musculoskeletal – Clinical Assessment & Triage Service	The Musculoskeletal – Clinical Assessment & Triage Service (CATS) is in place, diverting activity from the acute setting, improving patient experience/outcome and reducing clinical variation.	• Service implemented.	• Evaluation impact was not available at the point of publication.

Children's & Young Peoples Services (1)			Driving our work	
			• Increase the number of children reaching a good level of development at the end of reception. (Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach). • Increase the no. of children at 99.6th centile receiving support to manage their weight (Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach). • Reduce family breakdowns and the number of Care Home Placements a CYP has through support to the CYP and staff closest to them.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
49	Early Years (Start Well)	The goal is to improve outcomes and reduce inequalities in children's health, social, emotional, and physical development in the early years (0-5) through school readiness. The initial focus is on SEND and speech-language and communication needs.	• System Agreement to the new model.	• Information was not available at the point of publication.
50	Long Term conditions – pathway(s) re-design	Delivery of transformation of children and young adult's pathways for Long Term Conditions: • Asthma • Obesity • Diabetes • Epilepsy	• Public health-led schemes to support communication and education put in place.	• Further proposals in development. Information was not available at the point of publication.
51	Cancer End of Life	The original plans for investing in Palliative Care and end-of-life match funding received from NHS England for Children and Young People were revised to ensure a greater range of options for families of children and young people entering end-of-life.		• Proposals in development. Information was not available at the point of publication.

Children's & Young Peoples Services (2)			Driving our work	
			• Improve access to diagnostic services and reduce waiting times for Neurodiversity / LD & Autistic Spectrum Conditions. • Reduce the MH emergency admission rate per 100,000 persons with a diagnostic code that includes Autistic spectrum conditions or learning disabilities. • Reduce the proportion of people who are receiving care in a hospital whose care and support needs can be met in the community for those with Neurodiversity / LD & Autistic Spectrum Conditions.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
52	Neurodevelopment Autism in Schools	Autism in Schools - An NHSE-led initiative to support inclusion and access for CYP with Autism in Schools, focusing on transitions from primary to secondary schools.		• Proposals in development. Information was not available at the point of publication.
53	Neurodevelopment Children & Young people's Key working	CYP Key working - An NHSE-led initiative to ensure every CYP with Autism and or a Learning Disability has a key worker to support them		• Proposals in development. Information was not available at the point of publication.
54	Emotionally based school absence project	An NHSE-led initiative to ensure CYP who are not attending school due to emotional needs are supported back into school, an integrated education and health initiative.		• Proposals in development. Information was not available at the point of publication.
55	Neurodevelopment Assessment Community Hubs	Neurodevelopment Assessment Transformation initiative and Wrap Around ND Community Hubs to transform pathways to ensure they are as efficient and effective as possible.		• Proposals in development. Information was not available at the point of publication.

Children's & Young Peoples Services (3)			Driving our work	
			• Increase the proportion of people who receive a response from healthcare professionals when in a mental health emergency. • Increase the proportion of people with a mental illness who have access to early interventions. • Increase the proportion of children and young people waiting 4 weeks or less to start receiving help from community mental health services.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
56	Mental Health Crisis Mental Health Eating Disorders	Deliver the Derby & Derbyshire JUCD priorities identified from the LTP whereby all CYP experiencing MH crisis can access crisis assessment 24/7 and intensive support for seven days. • To improve the outcomes for children with mental health urgent care needs and improve the system's efficiency in delivering these. • We aim to build support around the child and maintain key relationships and positive networks. • Wherever possible, our children and young people should not be moving to placements/hospitals due to lack of support. • To stem escalation and respond by supporting all Derbyshire CYP at the earliest opportunity. • Deliver the Derby & Derbyshire JUCD priorities identified from the LTP for Eating Disorders, whereby access to family therapy is improved.		• Proposals in development. Information was not available at the point of publication.
57	Mental Health Community	To deliver the CYP Transformation to ensure they receive timely and appropriate care to meet their emotional and mental health needs: • Reduce health inequalities with an emphasis on boys / young men and our black and ethnic minority populations. • Improve outcomes for CYP. • Improve participation and co-production. • Improve our response to young adults. • Continue to improve our early Intervention and Targeted Support offer and Expand Mental Health Support Teams in Schools. • Continue to support children in care.		• Proposals in development. Information was not available at the point of publication.

Adult Mental Health & Learning Disabilities (1)			Driving our work	
			• Eliminating inappropriate out-of-area placements. • Increase access to transformed models of the adult community and perinatal and children's and young people's mental health.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
58	Adult- Inpatients	• To improve the quality of Mental Health inpatient services, eliminating inappropriate out-of-area placements. • To improve the quality of Mental Health inpatient services and reduce the use of inpatient high-dependency rehabilitation services (locked Rehab). • To redevelop our estate to enable the elimination of out-of-area and reduce locked rehabilitation – sites: Kingsway Hospital in Derby (PICU), 34 Bedded Female Acute MH Unit (Radbourne Derby), 12 bedded relocations of Older Adult MH Unit (Walton Hospital) & 8 Bedded Female Enhanced Care MH Unit (Audrey House Kingsway Hospital Derby).	• Capital monies secured. Building works were initiated. • Co-production of clinical strategy. • A review of community support offers to enable individuals to receive the care required in their own homes.	• Building works are to be completed, and new wards will be mobilised.
59	Adult Community-Urgent Care Services	To improve access to and timeliness of urgent specialist MH community support via MH Helpline & crisis services to: • Increase urgent access to specialist advice and guidance • Increase in urgent access to specialist MH support for people in Crisis	• Operational policies reviewed.	• Proposals in development. Information was not available at the point of publication.
60	Improve Access to Adult Community - Community Mental Health Team	Improve access to strength-based community support services. Improve identification of increased risk of physical health co-morbidities, increase access to treatment and interventions to reduce risk factors achieve by: • Roll out and embed the 'Living Well' model. • Increase uptake of Annual health checks (AHC) for people with diagnosed severe mental illness (SMI).	• Roll out of transformed service model across all areas. • Increased uptake within primary care of achievement of all 6 health checks.	• Information was not available at the point of publication.

Adult Mental Health & Learning Disabilities (2)			Driving our work	
			• Increase access to transformed models of the adult community and perinatal and children's and young people's mental health. • Reducing the reliance on inpatient care for people with Learning Disabilities and Autistic people- No more than 30 Adults and no more than 3 CYP with LD or Autism per 1 million population. • Deliver Annual Health Checks to 75% of those aged 14+ and on the GP Learning Disability register.	
#	Projects	Purpose	2023-24 Summary of impact to date	2024-25 Progress & Impact
61	Adult Community-Mental Health Perinatal	• Improve access and completed treatments • Increase access to spouse/partner.	• We have increased the number of women accessing specialist perinatal and maternal mental health services by 80% over the 2023/24 and ended the year in the top 10 of ICBs nationally for best access levels.	• Information was not available at the point of publication.
62	Adult Community-Mental Health Talking Therapies	• Improve access and completed treatments - in line with Talking Therapies manual. • Improve reliable recovery and reliable improvement.		• Information was not available at the point of publication.
63	Adult Community-Mental Health Dementia Diagnosis	Improve access and complete diagnostics Improve care and support.	Over the course of 2023/24 we exceeded our target dementia diagnosis rate, achieving 68.2%, which represented a 2pp improvement on the March 2023 position	• Information not available at the point of publication.
64	Learning Disabilities and Autistic Transformation – Inpatient Services	To review the service, offer for people accessing NHS-funded short breaks. To review the inpatient assessment and treatment offered for people with a learning disability.	• Discovery phase complete.	• Information not available at the point of publication.
65	Learning Disabilities and Autistic Transformation Urgent Care Services	To support more people to access urgent assessment and treatment within their own homes and reduce the use of inpatient services for the assessment and treatment of people with learning difficulties and co-occurring mental health/behavioural needs.	• Information not available at the point of publication.	• Information not available at the point of publication.
66	Learning Disabilities and Autistic Transformation Community Services	Access to treatment and interventions to reduce risk factors should be increased to improve the identification of people at increased risk of physical health co-morbidities. One such intervention is to increase the uptake of Annual health checks for people with diagnosed learning disabilities.	• Increase uptake of Annual health checks for people with diagnosed learning disabilities.	• Information not available at the point of publication.

Adult Mental Health & Learning Disabilities (3)			Driving our work	
			• Increase attainment levels of SMI Annual Physical Health Checks in Primary Care to meet NHSE attainment expectation of 75% by the end of 2025 / 26. • Mental Health - Deliver a full annual physical health check in at least 60% people with severe mental illness by March 2025. • Consolidate Eating Disorders Medical Monitoring Pathway between Primary & Secondary Care. • Reduce the number of people dying from suicide and improve bereavement support.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
67	Community Mental Health Access - Annual Health Checks	To improve identification of increased risk of physical health co-morbidities, increase access to treatment and interventions to reduce risk factors via: • Annual health checks for people with severe mental illness (SMI) and people with a learning disability.	• Increased uptake within primary care of achievement of all 6 health checks.	• Information not available at the point of publication.
68	Community Mental Health Access – Eating Disorder Service	To improve the identification of people at increased risk of physical health co-morbidities, access to treatment and interventions to reduce risk factors via eating disorder service pathway improvements will be increased. Locally enhanced service will be introduced for Primary Care.	• Improved pathway of care for patients.	• Information not available at the point of publication.
69	Derbyshire Suicide Prevention Partnership	To improve access to suicide prevention and postvention support.	• Information not available at the point of publication.	• Information not available at the point of publication.

Fragile Services (C@S)			**Driving our work**	
			• Workforce recruitment and retention challenges. • Inability to deliver a sustainable, safe, high-quality clinical care model (service fragility). • Eliminate 65-week waits by September 2024 at the latest.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
70	Ophthalmology	To develop a single Derbyshire Ophthalmology service which addresses current service fragility and delivers a sustainable model of care that meets local needs and delivers the best value. Ophthalmology is one of our highest-risk fragile services, driven by a shortage in the substantive medical workforce, particularly at CRH. The acute providers have agreed to work together to develop a single provider model that enables the best use of the clinical workforce and operates an agreed approach to using acute, independent sector, and community capacity.	• Case for change drafted preferred option identified.	• PID signed off, project team in place, demand and capacity. • Delivery of business case by January 2025, improvements to RTT.
71	Haematology	To reduce inequities in access and service fragility through collaboration and mutual aid		• Mutual aid arrangement is in place; impact will be reviewed from August 2024. • The impact is expected to be an increase in CRH outpatient activity and a decrease in UHDB routine outpatient referrals and backlog.
72	CAMHS	Improve resilience in CAMHS services, reduce unwarranted variation, and improve cost-effectiveness through collaboration.		• Mutual aid arrangement is in place; impact will be reviewed from August 24. • Reduction in reliance on locums, achievement of 5% CIP

Estates Programme (C@S)			Driving our work	
			• Use of resources - Deliver a balanced net system financial position for 2024/25.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
74	System Infrastructure Strategy	Set out our overall principles and priorities for the NHS estate over the next five years, including reducing the total number and cost of NHS premises in the ICS, ensuring estates are fit for the future and remodelling how estates are used to deliver integrated care in our places.		• Infrastructure strategy is being drafted and is with NHSE for approval. • We are working with Community Health Partners to develop 5,10,15-year estate plans using ADEPT. • Data collection has been undertaken, core flex and tail premises identified, utilisation data pooled, an initial list of sites to deliver an efficiency plan through improved utilisation developed and socialised, and more detailed proposals for each site are now being worked on.
74	Medium- and long-term plans for estate utilisation	Develop a medium—and long-term plan for estate utilisation driven by our clinical change programmes. This plan sets out what impact this will have on how and where demand is met and helps us transition to an estate profile that is fit for the future.		
75	Efficient use of premises	Work to improve estate utilisation and the efficient use of premises, including sharing space and divesting of no longer required premises.		

Procurement Programme (C@S)			Driving our work	
			• Use of resources - Deliver a balanced net system financial position for 2024/25.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
76	Shared procurement workplan	To create efficiencies and deliver better value for money through shared procurement activities.		• Financial Savings range £1.4M to £2.9m (including digital contracts) plus further £0.5m relating to function consolidation
77	Shared procurements	To create efficiencies and deliver better value for money through shared procurement activities.		
78	Improved supply chain management			

Shared Services (C@S)			**Driving our work**	
			• Use of resources - Deliver a balanced net system financial position for 2024/25 • Eliminate 65-week waits by September 2024 at the latest.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
79	Shared Services	The shared services model incorporates individual back-office functions, including finance, procurement, HR, estates, legal, and corporate.		• To develop a business case for a JUCD shared services model incorporating multiple back-office functions.
80	MSK	Improve the MSK service across Derbyshire & Derby through: • Collaboration between community, primary care, and acute care is needed to strengthen referral and assessment and maximise treatment in the community. • Ensuring a focus on pre-op optimisation at the referral point to secondary care. • To support the above, develop a single access point integrated with clinical assessment and onward booking. • Digital platform and data sharing for SPA and referral assessment. • Agreed, consistent pathways and referral criteria across the system, including the independent sector.		• No update was available at the point of publication.
81	Speech and Language Therapy	To improve resilience, reduce unwarranted variation and long waits for children through JUCD single pathway, single point of access & single provider.	• Agreed on a single pathway, developed option appraisal for the future operating model, and agreed on a single provider to be hosted by DCHS.	• Better use of capacity and workforce, improved efficiency markers (time to triage, time to first appt, new to follow up ratios).
82	Primary/Secondary Care Interface	To improve the primary/secondary care interface through process improvements, digital enablement, and clinical network development.		• No update was available at the point of publication.

Integrated Pharmacy & Medicines Optimisation (IPMO) (1)			Driving our work	
			• Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • Support primary care practices to ensure appointments within 2 weeks and urgent assessment same day or the next day. • Nationally contracted Community Pharmacy Services, reducing pressures on other workforces [Fuller Stocktake Report – 2022] • Over-Prescribing Review, National AHSN Polypharmacy Programme.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
83	Integrating community pharmacy services	Fully integrate Community pharmacy services to: • Improve experience of care • Improve patient outcomes • Improve access • Relieve pressures in the primary care workforce • Reducing avoidable medicines harm	• Launch of Pharmacy First scheme to increase access to primary care.	• Increase in the number of Pharmacy First consultations carried out.
84	Hypertension - going Further & Faster	Reduce cardiovascular events by: • Increasing the number of Blood Pressure checks being carried out across Derbyshire to increase detection of those with undiagnosed Hypertension	• The Hypertension case finding project has achieved an increase of 4113 BPs monitored, 1228 of which (30%) were identified as high or very high.	
85	Pharmacy-led lipid management service.	Reduce cardiovascular events by: • Increasing the identification of eligible secondary prevention cases • Increasing capacity within secondary care lipid clinics via a system-wide pharmacy hyperlipaemia team • Increased capacity for PCSK9 inhibitor & inclisiran initiations and monitoring to include administration within Community Pharmacy	• Prevention and health inequalities—By March 2025, Provide lipid-lowering therapy treatment for 65% of people with a CVD risk score of greater than 20%.	
86	Improving chronic non-cancer pain management by reducing harm from opioids.	To work together as a system across Derby and Derbyshire to deliver improvements in pain management that both enhance the care of people living with chronic non-cancer pain and reduce the harm from opioids.	• Reducing harm from opioids programme—work plan delivered, including health and wellbeing Coaches and social prescriber-led patient programme.	• Reduction in the number of patients aged 18+ currently prescribed oral or transdermal opioids for more than 3 months

Integrated Pharmacy & Medicines Optimisation (IPMO) (2)			Driving our work	
			• Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • Support primary care practices to ensure appointments within 2 weeks and urgent assessment same day or the next day. • Nationally contracted Community Pharmacy Services, reducing pressures on other workforces [Fuller Stocktake Report – 2022] • Over-Prescribing Review, National AHSN Polypharmacy Programme.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
87	Antimicrobial Resistance	System Antimicrobial Strategy Implementation To deliver the Derbyshire-wide AMR strategy to: • Minimise infection • Demonstrate appropriate of antimicrobial • Provide safe and effective care • Engage with the public	• Refreshed and progressed implementation of the AMR strategy for 2023 to 2025.	• Reduction in the overall volume of antibacterials prescribed - primary & secondary care in line with national targets. • Increase in Proportion of Amoxicillin 500mg capsule prescriptions issued as 5-day courses in line with national targets. • Reduction in Proportion of total antibiotic treatment days administered intravenously in line with national targets.
88	Optimising & prioritising medication review	Optimise the quality and delivery of medication reviews to: • Improve patient experience by promoting .shared decision-making. • Reduction in harm. • Optimising health resources. • Reduction in polypharmacy.	• Developed approach and work plan.	• Increase in clinicians who have undertaken local training (inc QUEST). • Decrease in Percentage of Pts prescribed 4 or more medicines that can have an unintended hypotensive effect. • Decrease in Percentage of Pts prescribed 4 or more medicines with moderate to high anticholinergic burden. • Decrease in Percentage of Pts prescribed 10 or more unique medicines >75yrs.

Integrated Pharmacy & Medicines Optimisation (IPMO) (3)			Driving our work	
			• Prevention and health inequalities - Address health inequalities and deliver on the Core20PLUS5 approach. • Support primary care practices to ensure appointments within 2 weeks and urgent assessment same day or the next day. • Nationally contracted Community Pharmacy Services, reducing pressures on other workforces [Fuller Stocktake Report – 2022] • Over-Prescribing Review, National AHSN Polypharmacy Programme.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
89	Pharmacy workforce	• Create a strong, credible and inclusive voice to speak to and on behalf of pharmacy. • Attract and recruit the required pharmacy workforce. • Provide support and leadership during trainee and foundation years. • Maintain a growing, skilled, agile and resilient workforce with opportunities for career development. • Introduce, facilitate and support new roles and ways of working.	• Pharmacy faculty established with system and external involvement, work developed, and implementation started.	• Reduction in Vacancy rate (primary & secondary care). • Reduction in Staff turnover rate. • Increase in the number of foundation year places for Pharmacists. • Increase in the number of training places for Pharmacy Technicians. • Increase in the number of roles for non-pharmacy registered staff, including Science Manufacturing Technicians/Science Graduates.

Workforce Programme (1)			**Driving our work**	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
90	People Scaling	• Creating a high quality and consistent People Services offering, scaling People Services through improved collaboration by: • Identification of opportunities for scaling recruitment processes, collaboration, and consistency as practicable and beneficial, as well as greater collaboration and improved efficiency within Joined Up Care Derbyshire. • Identifying opportunities for Trusts in Derbyshire to realise benefits of scale through collaborative working, which may lead to collaboration of improvement, shared ideas, aligned or cross-cutting provision(s), alignment of policies, training and documentation and/or streamlined internal movements across Joined Up Care Derbyshire. • Enable a more aligned approach, viewing people as system assets to be deployed wherever their skills fit best through internal movements / sideways transfer.	• Membership established and initial scoping completed.	• Scaling recruitment processes phase 1: identifying opportunities complete. • Trust level recommendations identified. • Impact on a reduction in vacancies and improved retention (note it is impossible to quantify as there will also be many other factors contributing to improvements in these areas).
91	Contingent Workforce/ Reservists	• Developing a comprehensive contingent workforce model that can flexibly support Patient flow and Patient recovery, transcending organisational boundaries. • Develop a system approach to temporary workforce solutions that improve workforce efficiency and increase resilience.	• A workforce sharing agreement is in place, increasing the number of services signed up.	• Reservist programme is in place across the system. • A system 'flexible working' action plan was formulated. • The practice nurse role is planned to be operational by Q2. • Scoping of other roles to help fill gaps at the system level where agency usage for specialist roles not available on banks at each organisation is in process.

Workforce Programme (2)			**Driving our work**	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition. • Use of resources—Reduce agency spending to a maximum of 3.2% of the total pay bill by 2024/25.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
92	Retention Programme	Deliver the national directive of work to improve workforce retention through a system-wide retention programme.	• System definition of retention and framework to govern the programme – four pillars of the employment cycle. • Flexible working system action plan formulated. • Colleague experience app through BETA testing, with further features following initial testing.	• Successful pharmacy workforce retention conference with further learning and projects planned.
93	Agency Reduction	• Develop a System Agency Reduction Plan to drive forward actions agreed upon at a system level, reduce overall agency usage, and share learning across providers to make improvements. • Developing an integrated system rather than an organisational approach to addressing workforce supply (in this case, temporary staffing usage) requirements.	• Improved triangulation with finance and accuracy of data associated with temporary staffing—reasons for agency requests previously captured at 13% have improved to 87%. • Improving understanding of the position - enabling targeted actions. • Off Framework usage has been an area of focus for this group - Off Framework agency exit strategies translated into the 2024/25 workforce plan submission. • Identifying areas where off-framework usage cannot be safely eradicated escalated to NHSE.	• Monthly tracking and monitoring in place. • Steering Group established to progress at pace. • Off framework trajectories/ action plans confirmed. • Reduction in agency usage in line with NHSE expectations/ requirements. • Removal of Off Framework agency usage by 1 July (note exceptions have been submitted as part of the action plans to NHSE).

Workforce Programme (3)			Driving our work	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
94	Derbyshire Academy	• Developing a system approach to assessing workforce supply requirements. • Expand clinical placement capacity across all professional groups to meet future workforce demand and develop our educator workforce correspondingly. • Clinical education expansion requirements (including apprenticeship) for Long Term Workforce plan. • Liaise with HEIs to develop partnership agreements that meet the NHSE requirements. • Increase capability and improve career development for Advanced Care Practitioners across the system • Allied Health Professional preceptorship alignment with HCPC principles and NHSE Standards Framework • Develop a standardised system approach and improve access to apprenticeships. • Lead and deliver system-wide recruitment campaigns and improve the future pipeline by scaling up engagement. • Ensure Quality Placements and expansion to meet training needs and national shortfalls. • Nursing and midwifery - make nursing in Derbyshire attractive and expand future pipelines. • Supporting training capacity for Foundation Year Trainee (FYT) Pharmacists. • Development of digital skills amongst our workforce. • Expanding clinical placement capacity across all professional groups to meet future workforce demand and the corresponding development of the educator workforce.	• Standardised approach to apprenticeship across the system, including system coordination of apprenticeship levy to support growing our current and future workforce into new roles and through upskilling to work differently. £500,000 re-invested across the ICB through levy gifting, which would have been lost through the levy expiration process. • Derbyshire Placement Faculty established (including HEIs and Social Care) to enable placement expansion. • Central point for Placement expansion to meet future training needs and national shortfalls/ICS supply needs. • Increased retention and support for NQNs to support a flexible and adaptable newly qualified workforce with skills to work across the system. Established patient pathway rotations across the system, with the first cohort transitioning into permanent posts. • Developed a matrix of Professional Nurse Advocate activity and where it overlaps health and wellbeing, career development and clinical supervision within the Trusts. • Training offers on organisations' intranets, including the Oliver McGowan System Training Programme rollout.	• Development of Derbyshire Career pathways from entry levels to Enhancing, Advancing Practice and Non-Medical Consultancy. • Collation of Nursing and midwifery data to inform system-wide workforce planning and recruitment strategies. • Development of Derbyshire Apprenticeship Strategy underway. • Building Healthier Communities: Contributing to building a healthier community by implementing various anchor projects to widen career access and focusing on inclusion. • NHS LTWP of 27% Target for placement expansion 28/29 met and continues to increase capacity.

Workforce Programme (4)			Driving our work	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
95	Derbyshire Academy (part 2)	Prioritise investment in training and development in prevention, personalisation, and health inequalities.	• Aligned and agreed the 11 mandatory subjects to reflect the Core Skills Training Framework (CSTF) across the four NHS organisations. This will support staff movement across the system, reduce duplication of training, thus saving time and training costs, and allow benchmarking of compliance. • Derbyshire Advanced Practice Strategy developed. • Pharmacy Workforce Strategy developed • Increase retention among Advanced Care Practitioners (ACPs) through a system-wide approach to standardising e-portfolio, support, and supervision and scaling up the number of ACPs by improving career opportunities. • Multi-sector training posts for Foundation Year Pharmacists and Pre-Registration Pharmacy Technicians.	
96	People Digital - Project Derbyshire	To improve workforce data quality, enabling effective workforce planning and developing a consistent approach to workforce data, reporting, and analytics across Derbyshire ICS.	• Established an initial project plan and project board to oversee the initial development phase.	• Functional Implementation Group established to share best practices and ideas and work on standardisation of coding.

Workforce Programme (5)			**Driving our work**	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
97	Workforce Planning and Transformation Workforce Supply	• Working with local Places and the wider Provider Collaborative to define the workforce needs across care pathways. This will facilitate the need to accelerate the work on defining the workforce model(s) needed and, where necessary, reshape/scale the currently operational offering. This is vital so all partners know what is needed to enhance the integrated community care offering, and more specific action can be organised to bring it about. • Appraise the limited progress on restructuring how clinicians work across different care settings. • Develop an understanding of the current workforce and the requirements to respond to the integrated care strategy and JFP. Create a joint approach between service leads and People Services to develop plans that bridge the gap by using new approaches to skill mix, expanding/ introducing new roles, and deploying staff closer to service users. • Understand workforce productivity and improvement opportunities by applying nationally developed tools and approaches (e.g., employing the STAR model).	• Established the NHS Trust workforce baseline position and alignment with wage costs.	• This will be an ongoing enabling programme of work needed to support the large-scale programmes as they define their models of care.

Workforce Programme (6)			**Driving our work**	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition. • Use of resources - Deliver a balanced net system financial position for 2024/25.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
98	Workforce Planning and Transformation Managing our Pay Costs to Plan	• Developing an integrated system approach to workforce planning and reporting to monitor the delivery of the strategic workforce objectives. • Utilising the analysis to build workforce planning skills and resources to ensure the required skills and competencies to support and deliver a robust organisational workforce plan. Training and capacity building - developing an achievable workforce plan that focuses on transitioning the current workforce to deliver the requirements described in the 5-year forward plan.	• Established the NHS Trust workforce baseline position and alignment with wage costs. • A workforce dashboard was developed, allowing greater scrutiny of the position.	• Building on the work undertaken in 2023/24, the workforce operational plans have been developed in close alignment with the pay bill. • This position is now being reported routinely to identify areas where the position is going off plan and where remedial actions are needed. • 0.96% increase in the total workforce (including EMAS). • Improved triangulated plans across workforce, finance and activity. • Workforce plans aligned to pathways.
99	Equality, Diversity and Inclusion	• Workplan to deliver the six high-impact actions identified within the National NHS EDI Improvement Plan. • This plan aims to address the widely known intersectional impacts of discrimination and bias, improve equality, diversity and inclusion, and enhance the sense of belonging for NHS staff to improve their experience. • This is central to achieving the EDI vision of 'belonging in Derbyshire; for everyone in the health and social care community to feel that Derbyshire is where they belong'. • Deliver the Active Bystander and CQ Facilitator Programme, supporting effective working across our culturally diverse system and the vision of 'belonging in Derbyshire'.	• Agreement to focus on High Impact Action 2 (embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity) and 6 (Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur) as a system. • Development of inclusive recruitment practices across the system - all training is complete, and focus groups have fed through their recommendations, with the recruitment work programme picking up the implementation of the recommendations.	

Workforce Programme (7)			Driving our work	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition. • Use of resources - Deliver a balanced net system financial position for 2024/25.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
			• The Active Bystander programme has been rolled out across Derbyshire, starting with a Train the Trainer programme.	
100	Leadership Development & Talent Management	• Development of a consistent core offer for leadership development and induction for all new leaders anywhere in the system, which supports a culture of improvement, encouraging learning and promoting system working. • Creating an inclusive talent approach as the driver for recruitment and development. This includes unified approaches to Leadership Development, Talent Management Development, and organisational development (OD).	• New system-wide appraisal process introduced. • Mapped core leadership offers across the system to establish access to leadership development. • Identifying gaps to deliver a consistent core offer of leadership development for aspiring, emerging, middle-level, and senior leaders available to people anywhere in the system. • Reviewed digital booking options for leadership offers to reduce admin time required. • Ongoing delivery of the Mary Seacole programme. • Core Leadership offer embedded across the system and considered “business as usual”.	

Workforce Programme (8)			Driving our work	
			• There is an increasing demand for services (Health and Care) with a deficit in the available workforce required to meet this demand, compounded by an ageing workforce and increased attrition. • Use of resources - Deliver a balanced net system financial position for 2024/25.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
101	Health, Safety and Wellbeing	Collaborative delivery of an equitable range of programmes and initiatives to support all health and social care colleagues across Derbyshire and Derby City – helping colleagues to remain healthy, safe and well in all aspects of life.	• Programme of delivery inc. Mental and Emotional Health, MSK / Physical Health and Health Inequalities to support health, wellbeing and workforce retention, based on a robust Health Needs Analysis. • National recognition as an Inclusive Menopause Friendly Employer and award for cross-sector working. • Over 56k engagements in the programme in 2023/24. Month-on-month growth since 220 colleagues per day. Representing 136% growth in a year. • Demonstrable impact within the Neurodiversity and Menopause workstreams. 20% reduction in sickness absence pilot. • Regular Neurodiverse Cafés, working with a Disability or Health Condition Support Group, and Supporting your team with a Disability or Health condition are embedded within the timetable. • System Health Needs Analysis results complete. • 114% increase in Peer Psychological Support. • The Menopause programme won the Henpicked Menopause Friendly Employer award for 'Most Inclusive Employer' in 2023. • This was a support programme, which is now business as usual.	

Digital Programme			Driving our work	
The Digital Programme is an enabling programme of work that leads and supports digital transformation and innovation in health and social care to transform the lives of our community. Our projects are at the forefront of digitising healthcare processes, enhancing data sharing across various sectors, and integrating technology to improve patient outcomes.			The Digital Programme of Work has been informed by JUCD system-wide and organisational digital priorities and is also directed by national requirements such as Frontline Digitisation. Digital transformation is necessary to support the shift in care from illness to wellness. It provides the tools and technologies required to transform into new models of care delivery and helps address some of the challenges faced across the system.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Forecast impact summary**
102	Derbyshire Shared Care Record (DSCR)	The Derbyshire Shared Care Record is a confidential computer record that joins different records to create a more comprehensive and up-to-date record of you.	Interoperability achieved with partner organisations: **View data**: · Ashgate Hospice - Treetops - Blythe House - DHU - Primary Care Networks - Derbyshire County Council Adults - East Midlands Ambulance Service. Partner organisations: **Viewing and sharing data** · DCHFT · Derby City Council Adult Social Care and Children's Social Care, Derbyshire County Council Adult Social Care and Children's Social Care, Chesterfield Hospital, University Hospitals of Derby and Burton - Primary Care GP Practices.	• Increased interoperability with partner organisations – EMAS to support improved support to emergency crews and expand the local authority data set to include Children's services. • Digitisation of the RESPECT document in the DSCR to further improve end-of-life (EoL) care by sharing up-to-date EoL plans more widely.
103	Electronic Patient Record (EPR)	Implement an Electronic Patient Record for Chesterfield Royal Hospital and University Hospitals Derby and Burton.	• EPR Full business case developed, and national funding approved to progress procurement. • EPR supplier secured via procurement process – NerveCentre. • Implementation and deployment plan agreed. • The benefits realisation plan agreed upon as part of the business case, detailing cash release, non-cash release, and legacy system decommissioning.	• Removal of paper records, optimisation of system and legacy record management – efficiencies quantified. • Improved Patient Safety rollout, e-obs, Assessments, HOOH and Nursing documents
104	Digitisation in Social Care (DiSC)	Implement digital social care records (DSCR) for Adult Social Care (ASC) providers across Derbyshire. This will ensure that data is accurate, is captured at the point of care and can be shared between care settings. National Programme coordinated at the system level. There are approximately 550 ASC providers across Derby and Derbyshire.	73% of care providers are reporting using a digital care record from a starting position in 22/23 of 44%. On average, care providers report: • Saving 20 minutes per day on record activity • Saving 24 hours per year on audit • Saving 20 minutes per day at handover • Saving over £2000 per year on stationery and storage costs.	• Meet the national target of 80% of providers using a digital care record. • Work with providers to maximise functionality within the systems • Consider and plan towards integration with the Derbyshire Shared Care Record.

Population Health Management Programme			Driving our work	
Derby and Derbyshire Health System organisations will collaborate to develop a new Health Intelligence Platform and System's Intelligence Function.			• To enable an increased focus across our NHS organisations on high-quality data and analytics service to provide local teams with a precise analysis of local problems and assets, vital to support the population health management agenda in Primary Care and PLACE more general. • Population Health Management data to plan and target the provision and improvement of care	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
105	Re-design - ICB Business Intelligence Team		• We have established a system analytics network. • Completed the re-design of the ICB Business Intelligence Team. • A data request and triage process have been implemented.	
106	Central database		• Our central database is live in partnership with the NETs (CSU).	
107	Data Sharing Agreement			• We are progressing with our multi-partner data-sharing agreement, which we aim to sign off on in July.
108	Patient Level Costing	Patient Level Costing is operational across all areas of NHS provision, including General Practice.		• No update is available at the point of publication.
109	Better data to make better decisions	Patient-centred outcome measures relating to at least 80% of the disease burden are being reported.		• We are building a system surveillance report available in October 2024.
110	Data Science Training Academy	Develop the skills of our analytical workforce through a fully operational Data Science Training Academy.	• Two staff members completed the L4 Data Analyst Apprenticeship, and one was studying, bringing new skills and enhancing current techniques.	• There has been an increase in the number of team members. Two staff members are completing the L4 Data Analyst Apprenticeship pathway. • The aim is for another five staff members to begin the data apprenticeship this year.

Green Agenda & Net Zero initiatives (1)			Driving our work	
			• Reducing the CO2e impact of inhalers, in line with the commitment of a 25% reduction in 2023/24 on a 2019/20 baseline. • Travel and Transport Modal Shift - 100% of Trusts to have 3 or more schemes/interventions in place to support modal shift.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
111	Low Carbon Inhalers	To reduce the CO2e impact of inhalers, in line with the commitment of 25% in 2023/24. The ICS is predicting an approximate reduction of 34% for the end of 23/24 - by using lower carbon inhalers. Our second priority is to utilise dry powder inhalers, which have a much lower carbon footprint than Metered Dose Inhalers (as above)	• Target to date is 34% by the end of 23/24 – delivered.	• Target continues; however, it will be slower because the ICB has surpassed the 25% NHSE target for 23/25.
112	Inhaler recycling	Encouraging patients to return old or unwanted inhalers to pharmacies for environmentally safe disposal through reminders and promotions		• To reduce emissions and cut down on carbon waste, as inhalers in landfills can still contribute to the carbon footprint. • Proposed awaiting sign-off.
113	Medical Gases	Transforming anaesthetic practice using an alternative to desflurane. • Reducing the proportion of desflurane used in surgery to less than 2% of overall volatile anaesthetic gases volume in all trusts in line with the NHS Standard Contract	• Derbyshire ICS is showing 0.9% usage to Q4 2023/24. Exceeded Desflurane usage reduction target across both acute trusts.	• To reduce to 0% in Derbyshire. Reduction in Emissions(tCO2e) from nitrous oxide and mixed nitrous oxide
114	Cycle to Work	The introduction of a salary sacrifice scheme will enable staff to purchase bicycles.	• There are ten staff at the ICB who are currently using the scheme.	• Information was not available at the point of publication.
115	Car Share Scheme	A lift share policy and communication campaign.	• Scheme in place; however, uptake across Derbyshire is low, and an action plan is in place to increase take-up through comms and engagement among Derbyshire employees.	• Information was not available at the point of publication.
116	Electric vehicle charging points.	Derbyshire providers have schemes and fleet schemes in place; however, currently, the ICS have a high risk due to insufficient EV charging points across the Derbyshire footprint. To identify options to expand the number of electric vehicle charging points.		• Proposals in development.

Green Agenda & Net Zero initiatives (2)			**Driving our work**	
			• Travel and Transport Modal Shift: 100% of Trusts will have three or more schemes/interventions in place to support modal shift. • Harnessing the opportunities presented by digital transformation to streamline service delivery and supporting functions while improving the associated use of resources and reducing carbon emissions.	
#	**Projects**	**Purpose**	**2023-24 Summary of impact to date**	**2024-25 Progress & Impact**
117	Our Carbon Footprint	Developing our data on carbon emissions to aid our understanding of organisation and service level carbon performance. Examples include: • Capture data on offering digital appointments instead of patients travelling to a site.		• Proposals in development.

ICB Function (1)		
#	**Driving our Work (2023-24)**	**2024-25 Summary of Progress**
118	Strategic Alignment • Navigating the various strategies, goals, and objectives is more complicated than necessary. It is critical that all teams, whether they are delivering for today or tomorrow, can see a connection between what they are doing and the collective future direction of travel.	• In collaboration with system partners, commission a review of the current portfolio of strategies, goals, objectives, etc to bring greater strategic alignment and simplify the line of sight.

119	Strategic Deployment & System PMO
	
	• Where it is not the case already, all improvement aims will need to be converted into tangible actions with a clear process for tracking, reporting and governing progress; this will include establishing clarity on the following:
	  • Key enabling actions
	  • Critical milestones
	  • Portfolio of improvement activities and programmes/ projects
	  • Goals and expected outputs – covering each year of the plan
	  • Measurement of process and output, as well as the impact of the outcomes.
	  • Large-scale change governance – including the accountable and responsible officers, forums and reporting arrangements.
	  • Interdependency management—ensuring different but related projects are joined up, with identified named leads to enable this. These projects need to be connected to ensure maximum value is realised. This may present challenges, for example, because of traditional contractual arrangements between one constituent organisation and a supplier.
	
	• Reframing the Derby and Derbyshire NHS efficiency improvement programme: By focusing on identifying waste as an organising principle and reducing waste as a core objective, we will be able to address the issue of 'inefficiency' in a more holistic and scalable way across different care and service settings.
	
	• While the Programme Management Office (PMO) capability exists to support collaboration at scale initiatives, we do not have this capability at a system level.
		We are proposing to:
		
		• Setting up an integrated Strategic Deployment and Portfolio Management Office to align our system goals and change initiatives.
		
		• Transition to a new large-scale change governance and assurance framework, which may result in existing projects and programmes being absorbed into others. Ensure that the design of each programme and project has the triple aim of its centre—improving quality, performance, and productivity.
		
		• Conduct a deep-dive review of our portfolio of complex programmes, identifying where we need to accelerate our plans, pause, or recommend stopping initiatives that cannot demonstrate improved quality, performance, and productivity outcomes.
		
		• Map our existing change capability and where it is deployed.
		
		• The delivery of our Primary Care Improvement strategy will be part of the Community Care Improvement programme.
		
		• Bring greater transparency and momentum to the programmes and projects that constitute Collaboration at Scale.

ICB Function (2)		
#	**Driving our Work (2023-24)**	**2024-25 Summary of Progress**
120	The availability of suitably skilled and experienced programme and change managers and practitioners will be a key factor in determining the pace at which improvements occur.	• We are proposing a capacity and capability assessment across our NHS family. In conducting a deep-dive review of our portfolio of complex programmes, we identify where our specialist resource is currently deployed.
121	Change/Improvement science and quality improvement methodologies need to play a key role in facilitating the move from agreed goals to delivering improved outcomes, and the use of the significant QSIR (Quality, service improvement and redesign) capability within the JUCD NHS system will be key in ensuring good quality application of that science.	• Our goal is to ensure an increased focus across our NHS organisations on high-quality project management support to manage change. • To build upon and accelerate the work of the Collaboration at scale PMO team in building capability and capacity of large-scale change and continuous improvement across our NHS family.
122	Operating Framework - Governance & Assurance – Operational Management • Existing governance and delivery arrangements are currently organisation-centred, which can inhibit system collaboration and the added value of working across organisations to achieve a single, shared aim. Governance mechanisms established through Place and several connected work programmes need greater ownership, visibility and system backing.	• Our system of operational governance and assurance continues to evolve. We are working together as partners to reduce the potential tension regarding organisational sovereignty and their differential operating frameworks, as demonstrated through individual policies, procedures, structure, etc., alongside the need for teams of people to work together with shared purposes and aligned goals.
123	Strategic Commissioning • In the transition from CCG (Clinical Commissioning Groups) to ICB, it was widely accepted that the commissioner's commissioning function needed to transition from the tactical level of commissioning (based principally on care pathway development and inter-provider/organisational facilitation) to a strategic level (based principally on understanding the population's health and health needs and commissioning in line with these needs).	• We are developing a strategic Commissioning Prioritisation Policy for the next five-year period. This policy will act as a framework to enable the ICB to prioritise (and thus deprioritise) which healthcare interventions will be commissioned during the JFP period and beyond. This policy will be developed with partners in time for it to be used in the 2025/26 Operational Planning process.

ICB Function (3)		
#	**Driving our Work (2023-24)**	**2024-25 Summary of Progress**
124	Ensuring an increased focus across our NHS organisations on (ii) communication and engagement teams to design and deliver more effective ways of engaging with marginalised and disadvantaged communities;	• Insight Framework exploratory work funded, tool developed to assess readiness for insightful conversations with the public, piloted in c25 settings, ranging from GP practices to communities of geographical interest groups. Collating findings to inform next steps. Findings from Insight Framework pilots to form the basis of system insight strategy. • Hypertension case finding work in Derby developed with community partners, utilising insight-driven intervention and promotion with a significant increase in the collation of BPs and onward referrals. Blueprint for future intervention work, forging strong relationships in the development and delivery phase. This work has led to ICB Communications and Engagement Team members being invited to the Derby Health Inequalities meetings to understand opportunities to strengthen the relationship between the NHS and communities. • The intelligence gained via the deployment of the Framework will support the continuous conversation that needs to occur around the JFP into the 2025 refresh. • We are developing our Lay Reference Group, connected to the Insight Framework, to diversify the pool of citizens wishing to step into more formal involvement, learn more about the NHS, and help shape our approach. The aim is to develop a supportive environment/network to grow people's confidence in formal decision-making structures.
125	Ensure coordinated, consistent and joined-up communications support using appropriate media channels tailored to meet the needs of the target population to improve health	• Introduction of OASIS campaign planning tool to assess audience and outcomes. Used for all major campaigns, including Covid vaccination, MSK digital app and winter planning. • Hypertension case-finding work in Derby was developed with community partners. It utilized insight-driven intervention and promotion, with a significant increase in the collation of BPs and onward referrals. This work provided a blueprint for future intervention work, forging strong relationships in the development and delivery phases. • Commenced adoption of the Health Literacy approach.