NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC AGENDA

17th July 2025 at 9:15am to 11:15am

Joseph Wright Room, Council House, Derby

"To support people in Derby and Derbyshire to live their healthiest lives, creating a sustainable, joined-up health and social care system for now and the future".

Our aims: to **improve outcomes** in population health and healthcare; **tackle inequalities** in outcomes, experiences and access; enhance **productivity and value for money**; and support broader **social and economic development**.

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

Ref	Time	Item	Presenter	Type	Enc.
Introductory Items					
ICBP/2526/027	09:15	Welcome, introductions and apologies: Michelle Arrowsmith, Stephen Posey, Sue Sunderland	Dr Kathy McLean	–	Verbal
ICBP/2526/028	-	Confirmation of quoracy	Dr Kathy McLean	–	Verbal
ICBP/2526/029	-	Board Member Register of Interests	Dr Kathy McLean	Information	✓
Minutes & Matters Arising					
ICBP/2526/030	09:20	Minutes from the meeting held on 22nd May 2025	Dr Kathy McLean	Decision	✓
ICBP/2526/031	-	Action Log – May 2025	Dr Kathy McLean	Discussion	✓
Leadership					
ICBP/2526/032	09:25	Citizen Story: Jericho House - The Living Recovery Foundation	Helen Dillistone, Neil Ainslie, David Parkinson	Information	✓
ICBP/2526/033	09:45	Chair's Report	Dr Kathy McLean	Decision/ Information	✓
ICBP/2526/034	09:50	Chief Executive Officer's Report	Dr Chris Clayton	Information	✓
Strategy					
ICBP/2526/035	09:55	10 Year Health Plan for England	Dr Kathy McLean, Dr Chris Clayton	Assurance	✓
Delivery and Performance					
ICBP/2526/036	10:15	Integrated Performance Report	Executive Directors, Committee Chairs	Assurance	✓
People and Culture					
ICBP/2526/037	10:30	One Workforce People Plan Update Report	Lee Radford	Assurance	✓

Ref	Time	Item	Presenter	Type	Enc.
Governance & Risk					
ICBP/2526/038	10:40	Fit and Proper Person Test	Dr Kathy McLean	Assurance	✓
ICBP/2526/039	10:50	Board Assurance Framework - Quarter 1 2025/26	Helen Dillistone	Decision	✓
ICBP/2526/040	11:00	Integrated Care Board Risk Register Report - as at 30th June 2025	Helen Dillistone	Decision	✓
ICBP/2526/041	11:05	Committee Assurance Reports • Audit and Governance Committee • Finance and Performance Committee • People and Culture Committee • Strategic Commissioning and Integration Committee • Quality, Safety and Improvement Committee • Joint Transition Committee	Committee Chairs	Assurance	✓
For Information					
ICBP/2526/042	11:10	ICB Constitution	Helen Dillistone	Information	✓
Closing Items					
ICBP/2526/043	11:15	Risks identified during the course of the meeting	Dr Kathy McLean	Discussion	Verbal
ICBP/2526/044	-	2025/26 Board Forward Planner – Public	Dr Kathy McLean	Information	✓
ICBP/2526/045	11.20	Questions received from the public relating to items on the agenda	Dr Kathy McLean	-	Verbal
ICBP/2526/046	11:25	Any Other Business • Intensive and Assertive Community Mental Health Treatment Update	Mark Powell, Prof. Dean Howells	Assurance	✓
ICBP/2526/047	11:30	Close	Dr Kathy McLean	-	Verbal

2025/26 Schedule of Board Meetings:

Date & Time:	Venue:
22nd May 2025, 9.15 am – 11.15am	Council House, Derby, DE1 2FS
17th July 2025, 9.15 am – 11.15am	Council House, Derby, DE1 2FS
18th September 2025, 9.15 am – 11.15am	Post Mill Centre, Alfreton, DE55 2EJ
20th November 2025, 9.15 am – 11.15am	Council House, Derby, DE1 2FS
22nd January 2026, 9.15 am – 11.15am	Council House, Derby, DE1 2FS
19th March 2026, 9.15 am – 11.15am	Council House, Derby, DE1 2FS

Item 029

NHS DERBY AND DERBYSHIRE ICB BOARD REGISTER OF INTERESTS 2025/26

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

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Arrowsmith	Michelle	Chief Strategy and Delivery Officer/ Deputy Chief Executive Officer	Finance & Performance Committee Strategic Commissioning & Integration Committee ICS Executive Team Meeting Midlands 111 Board Gender Dysphoria Working Group Planned Care Board	Director of husband's company - Woodford Woodworking Tooling Ltd				✓	01/11/14	Ongoing	No action required as not relevant to any ICB business
Austin	Jim	Participant to the Board for Place	Primary & Community Care Delivery Board Chair of Digital and Data Delivery Board Integrated Place Executive ICS Executive Team Meeting Derbyshire County Place Partnership Board	CEO of Derbyshire Community Health Services NHS Foundation Trust	✓				16/09/24	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Spouse is a locum GP and the Local Place Alliance lead for High Peak (8 hours per week)				✓	01/11/22	Ongoing	
Bhatia	Avi	Participant to the Board for the Clinical & Professional Leadership Group	Chair - Clinical and Professional Leadership Group, Derbyshire ICS Strategic Commissioning & Integration Committee Erewash Place Alliance Group Primary & Secondary Care Interface Working Group	GP partner at Moir Medical Centre	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				GP partner at Erewash Health Partnership	✓				01/07/22	Ongoing	
				Part landlord / owner of premises at College Street Medical Practice, Long Eaton, Nottingham	✓				01/07/22	Ongoing	
				Spouse works for Nottingham University Hospitals				✓	01/07/22	Ongoing	
				Work as Training Programme Director and as an Associate Postgraduate Dean for the East Midlands GP Deanery, NHSE		✓			29/10/24	Ongoing	
Clayton	Chris	Chief Executive Officer	ICS Executive Team Meeting	Spouse is a partner in PWC				✓	01/07/22	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Dentith	Jill	Non-Executive Member	Audit & Governance Committee Finance & Performance Committee Quality & Performance Committee	Self-employed through own management consultancy business trading as Jill Dentith Consulting	✓				2012	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Director of Jon Carr Structural Design Ltd	✓				06/04/21	Ongoing	
Dillistone	Helen	Chief of Staff	Audit & Governance Committee Greener Delivery Board Strategic Commissioning & Integration Committee	Nil							No action required
Finn*	Claire	Interim Chief Finance Officer	Audit & Governance Committee Finance & Performance Committee Strategic Commissioning & Integration Committee Integrated Place Executive ICS Executive Team Meeting Midlands 111 Board	Trustee of Newfield Charitable Trust			✓		01/10/23	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Gildea	Margaret	Non-Executive Member / Senior Independent Director	People & Culture Committee Strategic Commissioning & Integration Committee Quality, Safety & Improvement Committee Remuneration Committee Derby City Health & Wellbeing Board	Director of Organisation Change Solutions a leadership, management and OD consultancy. I do not work for any organisation in the NHS, but do provide coaching and OD support for First Steps ED, an eating disorder charity	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Chair of Melbourne Assembly Rooms (a voluntary not for profit organisation that runs the former SDDC controlled leisure centre)			✓		01/07/22	Ongoing	
Houlston	Ellie	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)	System Quality Group Integrated Care Partnership Health and Wellbeing Board - Derbyshire County Council Women's Health Hub Steering Group ICS Executive Team Meeting Derbyshire County Place Partnership Board	Director of Public Health, Derbyshire County Council	✓				01/09/22	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair. Sheffield based - unlikely to bid in work in Derbyshire
				Director and Trustee of SOAR Community			✓		01/09/22	Ongoing	
Howells	Dean	Chief Nurse Officer	People & Culture Committee Quality, Safety & Improvement Committee Local Maternity and Neonatal System Board Clinical and Professional Leadership Group Information Governance Assurance Forum ICS Executive Team Meeting Midlands 111 Board	Honorary Professor, University of Wolverhampton		✓			13/09/23	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair.

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McLean	Kathy	ICB Chair	Remuneration Committee	Kathy McLean Limited - a private limited company offering health related advice	✓				05/08/19	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Occasional adviser for CQC well led inspections	✓				24/06/22	Ongoing	
				Chair of Nottingham and Nottinghamshire Integrated Care Board		✓			01/02/21	Ongoing	
				Chair of Nottingham and Nottinghamshire Integrated Care Partnership		✓			01/02/21	Ongoing	
				Joint Chair of Joint Negotiating Committee Staff and Associate Specialists on behalf of NHS Employers		✓			24/06/22	Ongoing	
				Member of NHS Employers Policy Board		✓			Ongoing	Ongoing	
				Chair of the Public Service Consultants	✓				01/05/25	Ongoing	
				Chair of ICS Network, NHS Confederation		✓			01/04/24	Ongoing	
				Chair of East Midlands Specialised & Joint Committees		✓			01/04/24	Ongoing	
				Advisor to Oxehealth	✓				17/02/22	Ongoing	
				Trustee for NHS Confederation		✓			TBC	Ongoing	
Mott	Andrew	GP Amber Valley (Primary Medical Services Partner Member)	System Quality Group Joint Area Prescribing Committee Derbyshire Prescribing Group Clinical and Professional Leadership Group End of Life Programme Board Children's Urgent Care Group Community Same Day Urgent Care Delivery Group Amber Valley Place Alliance Group Virtual Wards Delivery Group GP Leadership Group Women's Health Hub Steering Group Primary & Community Care Delivery Group Seasonal Vaccination Sub-Group Primary & Secondary Care Interface Working Group	GP Partner of Jessop Medical Practice	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Practice is shareholder in Amber Valley Health Ltd (provides services to our PCN)	✓				01/07/22	Ongoing	
				Medical Director, Derbyshire GP Provider Board	✓				01/07/22	Ongoing	
				Managing Partner at Jessop Medical Practice, involved in all aspects of provision of primary medical services to our registered population.		✓			01/07/22	Ongoing	
				Wife is Consultant Paediatrician at UHDBFT				✓	01/07/22	Ongoing	
Okubadejo	Adedeji	Clinical Lead Member	Audit & Governance Committee Strategic Commissioning & Integration Committee Quality, Safety & Improvement Committee Remuneration Committee	Director, Carwis Consulting Ltd. Provision of clinical anaesthetic and pain management services as well as management consulting services to patients and organisations in the independent healthcare sector	✓				01/04/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Provision of private clinical anaesthesia services	✓				01/04/23	Ongoing	
				Director and Chairman, OBIC UK. Working to improve educational attainment of children from black and minority ethnic communities in the UK			✓		01/04/23	Ongoing	
Posey	Stephen	Chief Executive Officer, UHDBFT (NHS Trust & FT Partner Member)	Provider Collaborative Leadership Board (Chair)	Chief Executive Officer of UHDBFT	✓				01/08/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Partner is Chief Executive Officer of the Royal College of Obstetricians and Gynaecologists				✓	01/08/23	Ongoing	
				Partner is a Non-Executive Director for the Kent, Surrey & Sussex (KSS) AHSN				✓	01/08/23	Ongoing	
				Partner is a Non-Executive Director for Manx Care				✓	17/05/23	Ongoing	
				Chair of Stakeholder Group - East Midlands Research Delivery Network		✓			01/04/25	Ongoing	
Powell	Mark	Chief Executive Officer, DHcFT (NHS Trust & FT Partner Member)	N/A	CEO of Derbyshire Healthcare NHS Foundation Trust	✓				01/04/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				Treasurer of Derby Athletic Club			✓		01/03/22	Ongoing	
Radford	Lee	Chief People Officer	Finance & Performance Committee People & Culture Committee ICS Executive Team Meeting	Nil							No action required
Shields	Bill	Chief Finance Officer	Audit & Governance Committee Finance & Performance Committee Strategic Commissioning & Integration Committee Integrated Place Executive ICS Executive Team Meeting Midlands 111 Board	Chair of HFMA Financial Recovery Group & Vice Chair of HFMA ICB CFO Forum		✓			01/10/24	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
				On secondment from NHS Devon ICB as Joint Chief Finance Officer at NHS Derby and Derbyshire ICB and NHS Nottingham and Nottinghamshire ICB		✓			01/04/25	Ongoing	

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Simpson	Paul	Local Authority Partner Member	N/A	Chief Executive Officer, Derby City Council	✓				Ongoing	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair.
Smith	Nigel	Non-Executive Member	Audit & Governance Committee Finance & Performance Committee People & Culture Committee Remuneration Committee	NED at Nottinghamshire Healthcare NHS FT Trustee at Derbyshire Districts Citizens Advice Bureau Associate Hospital Manager at Rotherham, Doncaster and South Humber NHS FT	✓ ✓	 ✓ 			02/02/22 01/02/19 01/09/19	Ongoing Ongoing Ongoing	Declare interets when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
Sunderland	Sue	Non-Executive Member	Audit and Governance Committee Finance & Performance Committee People & Culture Committee IFR Panels CFI Panels	Audit Chair NED, Nottinghamshire Healthcare Trust Independent Audit Chair of Joint Audit, Risk & Assurance Committee for Derbyshire Office of the Police & Crime Commissioner and Chief Constable Husband is an independent person sitting on Derby City Council's Audit Committee	✓ ✓			 ✓	01/07/22 01/07/22 01/07/22	Ongoing Ongoing Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair
Weiner	Chris	Chief Medical Officer	Strategic Commissioning & Integration Committee Quality, Safety & Improvement Committee System Quality Group EMAS 999 Clinical Quality Review Group Clinical and Professional Leadership Group ICS Executive Team Meeting Digital & Data Board	Visiting Professor (Public Health), University of Derby		✓			15/05/25	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisations are potential provider unless otherwise agreed by the meeting chair

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD MEETING IN PUBLIC

Thursday, 22nd May 2025

Joseph Wright Room, Council House, Derby DE1 2FS

Unconfirmed Minutes

Present:		
Dr Kathy McLean	KM	ICB Chair (Meeting Chair)
Michelle Arrowsmith	MA	ICB Chief Strategy and Delivery Officer / Deputy CEO
Jim Austin	JA	Chief Executive Officer, DCHSFT (Participant Member to the Board for Place)
Dr Avi Bhatia	AB	Participant to the Board for the Clinical & Professional Leadership Group
Dr Chris Clayton	CC	ICB Chief Executive Officer
Jill Dentith	JED	ICB Non-Executive Member
Helen Dillistone	HD	ICB Chief of Staff
Margaret Gildea	MG	ICB Non-Executive Member / Senior Non-Executive Member
Prof Dean Howells	DH	ICB Chief Nurse
Dr Andrew Mott	AM	GP Amber Valley (Partner Member for Primary Care Services) / Medical Director of GP Provider Board
Dr Deji Okubadejo	DO	ICB Clinical Lead Member
Stephen Posey	SPo	Chief Executive, UHDBFT / Chair of the Provider Collaborative Leadership Board (NHS Trust and FT Partner Member)
Mark Powell	MP	Chief Executive DHcFT (NHS Trust and FT Partner Member)
Lee Radford	LR	ICB Chief People Officer
Bill Shields	BS	ICB Joint Chief Finance Officer with NNICB
Nigel Smith	NS	ICB Non-Executive Member
Sue Sunderland	SS	ICB Non-Executive Member
Prof. Chris Weiner	CW	ICB Chief Medical Officer
In Attendance:		
Amjad Ashraf	AA	Derby Health Inequalities Partnership, Community One and Community Action Derby
Ailya Habib	AH	Programme Support Coordinator, Community Action Derby
Nicki Doherty	ND	ICB Director of Place and Partnerships
Kathryn Durrant	KD	ICB Executive Board Secretary
Matt Graham	MGr	Director of Strategy, Harrogate and District NHS Foundation Trust
Suzanne Pickering	SP	ICB Head of Governance
Sean Thornton	ST	ICB Director of Communications and Engagement
1 member of the public		
Apologies:		
Ellie Houlston	EH	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)
Paul Simpson	PS	Chief Executive, Derby City Council (Local Authority Partner Member)

Item No.	Item	Action
ICBP/2526/001	**Welcome, introductions and apologies:** The Chair, Dr Kathy McLean (KM) welcomed all Board Members and attendees to the Board Meeting in Public. The Chair welcomed the colleagues attending to present the Citizens' Story and colleagues attending to observe. Apologies for absence were received as noted above.	

ICBP/2526/002	**Confirmation of quoracy** It was confirmed that the meeting was quorate.	
ICBP/2526/003	**Declarations of Interest** The Chair reminded Committee Members of their obligation to declare any interests they may have on issues arising at Committee meetings which might conflict with the business of the ICB. Declarations made by members of the Board are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the ICB Board Secretary or the ICB website, using the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/integrated-care-board-meetings/	
ICBP/2526/004	**Minutes of the meeting held on 20th March 2025** **The Board APPROVED the minutes of the above meeting as a true and accurate record of the discussions held.**	
ICBP/2526/005	**Action Log – March 2025** **The Board NOTED the action log.**	
ICBP/2526/006	**Citizen Story: Derbyshire Heath Inequalities Partnership (DHIP)** Amjad Ashraf and Ailya Habib presented the Citizen Story to the Board. It was noted that the Chair has visited DHIP and that the organisation has carried out fantastic work over some years. DHIP was set up to address inequalities in Derby, initially in response to the disproportionate impact of the Covid 19 pandemic on deprived communities, particularly ethnic minority communities, against a backdrop of cuts, and with a view to ensuring that commissioners gained a greater understanding and recognition of the realities in the community and the value of the voluntary sector in addressing inequalities. An overview was given of DHIP's work, with the following areas highlighted: • disparity between communities, such as the difference in life expectancy of 10-15 years between the most and least deprived areas in Derby; • barriers to accessing healthcare in deprived communities and successful approaches taken to addressing these barriers; • the importance of co-production, community input and holding the system to account; and • positive results derived from projects supported through funding received under the CORE25PLUS5 programme. The following comments were made: • the Board expressed thanks to the DHIP representatives and noted that they are very powerful advocates for disadvantaged communities; • one of the core purposes of the ICB is to reduce inequalities in healthcare and it is interesting and helpful to learn about successes such as linking screening and vaccination sessions to existing clubs; • the ICB must address current challenges and barriers to successful engagement with communities and their leadership; foundations must be set for these discussions at ground level, with real knowledge and insight of the communities; • modest amounts of funding can make a real difference in communities with strong local community leadership and effective partnership working; • the medium and long term overall impact of this work on the health of disadvantaged communities must be measured and evaluated. Moving forward, the focus on coproduction, engagement, population health and staying connected with DHIP and others must be prioritised; • the public engagement frameworks developed will have a substantial impact on all commissioning decisions. The Board are hopeful that more impact can be made in future by making coproduction frameworks more integrated; and	

	• the Board must be mindful of how to support the infrastructure of voluntary organisations; a report around infrastructure will come to the Board in due course on behalf of the broader partnership in the ICP space. **Action: It would be very useful to share DHIP's community work with Board Members to demonstrate the lived realities of deprived communities. Presenting this work through strategic commissioning or at Board level will help ensure the ICB is held accountable and that these issues receive appropriate visibility.** The Chair thanked the Citizen Story representatives. **The Board NOTED the Citizen Story.**	**HD**
ICBP/2526/007	**Chair's Report** The Chair highlighted the following from her report: • the Derbyshire system is currently navigating a period of significant change, with recent announcements affecting the NHS, ICBs, NHSE and Trusts. Colleagues across the system are working hard to respond to these developments; • a joint board session with NNICB on the 9th April 2025 was positive, timely and constructive; • work continues on shaping future arrangements, with a requirement to reduce costs by the end of Q3 2025/26. This will require sustained effort over the coming months; • it was recognised that this is a challenging and uncertain time, with many staff concerned and anxious about personal circumstances. The Chair extended empathy to all affected; • there are positive developments. The ICB blueprint outlines the promising future role ICBs will have in strategic commissioning and neighbourhood health. Further guidance is awaited, such as the 10-year plan, which is likely to be published before the parliamentary recess; and • a series of podcasts and interviews with the Chair are being produced to highlight positive work across the system. **The Board NOTED the Chair's report.**	
ICBP/2526/008	**Chief Executive's Report** The Chief Executive was supportive of the Chair's update and stated that the importance of her influence in local community work and upward influence on policies was noted and appreciated. The report focused on the influence of the ICB on broader areas and the following points from the report were highlighted: • the importance of the role of an ICB and broader partnership was stressed, with responsibilities around strategic direction and policy, neighbourhood health, the voluntary sector and community connectivity. The agenda reflects these themes; • Dr Duncan Gooch, a GP in Erewash, is now Chair of the NHS Confederation's Primary Care Network, Dr Aklak Choudhury of UHDB has been appointed Clinical Director for improvement for the Royal College of Physicians and Dr Chris Weiner, the ICB's Chief Medical Officer, is now Professor of Public Health (Visiting) at the University of Derby. The Board congratulated these colleagues; and • thanks were extended to all colleagues across the system for the progress made throughout 2024/25 and for helping to meet financial objectives. The following comments and clarifications were made with regards to the Chair's and Chief Executive's reports: • the timeline for implementation of the cost reduction changes was clarified. Organisations will be monitored on progress of delivering the changes through quarter 3 of 2025/26 and the assumption is that the changes will be completed by the start of quarter 4; and • the difference between ICB running costs and programme costs was clarified. Programme costs are spend on supporting services within the ICB, such as support to neighbourhood health, whereas running costs are spend on the organisation itself, such as the Board. The bulk of the financial resource is in	

	commissioning of delivery. It was noted that the cost reduction must equate to £18.76 per head of population. **The Board NOTED the Chief Executive's report.**	
ICBP/2526/009	**Joint Forward Plan Refresh** MA gave an overview of the updated Joint Forward plan; in summary the plan has good foundations and there has been progress in the right direction. There may be some further changes to the plan in time however there is more to be done. The progress made with respect to focus on Children and Young people's services was highlighted. The plan was discussed, with the following comments: • the importance of data being brought to Board around outcomes for the population, including specific cohorts, and assessments of system progress against targets was stressed. Population health data around outcomes will inform strategic commissioning and enable the system to identify where resources will be best placed; • it was noted that the plan does not pull out the three shifts specifically; • highly linear work is taking place in health service programmes, but the shift to the neighbourhood health space will focus on seamless work around global health, inequalities, social determinates and holistic health, rather than specific clinical pathways; and • It was agreed that the plan is making good progress however more focus on the outcomes and higher expectations for processes will be required. **The ICB Board RECEIVED the Joint Forward Plan Refresh.**	
ICBP/2516/010	**Neighbourhood Health Development** Michelle Arrowsmith, Jim Austin and Nicki Doherty gave an overview of the paper and the importance of neighbourhood health development in terms of commissioning to support the three shifts, initially from acute to community; this will be brought back to Board later with a focus on supporting the other two shifts. The model and current position were discussed, with the following comments: • the proposal has been made around existing PCN footprints and local Place alliances, with around 18 integrated neighbourhood health and care services delivering care to natural population groups of around 100k; • the scale of the shift that will be required is not yet defined, however in the Community Transformation Programme (joint programme with local authorities) there is a £20m per annum opportunity to work at scale. The Darzi Report was clear about the horizon that must be reached and the hope is that the 10 Year Plan will be equally explicit around the proportion of changes that need to be made. The evidence base suggests that around 10% of resource must be dedicated to general practice, whereas it is currently around 5%; • the ICB will have a vital role in understanding and determining individual communities' requirements for resources as some communities may need more resource than others. The next step will be understanding the populations, engaging and coproducing with them to ensure equity. Feedback from populations will influence final decisions, rather than a top-down approach inflicting change without consultation; • a key aspect will be the ability of neighbourhoods to receive the money; some areas are well-prepared and almost ready however some will need more assistance to get to this stage; • the 10 year plan's description from a provider model perspective is eagerly anticipated. The ICB will be setting this up and input from Trust colleagues will be crucial; • there is national work taking place in parallel around community mental health pilots. The system will need to ensure that there is no duplication of work and	

	that the mental and physical health offers are both provided through appropriate infrastructure and mechanisms that are in place at the right time; • there is a concern that the model will be unfit for purpose if there is insufficient engagement with local populations. The system must ask people what they want in their area and which pathways will be most useful. If the population do not fully understand the model and what is on offer they will not use it; • there is evidence that previous work on shifting from acute to community has been successful, however this is not widely known in the system or among the population; some success stories include the work by Team Up around preventing older people being admitted to hospital. There is a strong foundation to build on and this should be communicated to the public; • pathways can be developed in conjunction with acute Trusts in the communities where they are visible to the population. Currently ownership of the national plan and targets are sitting with acute Trusts however these need to be owned and delivered locally to ensure best use of resource across the system; • in Erewash some work has taken place to understand how providers in a Place work together on allocation of resource and clinical accountability. Learning has been gained from this work and it provides a good basis to work from; • although there is a focus on ill health, the system must not miss the chance to address wider health concerns such as reducing disability chronicity and assisting disabled people to stay in work; and • the importance of bold strategic commissioning was stressed to ensure all services align to make the shifts and support the infrastructure. In summary the Chair noted that the neighbourhood health work is key and will be looked at in future, potentially in September's Board meeting. **The ICB Board NOTED the Neighbourhood Health paper and our current position in relation to the national guidance.**	
ICBP/2526/011	**Feedback from the engagement on the NHS 10 Year Plan** The feedback has been received from a range of workshops with the public and colleagues around 10 Year Plan and local strategies and has helped reshape the Joint Forward Plan. The focus was on the three shifts. Healthwatch, DHIP and local community groups contributed to the design of the workshops. Topics of feedback include communities and neighbourhoods, the importance of compassion, effective communications, cultural sensitivities and navigation of healthcare services. The importance of engagement with commissioning work and prioritising the needs and wishes of the population was stressed. The ICB must establish robust mechanisms to incorporate population feedback into its commissioning intentions. Ongoing, meaningful public engagement should be embedded within these processes to ensure services are responsive and accountable to community needs. **The ICB Board DISCUSSED and NOTED the NHS 10 Year Plan Feedback Report Summary 2025.**	
ICBP/2526/012	**Joint Capital Resource Plan 2025/26** The Joint Capital Plan was brought to Board for approval, having progressed through the Finance and Performance Committee. All ICBs need to produce and publish a plan. The plan was discussed, with the following comments: • the plan will link to the infrastructure strategy in due course. The infrastructure strategy will indicate where investment will be needed in future and highlight areas that are not needed or unfit for purpose. This will be helpful in minimising the pay element of the cost reductions. • there has been a subtle shift in how capital is allocated, which was primarily within Foundation Trusts however other considerations have been increased and there is a slight dilution effect around involvement of the shifts. It will be crucial	

	to clarify the strategic view of which authority will be primarily responsible for this; and • the neighbourhood model is starting to address estate infrastructures with a new vision of the estates required to deliver services. The model will enable providers to use estates as effectively as possible. **The ICB Board APPROVED the publication of the Joint Capital Resource Plan 2025/26.**	
ICBP/2526/013	**Prioritisation Policy and Process** The new policy and process are vital to improving community engagement and health outcomes. resource allocation must be strategic, prioritising some areas over others. Following a review of the previous processes, a flexible and adaptable prioritisation method has been redrawn. There is confidence in some aspects of the policy, however further refinement is needed. Flexibility of the policy will support ongoing development. There is a gap in non-executive oversight: some actions are brought to Board but others are enacted without clear oversight. The role of committee and non-executive review needs clarification, especially for major decisions like resource reallocation. These should follow established policies and be explicitly routed through appropriate committees. The policy documentation should be clarified accordingly; it may be useful for the Quality, Safety and Improvement Committee to be involved. The importance of the policy in enacting the three shifts and addressing inequality was stressed. **ACTION: To update the Prioritisation Policy and Process to clarify the process for non-executive oversight** **Subject to amendment as above, the ICB Board:** • **APPROVED the adoption of a new/updated prioritisation framework at ICB and system level; and** • **NOTED the report, as part of ongoing discussions in relation to implementation of a rolling prioritisation framework; and to support the development of the prioritisation process as part of a continuous system quality improvement process over the next financial year.**	**HD, CW**
ICBP/2526/014	**2025/26 Operational Plan – Final Submission** The Operational Plan has been signed off and submitted. There has been no strategic shift in this document from the version that was signed off by the Board. **The ICB Board APPROVED the 2025/26 Operational Plan.**	
ICBP/2526/015	**ICB Financial Plan 2025/26.** It was noted that the plan has been through the relevant committees ahead of Board. Congratulations and thanks were extended to staff for their hard work in finalising the plan. **The ICB Board NOTED the amendments to the ICB Financial Plan for 2025/26.**	
ICBP/2526/016	**Integrated Performance Report** **Performance** • although a lot of the systemic issues are long-standing and some targets have been missed, there has been a steady underlying improvement on most metrics and real improvements in urgent and emergency care; • the operating plan has significant delivery plans going to delivery board which will connect all improvement and quality work across commissioning and provider work to ensure that the 2025/26 plan is delivered and progress is made in all metrics; • the system will continue to make a concerted effort to reduce long waits and • mental health standards are being met very well. **Quality** • ongoing work is taking place with maternity services; • the review of the Winter washup has been received; this links to the harms review round the eight-hour wait which showed no harm although the	

	metrics around the harm being measured are not necessarily representative of the true picture; • in terms of SMI health checks, the target has been met with all 5000 assessments taking place. This is a great outcome, requiring a huge effort; • thanks were offered to CRHFT around analysis of blood sugar levels in the community. The Trust experienced issues with a malfunctioning machine; the malfunction has been corrected and the Trust have produced written guidance for how to respond to similar incidents for circulation to other Trusts. **Finance** • the recurring cost pressures from the previous financial year have been built into the plan for 2025/26; • the efficiency programme will not meet the plan unless £180m recurrent efficiency is found; the efficiencies have been identified however have not been delivered as yet and will need to be scheduled evenly throughout 2025/26; • delivery of recurrent savings will need to reach the target of 65%, which will be increased to 75% or over next year. A reasonable level of assurance is in place but there is a long way to go; and • The ICB should aim to anticipate that there will not be an extra £45m to support its position this year. The Finance Committee will need to demonstrate to the Board the position over the past few years to show improvements over the underlying position. For now Derbyshire is underfunded on the fairer funding formula. **Workforce** • The substantive workforce is broadly in line with the plan. There has been an increase in bank and agency staff caused by leave and sickness absence, however there are controls in place to ensure no unnecessary increase in use of temporary staff. • Elements around pay, waiting list initiatives, overtime and early starts of nursing cohorts are all positive. • While staff surveys taken in Autumn 2024 have yielded encouraging results in terms of morale, the results would likely be different if the survey was taken now. The reduction in costs will see reduction in substantive posts, which is creating uncertainty around the future and adversely affecting staff morale. • In a difficult landscape Derbyshire is currently in the best place possible and is recognised as a strong performer in the Midlands. Work is taking place to reduce surprise elements around unplanned resource requirements. **The ICB Board RECEIVED the Integrated Performance Report for assurance.**	
ICBP/2526/017	**Derby and Derbyshire ICB Emergency Planning Resilience and Response (EPRR) Policy** As a category 1 responder, the ICB is expected to have an EPRR policy in place, with annual Board review. The policy reflects the category 1 status and has been through several stages of development, including assurance processes through NHSE, and will go to NHSE again in due course. The policy is reviewed through the Audit and Governance Committee, which receives regular EPRR reports. If responsibility for EPRR is transferred to another organisation in the future. there will be a rigorous transfer process. **The ICB Board NOTED and SUPPORTED the ICB EPRR Policy.**	
ICBP/2526/018	**New Committee Terms of Reference (TORs)** The Strategic Commissioning and Integration Committee's TORs require a minor amendment to the scheme of delegation. Otherwise all committee TORs been recommended by the Committees to Board for approval as required and the work required to achieve this position was noted. **Subject to the minor amendment noted above, the ICB Board APPROVED the Committee Terms of References.**	
ICBP/2526/019	**ICB Committee Annual Reports 2024/25** The work required to produce the Committee Annual Reports was noted. There were no other comments or questions regarding the reports.	

	The ICB Board NOTED the ICB Committee Annual Reports for 2024/25.	
ICBP/2526/020	**Board Assurance Framework (BAF) Final Quarter 4 2024/25 position and Opening Quarter 1 2025/26 position** There will be a Board seminar session on BAF later in the year. The 10 Year Plan might be released in time for the Quarter 1 2025/26 position. There have been some changes to the BAF such as the cyber security risk which has been added and received by the relevant committee. The score has been reduced on this risk. Some risk scores remain static; measures to reduce these scores should be explored. An additional strategic risk in relation to the transition will need to be considered for Quarter 1 2025/26. **The ICB Board:** • **RECEIVED the final Quarter 4 2024/25 BAF strategic risks 1 to 11;** • **NOTED the risk score decreases in respect of strategic risk (SR):** ○ **Strategic Risk 11, owned by Finance and Performance Committee has been decreased from a very high score of 20 to a very high score of 16.** • **RECEIVED the opening Quarter 1 BAF position.**	
ICBP/2526/021	**Integrated Care Board Risk Register Report – as at 30th April 2025** New transition risks were proposed relating to staff health and wellbeing, loss of skills and knowledge and the ICB's ability to deliver the 2025/26 plan. **The ICB Board:** • **RECEIVED and NOTED:** ○ **Appendix 1, the Risk Register Report;** ○ **Appendix 2, which details the full ICB Corporate Risk Register;** ○ **Appendix 3, which summarises the movement of all risks in April 2025.** • **APPROVED CLOSURE of:** ◦ **Risk 33 relating to the current contractual dispute with Midlands and Lancashire Commissioning Support Unit.**	
ICBP/2526/022	**Committee Assurance Reports** The Committee Assurance Reports were received by the Board. The Audit and Governance Committee have reviewed the draft Annual Report and Accounts. The Committee is very pleased with the quality of the documents and have taken full assurance that they are as complete as possible at this stage. The Board noted the hard work that has gone into production of the documents. The Chair noted that there are areas across all assurance reports that have partial assurance and raised the question of how full assurance could be achieved. **The ICB Board RECEIVED the Committee Assurance Reports for assurance.**	
ICBP/2526/023	**Risks identified during the course of the meeting** Risks have been identified in relation to the transition period and the resultant effect on staff morale.	
ICBP/2526/024	**Forward Planner** The forward planner was taken as read. **The Board NOTED the forward planner for information.**	
ICBP/2526/025	**Questions received from members of the public** No questions were received from members of the public.	
ICBP/2526/026	**Any Other Business** No other business was brought to the Board.	

Date and Time of Next Meeting

Date: Thursday, 17th July 2025
Time: 9:15am to 11:15am
Venue: The Joseph Wright Room, Council House, Derby DE1 2FS

Derby and Derbyshire Integrated Care Board

ICB BOARD MEETING IN PUBLIC

ACTION LOG – MAY 2025

Item No.	Item Title	Lead	Action Required	Action Implemented	Due Date
ICBP/2324/050 20.7.2023	NHS Derby and Derbyshire One Workforce Strategy	Lee Radford	It was agreed that the Plan would return to a future Board for further discussion.	• The workforce plan review is in progress by the People and Culture Committee. • An update to Board on One Workforce strategy for DD was given by LR in Jan 2025. This will be brought back to Board for approval in Jan 2026. • Quarterly update reports to be presented to Board on progress and development of the plan.	**Jan 2026**
ICBP/2425/080 19.11.2024	Joint Forward Plan	Michelle Arrowsmith	Monitor and establish measure against system ambition and ensure there is a link to board assurance framework	The 2025/26 Operational Plan (year 3 of the JFP) delivery is measured and monitored in the main through our system delivery boards and any risks will be reflected in the 2025/26 Q1 BAF. Strategic Risks will be reviewed when the 10 year plan has been published in Q2 of 2025/26.	**September 2025**

Item 031

ICBP/2425/104 16.01.2025	Citizen's Story: Can community-based projects begin to reduce health inequalities?	Jim Austin, Chris Weiner, Andrew Fearn	It is recognised that the use of the data that supports community-based projects sits with the Integrated Place Executive (IPE) oversight and Place Alliances. The ability to collate, share and surface data is one that the ICB is leading on through the data teams. JA, CW and AF to update Board on progress and barriers	This action is in progress.	**September 2025**
ICBP/2324/ 131 20.03.2025	Operational Planning approach to 2025/26	Dr Avi Bhatia	Dr Avi Bhatia (AB) to work with the Clinical Professional Leadership Group (CPLG) and other relevant colleagues on aligning objectives for transformational change across all organisations.	AB - We continue to engage Clinical staff on alignment and working towards ongoing transformation of clinical services.	**July 2025**

NHS
Derby and Derbyshire
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NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

17th July 2025

Item: 032

Report Title	Citizens' Story – Jericho House - The Living Recovery Foundation							
Author	Christina Jones, Head of Communications							
Sponsor	Helen Dillistone, Chief of Staff							
Presenter	Helen Dillistone, Chief of Staff Neil Ainslie, CEO of the Living Recovery Foundation David Parkinson, Finance Manager, Living Recovery Foundation							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☒
Appendices (reports attached)	None							

Recommendations
The ICB Board are recommended to **NOTE** the Citizens' Story and ask questions of the panel.
Report Summary
The charity Jericho House helps men in Derby and Derbyshire with drug and alcohol addiction recovery. In response to the disbanding of the national charity Jericho Society, by which Jericho House was previously funded and run, the team have formed a new charity called 'The Living Recovery Foundation' and have a Board of trustees. They are now operating under this new name. Jericho House is a 9-bed residential addiction recovery project that provides a holistic approach to drug addiction with elements of housing support and re-settlement. ICB Chair Dr Kathy McLean visited the House in December to understand the model and see the impact for the population. The charity looks after around nine men at any one time and 75 per cent remain abstinent long term. On a monthly basis they also support around 50 family members by phone, email, social media and face to face at family support meetings. They continue to run the same service, which is an abstinence-based program that incorporates Cognitive Behavioural Therapy (CBT) and the 12-step model. The program emphasizes the value of lived experience, helping clients practically recognize and implement strategies and techniques in their daily lives. The unit has been operating for over 20 years and estimates it has saved the NHS more than £10 million since its inception. Individuals can self-refer or be referred through their GP or social services, although there is typically a waiting list of one to four months. The unit also has seven step-down facilities which help the men reintegrate into normal life once they have completed their time at Jericho House. Of those who complete the primary and aftercare stage, around 90% gain long term abstinence-based recovery. The men have a program of structured daily activities including morning focus and self-reflection groups, domestic skills and personal care, group therapy sessions, college courses, one-to-one key work sessions, structured outings and evening self-help meetings. All activities are based on personalized care plans, which are developed upon arrival and tailored to individual needs.

How does this paper support the 3 shifts of the NHS 10-Year Plan?					
From hospital to community	☒	From analogue to digital	☐	From sickness to prevention	☐

Integration with Board Assurance Framework and Key Strategic Risks					
SR1	Safe services with appropriate levels of care	☒	**SR2**	Reducing health inequalities, increase health outcomes and life expectancy	☒
SR3	Population engagement	☒	**SR4**	Sustainable financial position	☐
SR5	Affordable and sustainable workforce	☐	**SR7**	Aligned System decision-making	☐
SR8	Business intelligence and analytical solutions	☐	**SR10**	Digital transformation	☐
SR11	Cyber-attack and disruption	☐			☐

Conflicts of Interest	

Have the following been considered and actioned?			
Financial Impact	Yes ☐	No ☐	N/A ☒
Impact Assessments	Yes ☐	No ☐	N/A ☒
Equality Delivery System	Yes ☐	No ☐	N/A ☒
Health Inequalities	Yes ☐	No ☐	N/A ☒
Patient and Public Involvement	Yes ☐	No ☐	N/A ☒
ICS Greener Plan Targets	Yes ☐	No ☐	N/A ☒

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

17th July 2025

Item: 033

Report Title	Chair's Report							
Author	Sean Thornton, Director of Communications and Engagement							
Sponsor	Dr Kathy McLean, ICB Chair							
Presenter	Dr Kathy McLean, ICB Chair							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☒
Appendices (reports attached)	Appendix 1 - Joint ICB Transition Committee Terms of Reference.							

Recommendations

The ICB Board are recommended to **NOTE** the ICB Chair's report and **APPROVE** the Joint ICB Transition Committee terms of reference.

Report Summary

NHS Reform

It has been confirmed that NHS Derby and Derbyshire ICB will cluster with NHS Nottingham and Nottinghamshire ICB and NHS Lincolnshire ICB.

The clustered ICB will develop a single Board, with a single Chair and Chief Executive, who will in turn develop structures to deliver the ICB functions outlined in the national Model ICB Blueprint. The appointment process for the single Chair is expected to be completed by the end of July 2025, followed by the appointment of the single Chief Executive Officer, and engagements with executives and the wider workforce will then take place through the summer and autumn, including a statutory consultation with staff on new structures. We continue to work to a 31st December 2025 deadline to complete this process and demonstrate that we are meeting our costs reduction targets, which is around 45% for our cluster.

Each ICB will remain a statutory body until there is a change to legislation, which we anticipate may follow in 2026. In the meantime, we will be required to maintain appropriate oversight and governance, including audit and remuneration committees, although these can meet 'in common'.

We have established a Joint ICB Transition Committee between the three ICBs, with the primary purpose of overseeing and scrutinising arrangements for the transition of the ICBs into their future operating model. The terms of reference for the Joint ICB Transition Committee are appended to this report for the Board's approval.

NHS 10 Year Plan

As an ICB Chair, and as Chair of the NHS Confederation Network, I have been involved in some of the national conversations relating to this reform which has been much anticipated.

It is an ambitious and exciting plan and which we are looking forward to dissecting and understand further.

We very much welcome the strategic direction it sets out and its implementation will lead to improved care for our population, especially those facing health inequalities. Additional prevention and more care in the community will be very much welcomed and the focus on a neighbourhood health service plays into the work we have already been doing.

I was very pleased, for example, to see Derbyshire highlighted in the Plan as an area of good practice for neighbourhood health services illustrated through our area's flagship Team Up model.

Being able to showcase how we are already delivering in line with the plan's ambitions gives us a firm footing for the future.

The plan's key messages include:

- This plan is a bold, ambitious and necessary new course for the NHS.
- It seizes the opportunities provided by new technology, medicines, and innovation to deliver better care for all patients - no matter where they live or how much they earn - and better value for taxpayers.
- We are fundamentally reinventing our approach to healthcare, so that we can guarantee the NHS will be there for all who need it for generations to come.
- Through our three shifts – from hospital to community, from analogue to digital, and from treatment to prevention – we will personalise care, give more power to patients, and ensure that the best of the NHS is available to all.

It also continues to concentrate on the three shifts that have been the central tenet of the Government and NHS administration's messages about the NHS, seeking to shift from treatment to prevention, from analogue to digital, and from hospital to community care.

More detail on the three big shifts:

- **From hospital to community**; transforming healthcare with easier GP appointments, extended neighbourhood health centres, better dental care, quicker specialist referrals, convenient prescriptions, and round-the-clock mental health support - all designed to bring quality care closer to home.
- **From analogue to digital;** creating a seamless healthcare experience through digital innovation, with a unified patient record eliminating repetition, AI-enhanced doctor services and specialist self-referrals via the NHS app, a digital red book for children's health information, and online booking that ensures equitable NHS access nationwide.
- **From sickness to prevention;** shifting to preventative healthcare by making healthy choices easier—banning energy drinks for under-16s, offering new weight loss services, introducing home screening kits, and providing financial support to low-income families.

The plan sets out further elements of priority and reform as well.

But this is just the beginning. We will now digest and discuss the plan and consider what it means for us as an ICB and a system before deciding next steps.

Linked to the report we heard about the intended abolition of further national organisations including Healthwatch England, which advocates on behalf of patients, and the National Guardian's Office, which supports speaking up across the NHS.

We have worked very closely with Healthwatch in Derby and Derbyshire over the years and have seen first-hand some of their fantastic work for patients and therefore have extended our support to those teams over the weeks and months to come.

Local Visits and Discussions

I have continued my series of visits to local teams and establishments to further my understanding of how our system operates. These are such enlightening ways to spend time, forming new relations with our colleagues and partners and seeing firsthand the impact of the work that the ICB oversees.

My most recent visit was to Derbyshire Community Health Service's Sexual Health Promotion Team, where I was taken on a whistlestop tour by bus to see how the service works with underserved communities. The team took me round in their sexual health outreach van, which

visits specific locations each week to carry out screening checks and prevention advice including the Bosnia Herzegovina Centre, St Peter's Square and Milestone House in Derby. We stopped off at the Bosnia Herzegovina Community Centre, where I met with staff and witnessed first-hand the team's commitment to delivering support in welcoming, community-based settings.

Over the past year, the team's various outreach programmes such as market stalls, relationship and sex education workshops and rapid HIV testing have engaged more than 24,000 people across Derby and Derbyshire. Feedback shows that 95% of participants feel more confident accessing sexual health services after engaging with the outreach team. I was in awe of how passionate the Team were about their work. By meeting people where they are, they're helping to break down barriers, reduce stigma, and ensure that sexual health support is accessible to everyone. This kind of innovation and partnership is exactly what we need to tackle health inequalities across Derbyshire.

I also visited Ashgate Hospice in Chesterfield, which provides palliative and end-of-life care, free of charge, to people aged 18 and over. They care for people living with life-limiting illnesses including cancer, neurological diseases and end-stage heart, kidney and lung diseases. Hospice care is an extremely important part of our health service and getting the right surroundings and care makes a huge difference to people's lives. I was so grateful for the time the staff all spent with me and it is incredibly useful to get insight into the model of care when thinking about the way we commission health services for our population.

I have also recently enjoyed recording a series of podcasts with local health and care leaders. These have focussed initially on the three shifts, as set out by the Secretary of State for health and Social Care, and we will continue to record them over the months on an increasingly wide range of topics. We've called the series 'Healthy Conversations'; I am very grateful to everyone who has taken part so far and also helped to organise them. For anyone interested in listening, the podcasts are all published on Spotify.

NHS Confed Expo

More than 7000 colleagues from across the health and care sector attended this year's NHS Confederation Expo in Manchester. These are always exciting events, full of forward thinking and innovation, as well as an opportunity to hear the latest policy updates from national leaders. The keynote speeches from the Interim NHS England Chief Executive and Secretary of State for Health and Care are linked below:

- Sir Jim Mackey's keynote speech
- The Rt Hon Wes Streeting MP's keynote speech

Finally, and as I have said previously, we are well into a period of significant change and I wish to continue to acknowledge the uncertainty it brings and the anxiety it may cause for colleagues within the ICB. I record my thanks again to ICB staff for their dedication – this whole Board recognises that your efforts are invaluable as we move forward with purpose and resolve.

Dr Kathy McLean
ICB Chair

How does this paper support the 3 shifts of the NHS 10-Year Plan?					
From hospital to community	☒	From analogue to digital	☒	From sickness to prevention	☒

Integration with Board Assurance Framework and Key Strategic Risks					
SR1	Safe services with appropriate levels of care	☐	**SR2**	Reducing health inequalities, increase health outcomes and life expectancy	☒
SR3	Population engagement	☒	**SR4**	Sustainable financial position	☐
SR5	Affordable and sustainable workforce	☐	**SR7**	Aligned System decision-making	☐
SR8	Business intelligence and analytical solutions	☐	**SR10**	Digital transformation	☐

SR11	Cyber-attack and disruption	☐			☐

Conflicts of Interest	None identified		
Have the following been considered and actioned?			
Financial Impact	Yes ☐	No ☐	N/A ☒
Impact Assessments	Yes ☐	No ☐	N/A ☒
Equality Delivery System	Yes ☐	No ☐	N/A ☒
Health Inequalities	Yes ☐	No ☐	N/A ☒
Patient and Public Involvement	Yes ☐	No ☐	N/A ☒
ICS Greener Plan Targets	Yes ☐	No ☐	N/A ☒

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Joint ICB Transition Committee – Terms of Reference

1. Introduction/ Purpose	The Joint ICB Transition Committee ("the Joint Committee") is a joint committee of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ("the ICBs"), established in accordance with section 65Z5 of the National Health Service Act 2006 (as amended by the Health and Care Act 2022). The primary purpose of the Joint Committee is to oversee and scrutinise arrangements for the transition of the ICBs into their future operating model, in line with national guidance. Due to the nature of the Joint Committee's role, it will be time-limited in its establishment, with the Boards of the ICBs determining the appropriate timeframe for the Joint Committee to be dis-established. The Joint Committee is authorised to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from employees of the ICBs and all employees of the ICBs are directed to co-operate with any request made by the Joint Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
2. Duties	a) Oversee the establishment of robust programme management arrangements to deliver ICB transition requirements within the prescribed timeframe. b) Oversee the development and implementation of a fit for purpose ICB operating model. This will include ensuring that the proposed new model: • Is designed to effectively deliver revised ICB functions and responsibilities, in line with the Model ICB Blueprint, based on a robust 'make, buy, share' assessment across relevant geographies. • Delivers required efficiencies and is affordable within the financial allocation for the ICBs. • Is developed taking into account the feedback from the combined workforce of the ICBs, as appropriate. c) Oversee the development and implementation of fair and transparent exit and workforce change processes for ICB

	staff, in line with national guidance and local policy requirements, working in conjunction with each ICB's Remuneration (and Human Resources) Committee, as appropriate. This will include oversight of appropriate training and development and health and wellbeing initiatives for ICB staff to ensure they are well supported throughout the transition process. d) Oversee the establishment of effective governance arrangements to support the period of transition the new ICB operating model, and to ensure its ongoing effectiveness. e) Oversee the delivery of timely, open, and transparent staff and stakeholder communications throughout the transition process. f) Oversee the identification and management of risks relating to the transition process and future ICB operating model. g) Oversee arrangements for the safe transition of any transferred functions.
3. Membership	The membership of the Joint Committee will be comprised as follows: *NHS Derby and Derbyshire ICB:* a) Two Non-Executive Members of the Board b) Chief Executive c) Executive Director Lead for Transition *NHS Lincolnshire ICB:* d) Two Non-Executive Members of the Board e) Chief Executive f) Executive Director Lead for Transition *NHS Nottingham and Nottinghamshire ICB:* g) Two Non-Executive Members of the Board h) Chief Executive i) Executive Director Lead for Transition *Attendees* The Joint Committee may invite a range of Senior Managers from each ICB to attend meetings to support the Joint Committee in discharging its responsibilities.
4. Chair and deputy	The Boards of the ICBs will appoint a Non-Executive Member to be Chair of the Joint Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Joint Committee's Non-

	Executive membership will be nominated to deputise for that meeting.
5. Quorum	The Joint Committee will be quorate with a minimum of six members, to include at least one non-executive and one executive member from each ICB. If any Joint Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	It is expected that at the Joint Committee's meetings, decisions will be reached by consensus and a vote will not be required. Any decisions taken will be record in the minutes of the meeting. If consensus cannot be reached and if timeframes allow, then the item will be re-scheduled for discussion at the next meeting of the Joint Committee. Otherwise, decisions will be taken by simple majority.
7. Meeting arrangements	The Joint Committee will initially meet on a fortnightly basis, in line with the pace of change requirements. The required frequency of meetings will be kept under review and adjusted as appropriate as the transition period progresses. Members of the Joint Committee are expected to attend meetings wherever possible. The Joint Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Joint Committee will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Joint Committee to be open to the public. Secretariat support will be provided to the Joint Committee to ensure the day-to-day work of the Joint Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than three calendar days in advance of meetings and will be distributed by the secretary to the Committee. Agendas will be agreed with the Chair prior to the meeting.
8. Minutes of meetings	Minutes will be taken at all meetings and will be ratified by agreement of the Joint Committee at the following meeting.
9. Conflicts of interest management	In advance of any meeting of the Joint Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as

	ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Joint Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Joint Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Joint Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Joint Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Reporting responsibilities	The Joint Committee is accountable to the Boards of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB. The Joint Committee will provide assurance to the Boards that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, through submission of Committee Highlight Reports, summarising items discussed, decisions made and any specific areas of concern that warrant immediate Board attention. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
11. Review of terms of reference	Due to the focus of the Joint Committee's work and the nature of emerging guidance, these terms of reference will be kept under review on an ongoing basis to ensure continued fitness for purpose. Any proposed amendments to the terms of reference will be submitted to the ICBs' Boards for approval.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

17th July 2025

Item: 034

Report Title	Chief Executive Officer's Report							
Author	Dr Chris Clayton, ICB Chief Executive Officer							
Sponsor	Dr Chris Clayton, ICB Chief Executive Officer							
Presenter	Dr Chris Clayton, ICB Chief Executive Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices (reports attached)	None.							

Recommendations
The ICB Board are recommended to **NOTE** the ICB Chief Executive Officer's report.
Report Summary

NHS Reform

Since the Board meeting in May, the ICB has submitted a high-level planning assumption to NHSE that demonstrates a route to reducing ICB costs to £18.76 per head of population, in line with national requirements. The submission has been subject to regional and national ratification processes during June and it has been confirmed that NHS Derby and Derbyshire ICB will cluster with NHS Nottingham and Nottinghamshire ICB and NHS Lincolnshire ICB.

We await further information on the reform taking place within the Department of Health and Social Care and NHS England, who equally will be seeking to make cost reductions. This national process is running to a longer timetable than ICB changes, and we are aware that DHSC has announced its leadership structure in recent weeks. Of note for ICBs is that we continue to await the publication of the Model Region Blueprint, which will help solidify the roles and responsibilities as they sit between ICBs and regional offices.

Our NHS provider organisations also continue to determine their approach to their cost reduction programmes, which requires a saving of 50% saving against the growth costs of corporate posts incurred since 2019/20.

We have also now received the Government's NHS 10-Year Plan. It outlines the vision for improving NHS health and care services over the next decade.

The plan focuses on three key shifts: hospital to community, treatment to prevention, and analogue to digital. An open letter was issued to all colleagues from NHS England's Chief Executive, Sir Jim Mackey, and Secretary of State, Wes Streeting.

One of the key areas of the plan is around establishing a neighbourhood health service with teams working within local communities to help people access and receive care closer to home and free up resource in hospitals.

I was delighted to see our Team Up Service referenced in the plan as an example of how we are already delivering good practice in this area as part of the 10-Year Plan.

Our Clinical Director for Neighbourhood Care, Dr Penny Blackwell, spoke on BBC Radio 4's Today programme on the launch day, further highlighting the impact the service is having, helping to treat patients in their own home where possible. You can listen to Dr Blackwell's interview on the BBC Sounds website here (skip to 1:34).

I am very proud of both Team Up and of all the other impactful work all our teams do every day across Derby and Derbyshire, to make life better for our population which comes after years of focused attention – but our work will not stop here. The plan cements our direction of travel and gives us a firm footing

We look forward to enhancing our neighbourhood care model through the advent of our recently launched multi-partner Community Transformation Programme which is a flagship development for the Health and Care partnership that we have here in Derby and Derbyshire.

While the Plan gives us an important sense of NHS direction, these remain challenging times for us as an ICB as we face the cost reduction requirements that have been set out.

However, we must continue with our crucial work so we will now take some time to digest the Plan as an Executive Team and will discuss together and with our workforce in the near future to decide local next steps.

ICB Annual Assessment Framework

The National Health Service Act 2006 (as amended by the Health Service and Care Act 2022) established integrated care boards (ICBs). ICBs are statutory organisations that commission health and healthcare services for their area and work with local services, including local authorities and wider partners, to improve population health and deliver shared strategic priorities. Under the terms of the NHS Act (as amended), NHS England is required to undertake a performance assessment of each ICB in respect of each financial year and publish a report containing a summary of the results of each assessment.

NHS England published its guidance to support the 2024/25 annual assessment process in June. The assessment must assess how well the ICB has discharged its functions (both its powers and its duties) during the year. It must include, but is not limited to:

- the duty as to improvement in quality of services
- the duty as to reducing inequalities
- the duty to obtain appropriate advice
- the duty to have regard to the wider effect of decisions (the triple aim)
- the duty in respect of research
- the duty on public involvement and consultation
- the financial duties
- the duty to have regard to local assessments and strategies

The outcome of the annual assessment will take the form of a letter from the relevant NHS England Regional Director to the ICB Chair. The purpose of the assessment is to assess the ICBs performance and how well it has discharged its statutory functions.

Oversight Framework

The NHS Oversight Framework 2025/26 sets out how NHS England will assess NHS trusts, foundation trusts, and ICBs, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

The assessment will be the starting point for how NHS England works with organisations throughout the year and will help determine how they can support them to improve. The framework outlines the circumstances in which providers can obtain increased freedoms. It also describes how NHS England will determine whether a provider's performance falls below an acceptable standard and/or has governance concerns that may lead to the use of regulatory powers to secure improvement.

ICBs will not be segmented in 2025/26, recognising this will be a year of significant change as they transform in line with the Model ICB Blueprint. However, their performance will continue to be monitored across a range of oversight metrics including leadership capability and how well each ICB is performing its statutory duties.

The full report can be found here: https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/.

Contracting and Operational Performance
We now have validated data for Month 2 performance, and this is included in the integrated performance report. We are currently noting a mixed picture of performance across key targets, and are working with our trust colleagues to understand their mitigation plans to bring performance back on track.

We have now also signed contracts for 2025/26 with all providers, including those for which we are an associate commissioner for out of area providers. This has been a constructive dialogue to reach sign off, supported by a robust planning round during the spring.

Community Transformation Programme
The Board has been previously appraised of the health and care system's plan to undertake a broad community transformation programme during 2025/26. This is central programme to deliver our operational plan requirements for 2025/26, as well having an important bearing on our ability to sustain health and care services during the challenging winter period.

The NHS and Local Authority partners have committed to jointly funding the programme, and following a competitive tender process, we have appointed an external partner to support with our diagnostic, data and internal stakeholder engagement approach. This work commenced in May and its initial data diagnostic confirms that the original opportunities to improve care and services, identified in 2023, remain.

All partners have now committed to the next phase of the programme, which will focus on three initial transformation priorities: hospital front door and the manage of incoming demand for specialist care; complex discharge delays; and the utilisation of Pathway 1 care (through which patients return to the place they call home with a care package). We anticipate that this programme will fully mobilise during July and will begin to show return on investment from September onwards. Further areas of focus for the programme will be identified in due course.

Pay Awards
The Health and Social Care Secretary has announced the NHS Pay award for nursing and all staff employed on agenda for change contracts in England. The award of 3.6% will be backdated to 1 April 2025. NHS England has released a pay framework for very senior manager (VSM), designed to support the NHS in securing the best senior leaders, with the right skills and experience, to deliver exceptional care and services for patients and their local communities. The framework applies to all NHS Provider Trusts and integrated Care Boards (ICBs) and has been jointly produced by NHS England the Department of Health and Social Care (DHSC), with the policy owned by DHSC as introduced by the Secretary of State for Health and Social Care.

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

Chris Clayton
Chief Executive Officer

National updates

PM launches new era for NHS with easier care in neighbourhoods
The Prime Minister has launched the government's 10 Year Health Plan to bring the NHS closer to home.

NHS approves new IT system for GPs to help transform care
NHS England has approved a new cloud-based IT system for general practice, aiming to modernise digital infrastructure and improve patient care.

NHS England responds to ADHD Taskforce interim report
NHS England welcomed the ADHD Taskforce's interim findings and look forward to the report's conclusion and recommendations later this year.

NHS launches drive to catch one of the most lethal cancers
A new NHS pilot will proactively identify patients at risk of pancreatic cancer using GP records to improve early diagnosis.

NHS waiting list hits two-year low as staff work to 'turn the tide'
The NHS waiting list has fallen to its lowest level in two years, from 7.42 million to 7.39 million, with staff delivering "record numbers of checks, tests, treatments and appointments".

Millions to benefit from NHS robot drive
Robotic-assisted surgery will become the default for many keyhole procedures, with the NHS aiming to deliver half a million such operations annually by 2035.

NHS rolls out more personalised cervical screening for millions
From July, younger women who test negative for HPV, will safely be invited at 5-year intervals rather than 3, supported by new digital invitations and reminders via the NHS App.

Thousands affected by contaminated blood scandal to get bespoke NHS psychological care
Thousands of people affected and infected by the contaminated blood scandal will be able to self-refer for psychological treatment from a bespoke new NHS service.

New ambulances and faster emergency care for patients next winter
Nearly £450 million will fund almost 500 new ambulances, 15 new mental health crisis centres, and 40 Same Day Emergency Care units to shift care into the community and reduce A&E pressure.

GP practices improve access by embracing technology and increasing appointments
Almost every GP practice in England now uses digital phone systems and online triage tools, helping deliver 19% more appointments since April 2019.

NHS first in world to roll out 'revolutionary' blood test for cancer patients
Tens of thousands of patients with suspected lung or advanced breast cancer will now receive a new 'liquid biopsy' blood test that can detect tumour DNA, fast-track access to targeted therapies, and potentially save the NHS up to £11 million annually.

'Amazon-style' prescription tracking goes live in NHS App for millions of patients
Patients can now receive near real-time updates on their prescriptions, such as "ready to collect" or "dispatched by pharmacy", via the NHS App, reducing calls to pharmacies and freeing up staff time.

NHS App overhaul will break down barriers to healthcare and reduce inequalities
The upgraded NHS App will include new tools like "My Companion" and "My Choices" to give patients personalised, AI-powered health information and provider comparisons.

Innovator passports' set to accelerate cutting-edge NHS care
A new 'innovator passport' will allow new technology that has been robustly assessed by one NHS organisation to be easily rolled out to others.

World-first AI system to warn of NHS patient safety concerns
A pioneering AI early warning system will scan NHS data in real time to flag safety issues and trigger rapid inspections, aiming to prevent harm and improve care quality as part of the government's 10 Year Health Plan.

Health and Social Care Secretary speech on health inequalities
In a speech delivered in Blackpool, Wes Streeting highlighted stark regional health disparities, and outlined how the 10 year plan will help tackle these.

Home testing kits for lifesaving checks against cervical cancer
Women who have missed cervical screening invitations will be offered HPV self-sampling kits to use at home, aiming to boost participation and catch more cancers early as part of the upcoming 10 Year Health Plan.

Health and Social Care Secretary speech at RCOG World Congress
In his speech at the RCOG World Congress, Wes Streeting announced a national investigation into maternity and neonatal services, citing rising maternal death rates, persistent racial disparities, and widespread safety concerns across NHS trusts.

Sickle cell patients to get better treatment after £9 million boost
A £9 million investment will expand access to Spectra Optia machines and specialist centres for sickle cell patients, enabling faster, more convenient care and potentially saving the NHS up to £12.9 million annually.

Chancellor announces record investment to rebuild National Health Service
New investment includes up to £10 billion on technology and digital transformation, GP training to deliver millions more appointments and rolling out mental health support to all schools.

Patients to receive reminders and test results via the NHS App
A £50 million upgrade will enable millions more patients to receive appointment reminders, screening invitations, and test results through the NHS App, reducing missed appointments and saving the NHS an estimated £200 million over three years.

Nearly £1 billion for NHS frontline after agency spend crackdown
Savings from reduced agency staffing costs are being reinvested into frontline care, staff pay, and waiting list reductions.

Single-use vapes banned from 1 June 2025
The government has banned the sale of single-use vapes to curb youth nicotine addiction and reduce environmental waste, with fines and enforcement measures in place to ensure compliance.

Local Developments

Derby and Derbyshire ICB news

NHS 10 year plan welcomed by Derbyshire's NHS leaders
NHS leaders in Derby and Derbyshire have welcomed the publication of the government's NHS 10 year plan and thanked local people and staff for their contribution to it.

Dr Penny Blackwell shares Team Up successes as part of NHS 10-Year Plan launch
Clinical Director for Neighbourhood Care, Dr Penny Blackwell, spoke on BBC Radio 4's Today programme as part of the coverage for the launch of the NHS 10-Year Plan. Dr Blackwell shared insights into how our Team Up Service, which was directly referenced in the Plan, works. It was an example of how we are delivering good practice in line with the shift towards the neighbourhood care model which forms a major part of the 10-Year Plan.

30 stone man drops two trouser sizes and puts his Type 2 diabetes into remission on NHS programme
A 35-year-old Chesterfield man put his Type 2 diabetes into remission and lost five stone through the NHS Type 2 Diabetes Path to Remission Programme, transforming both his physical and mental health in under a year. BBC East Midlands Today shared the story.

'My heartburn symptoms turned out to be cancer'
BBC East Midlands Today shared the story of John Hatton, who supported our local campaign raising awareness of oesophageal cancer. John was 54-years-old when he was left "stunned" and "numb" following his diagnosis, and put his symptoms down to heartburn.

Second episode of Healthy Conversations podcast with Dr Kathy McLean now available
The second episode of the Healthy Conversations podcast, hosted by ICB Chair Dr Kathy McLean, explores Derbyshire's shift from analogue to digital healthcare, featuring insights from

Debbie Loke, Dawn Atkinson, and Arun Chidambaram on topics like electronic patient records, the NHS app, AI, and digital inclusion.

Update on review of services in Glossop
A review of over 200 NHS services in Glossop is ongoing, with differences in clinical policy application being examined and some services, such as fertility treatment, now under reconsideration.

Ashgate Hospice welcomes ICB Chair Dr Kathy McLean
Staff and patients at Ashgate Hospice welcomed the ICB chair Dr Kathy McLean this week for a tour of their upgraded facilities.

Tirzepatide: a new treatment option for managing obesity
The ICB issued a statement about Tirzepatide, announcing that whilst the drug has been made available on the NHS, it won't be offered locally until later on in the year.

New service in High Peak to reduce hospital admissions for non-medical emergencies
A new service in the High Peak is fast-tracking professionals to quicker help for non-medical emergencies in a bid to reduce unnecessary 999 calls and hospital admissions.

ICB Chair takes whistle-stop tour to see outreach work
Dr Kathy McLean, chair of the ICB, was treated to a whistle-stop bus tour of the outreach work done by Derbyshire's sexual health team within underserved communities.

Michelle Arrowsmith champions inclusive healthcare at learning disabilities health week
Michelle Arrowsmith, ICB Deputy CEO, met people living with learning disabilities and learnt about the hospital passport and how it can improve the care people receive.

Proud moments for Derby and Derbyshire at the HSJ Digital Awards
Derby and Derbyshire were proudly represented at the HSJ Digital Awards 2025, which celebrate excellence in digital innovation across the NHS.

Derby City Council

One Derbyshire, Two Councils: have your say on the future of local government
People across Derbyshire are being asked to have their say on how local council services are delivered in the future, as part of the biggest change to local government in 50 years.

Derby City Council's Andy Smith awarded CBE in King's Birthday Honours
Andy Smith, Strategic Director for People Services at Derby City Council, has been awarded a CBE for his outstanding services to disadvantaged and vulnerable children, recognising a lifelong commitment to social work shaped by his own experience in care and leadership roles both locally and nationally.

Chesterfield Royal Hospital

Chesterfield Royal Hospital launches new infant feeding and tongue-tie service
The new service provides feeding support and frenulotomy procedures for newborns. This new service comes in response to valuable feedback from new parents, the community and Derbyshire Maternity and Neonatal Voices (DMNV) highlighting the need for further feeding support following the procedure.

Success for CRH and UHDB at Procurement National Awards
A joint team made up of colleagues working in partnership across the NHS have claimed a national award for their outstanding work in the procurement and delivery of the UK's public services.

United Hospitals Derby and Burton

External patients across Derbyshire and Staffordshire to benefit from £70 million national investment in new radiotherapy machines

UHDB is one of 28 NHS Trusts across England set to receive a new, state-of-the-art linear accelerator (LINAC) radiotherapy machine, as part of a £70 million national investment in radiotherapy equipment by NHS England to provide faster access to cancer care.

Results of Governor elections announced for 2025
University Hospitals of Derby and Burton NHS Foundation Trust has announced the results of its 2025 Governor elections, with new Staff and Public Governors elected across several constituencies, including Solomon Idowu, Beverley Martin, and Jacqueline Clarke (elected unopposed) among others.

UHDB, one of leading national providers of pioneering cancer treatment, helps avid cyclist stay on the road
UHDB is one of only a handful of Trusts across the country to offer a new cancer treatment for prostate cancer patients to reduce radiotherapy side effects.

UHDB Board member Professor Jaspal Taggar 'humbled' by MBE in King's Birthday Honours
Professor Jaspal Taggar, Non-Executive Director at University Hospitals of Derby and Burton, has been awarded an MBE for his leadership in general practice, medical education, and research innovation, recognising his contributions to patient care and training the next generation of clinicians.

UHDB hospitals set for infrastructure upgrades after multi-million pound funding award
NHS facilities in Derbyshire and Staffordshire are set to benefit from nearly £8 million worth of infrastructure upgrades that will improve hospital environments for patients and staff.

Derbyshire Healthcare NHS FT

Derbyshire Healthcare opens its doors to a new 54-bed mental healthcare facility in Derby
Derbyshire Healthcare NHS Foundation Trust has opened the Carsington Unit, a new 54-bed mental health facility at Kingsway Hospital.

Derbyshire Healthcare officially opens newly refurbished Bluebell Ward in Walton, Chesterfield for older adults with mental health needs
Derbyshire Healthcare NHS Foundation Trust has officially opened the newly refurbished Bluebell Ward for older adults at Walton Hospital.

Voluntary Community and Social Enterprise Sector

Community Action's CEO appointed as VCSE sector representative for the East Midlands
Kim Harper, CEO of Community Action Derby, has been appointed by Mayor Claire Ward as the Voluntary, Community, and Social Enterprise (VCSE) Representative for the East Midlands.

A message to our community: Healthwatch Derbyshire's future
Healthwatch Derbyshire announces its closure, along with more than 150 other local Healthwatch Services. The piece reaffirms its commitment to the community as it awaits further guidance from the Department of Health and Social Care. Healthwatch Derby posted a similar message on their Facebook account.

Publications that may be of interest:

Joined Up Care Derbyshire | Monthly Newsletter April

Joined Up Care Derbyshire | Monthly Newsletter May

Joined Up Care Derbyshire | Monthly Newsletter June

How does this paper support the 3 shifts of the NHS 10-Year Plan?					
From hospital to community	☒	From analogue to digital	☒	From sickness to prevention	☒

Integration with Board Assurance Framework and Key Strategic Risks					
SR1	Safe services with appropriate levels of care	☐	**SR2**	Reducing health inequalities, increase health outcomes and life expectancy	☐
SR3	Population engagement	☒	**SR4**	Sustainable financial position	☐
SR5	Affordable and sustainable workforce	☐	**SR7**	Aligned System decision-making	☒
SR8	Business intelligence and analytical solutions	☐	**SR10**	Digital transformation	☐
SR11	Cyber-attack and disruption	☐			☐

Conflicts of Interest	None identified

Have the following been considered and actioned?			
Financial Impact	Yes ☐	No ☐	N/A ☒
Impact Assessments	Yes ☐	No ☐	N/A ☒
Equality Delivery System	Yes ☐	No ☐	N/A ☒
Health Inequalities	Yes ☐	No ☐	N/A ☒
Patient and Public Involvement	Yes ☐	No ☐	N/A ☒
ICS Greener Plan Targets	Yes ☐	No ☐	N/A ☒

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

17th July 2025

Item: 035

Report Title	10 Year Health Plan for England						
Author	Sean Thornton, Director of Communications and Engagement						
Sponsor	Dr Kathy McLean, ICB Chair						
Presenter	Dr Kathy McLean, ICB Chair Dr Chris Clayton, ICB Chief Executive						
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information ☐
Appendices (reports attached)	Appendix 1: Fit for the future: 10 Year Health Plan for England Executive Summary						

Recommendations

The ICB Board are recommended to **RECEIVE** the NHS Ten Year Plan published on July 3 2025.

Report Summary

The publication of the 10 Year Health Plan for England is a pivotal moment in the history of the NHS. It sets out a bold, ambitious and necessary new course for the NHS to guarantee its sustainability for generations to come. It seizes the opportunities provided by new technology, medicines, and innovation to deliver better care for all patients - no matter where they live or how much they earn - and better value for taxpayers.

We are fundamentally reinventing our approach to healthcare, so that we can guarantee the NHS will be there for all who need it for generations to come.

Through our three shifts – from hospital to community, from analogue to digital, and from treatment to prevention – we will personalise care, give more power to patients, and ensure that the best of the NHS is available to all. The full plan can be found here: Fit for the Future: 10 year Health Plan for England.

How does this paper support the 3 shifts of the NHS 10-Year Plan?

From hospital to community	☒	From analogue to digital	☒	From sickness to prevention	☒

Integration with Board Assurance Framework and Key Strategic Risks

SR1	Safe services with appropriate levels of care	☒	**SR2**	Reducing health inequalities, increase health outcomes and life expectancy	☒
SR3	Population engagement	☒	**SR4**	Sustainable financial position	☒
SR5	Affordable and sustainable workforce	☒	**SR7**	Aligned System decision-making	☒
SR8	Business intelligence and analytical solutions	☒	**SR10**	Digital transformation	☒
SR11	Cyber-attack and disruption	☒			☐

Conflicts of Interest	None identified

Have the following been considered and actioned?

Financial Impact	Yes ☐	No ☐	N/A ☒
Impact Assessments	Yes ☐	No ☐	N/A ☒
Equality Delivery System	Yes ☐	No ☐	N/A ☒
Health Inequalities	Yes ☐	No ☐	N/A ☒
Patient and Public Involvement	Yes ☐	No ☐	N/A ☒
ICS Greener Plan Targets	Yes ☐	No ☐	N/A ☒

UK Government

NHS

FIT FOR THE FUTURE

10 Year Health Plan for England

Executive Summary

July 2025

Executive Summary

The National Health Service (NHS) is at a historic crossroads. Lord Darzi's Investigation revealed the sheer extent of its current failings, concluding the NHS was in 'critical condition'. He set out in stark terms that this government's inheritance is an NHS where:

- many cannot get a GP or dental appointment
- waiting lists for hospital and community care[1] have ballooned
- staff are demoralised and demotivated[2]
- outcomes on major killers like cancer lag behind other countries[3].

That is why the NHS now stands at an existential brink. Demographic change and population ageing[4] are set to heap yet more demand on an already stretched health service. Without change, this will threaten yet worse access and outcomes - and even more will opt out to go private if they can afford to. People will increasingly wonder why they pay so much tax for a service they do not use, eroding the principle of solidarity that has sustained the NHS. We will be condemned to a poor service for poor people.

The choice for the NHS is stark: reform or die. We can continue down our current path, making tweaks to an increasingly unsustainable model, or we can take a new course and reimagine the NHS through transformational change that will guarantee its sustainability for generations to come. This Plan chooses the latter. It represents a break with the past.

That choice has been informed by the biggest conversation about the NHS in its history. Over the past 8 months, we have spoken to thousands of staff and members of the public and considered the 250,000 contributions to the Change.NHS website. The conclusion was clear: no one defends the status quo. Staff and patients are crying out for change.

This is a Plan to create a new model of care, fit for the future. It will be central to how we deliver on our health mission. We will take the NHS' founding principles - universal care, free at the point of delivery, based on need and funded through general taxation - and from those foundations, entirely reimagine how the NHS does care so patients have real choice and control over their health and care.

Science and technology will be key to that reinvention. Today the NHS is behind the technological curve. This Plan propels it to the front. The NHS of the future will be a service that offers instant access to help and appointments. One that predicts and prevents ill health rather than simply diagnosing and treating it. A patient-controlled system, in place of today's centralised state bureaucracy, and one where frontline staff are empowered to reshape services. A service with the core principles and values of the NHS but with the know-how of a wider network of technology, life sciences, local government, civil society and third sector organisations, working in partnership to improve the nation's health.

It will be a service equipped to narrow health inequalities. Evidence[5] shows that people in working class jobs, who are from ethnic minority backgrounds, who live in rural or coastal areas or deindustrialised inner cities, who have experienced domestic violence, or who are homeless, are more likely to experience worse NHS access, worse outcomes and to die younger. This is an intolerable injustice. Our reimagined NHS will be designed to tackle inequalities in both access and outcomes, as well as to give everyone, no matter who they are or where they come from, the means to engage with the NHS on their own terms.

Despite the scale of the challenge we face, there are more reasons for optimism than pessimism. The NHS is the best-placed system in the world to harness the advances we are seeing in artificial intelligence (AI) and genomic science. This Plan describes how we will use these advantages to propel the NHS into a position of global leadership. When coupled with our country's excellence in science, innovation and academia, the UK can lead the world in developing the treatments and technologies of the future[6].

This Plan will put the NHS at the front of the global genomics revolution and make the NHS the most artificial-intelligence -enabled care system in the world. We will get upstream of ill-health and make a reality of precision medicine. We will put the NHS on a sustainable footing by adopting a new value-based approach, that aligns resources to achieve better health outcomes. In turn, we will unlock broader economic benefits for the UK, helping to get people back into work and providing a bedrock for the industries of the future. This Plan will transform the NHS into an engine for economic growth rather than simply a beneficiary of it.

We will reinvent the NHS through 3 radical shifts - hospital to community, analogue to digital and sickness to prevention. These will be the core components of our new care model. To support the scale of change we need, we will ensure the whole NHS is ready to deliver these 3 shifts at pace: through a new operating model, by ushering in a new era of transparency; by creating a new workforce model with staff genuinely aligned with the future direction of reform, through a reshaped innovation strategy; by taking a different approach to NHS finances.

From hospital to community: the neighbourhood health service, designed around you

If the NHS does not feel like a single, coordinated, patient-orientated service, that is for a simple reason: it is not one. It is hospital-centric, detached from communities and organises its care into multiple, fragmented siloes. We need to shift to provide continuous, accessible and integrated care.

The neighbourhood health service is our alternative. It will bring care into local communities, convene professionals into patient-centered teams and end fragmentation. In doing so, it will revitalise access to general practice and enable hospitals to focus on providing world class specialist care to those who need it. Over time, it will combine with our new genomics population health service to provide predictive and preventative care that anticipates need, rather than just reacting to it.

At its core, the neighbourhood health service will embody our new preventative principle that care should happen as locally as it can: digitally by default, in a patient's home if possible, in a neighbourhood health centre when needed, in a hospital if necessary. To make this possible we will:

- shift the pattern of health spending. Over the course of this Plan, the share of expenditure on hospital care will fall, with proportionally greater investment in out-of-hospital care.
- This is not just a long-term ambition. We will also deliver this shift in investment over the next 3 to 4 years as local areas build and expand their neighbourhood health services

- end the 8am scramble by training thousands more GPs and building online advice into the NHS App. People who need one will be able to get a same-day GP appointment
- introduce 2 new contracts, with roll-out beginning next year, to encourage and allow GPs to work over larger geographies and lead new neighbourhood providers
- support people to be active participants in their own care by ensuring people with complex needs have an agreed care plan by 2027.
- at least double the number of people offered a Personal Health Budget by 2028 to 2029, offer 1 million people a Personal Health Budget by 2030, and ensure it is a universal offer for all who would benefit by 2035
- through the NHS App, allow patients to book appointments, communicate with professionals, receive advice, draft or view their care plan, and self-refer to local tests and services
- establish a neighbourhood health centre in every community, beginning with places where healthy life expectancy is lowest - a 'one stop shop' for patient care and the place from which multidisciplinary teams operate
- neighbourhood health centres will be open at least 12 hours a day and 6 days a week
- increase the role of community pharmacy in the management of long-term conditions and link them to the single patient record
- improve access to NHS dentistry, improve children's oral health and increase the number of NHS dentists working in the system by making the dental contract more attractive, and introducing tie-ins for those trained in the NHS
- deliver more urgent care in the community, in people's homes or through neighbourhood health centres to end hospital outpatients as we know it by 2035
- end the disgraceful spectacle of corridor care and restore the NHS constitutional standard of 92% of patients beginning elective treatment within 18 weeks
- expand same day emergency care services and co-located urgent treatment centres. We will support patients to book into the most appropriate urgent care service for them, via 111 or the app, before attending, by 2028
- invest up to £120 million to develop more dedicated mental health emergency departments, to ensure patients get fast, same-day access to specialist support in an appropriate setting
- free up hospitals to prioritise safe deployment of AI and harness new technology to bring the very best of cutting-edge care to all patients. All hospitals will be fully AI-enabled within the lifetime of this Plan

From analogue to digital: power in your hands

Modern technology has given us more power over our everyday lives. But that same scale of change has yet to come to the NHS. This Plan will take the NHS from the 20th century technological laggard it is today, to the 21st century leader it has the potential to be.

To do this, we will use the unique advantages of the NHS' healthcare model - world-leading data, its power in procurement and its means to deliver equal access - to create the most digitally accessible health system in the world. Patients will have a 'doctor in their pocket' in the form of the NHS App, while staff will be liberated from a burden of bureaucracy and administration.

By harnessing the digital revolution, we will be able to:

- ensure rapid access for those in generally good health

- free up physical access for those with the most complex needs
- help ensure the NHS' financial sustainability for future generations.

To make the move 'from bricks to clicks' we will:

- for the first time ever in the NHS, give patients real control over a single, secure and authoritative account of their data and single patient record to enable more co-ordinated, personalised and predictive care
- transform the NHS App into a world leading tool for patient access, empowerment and care planning.

By 2028, the app will be a full front door to the entire NHS. Through the app, patients will be able to:

- get instant advice for non-urgent care and help finding the most appropriate service first time, through My NHS GP
- choose their preferred provider, whether it delivers the best outcomes, has the best feedback or is simply closer to home, through My Choices
- book directly into tests where clinically appropriate through My Specialist, and hold consultations through the app with My Consult
- manage their medicines through My Medicines and book vaccines through My Vaccines
- manage a long-term condition through My Care, access and upload health data through My Health or get extra care support through My Companion

- manage their children's healthcare through My Children, or co-ordinate the care of a loved one or relative through My Carer
- allow patients to leave feedback on the care they have received - compiled and communicated back to providers, clinical teams and professionals in easy-to-action formats
- use continuous monitoring to help make proactive management of patients the new normal, allowing clinicians to reach out at the first signs of deterioration to prevent an emergency admission to hospital
- build 'HealthStore' to enable patients to access approved digital tools to manage or treat their conditions, enabling innovative businesses to work more collaboratively with the NHS and regulators
- introduce single sign on for staff and scale the use of technology like AI scribes to liberate staff from their current burden of bureaucracy and administration – freeing up time to care and to focus on the patient.

From sickness to prevention: power to make the healthy choice

People are living too long in ill health, the gap in healthy life expectancy between rich and poor is growing[7] and nearly 1 in 5 children leave primary school with obesity[8]. Our overall goal is to halve the gap in healthy life expectancy between the richest and poorest regions, while increasing it for everyone, and to raise the healthiest generation of children ever. This will boost our health, but also ensure the future sustainability of the NHS and support economic growth.

We will achieve our goals by harnessing a huge cross-societal energy on prevention. We will work with businesses, employers, investors, local authorities and mayors to create a healthier country together. Specifically, we will:

- deliver on our world-leading Tobacco and Vapes Bill, which will mean that children turning 16 this year (or younger) can never legally be sold tobacco. The number of 11 to 15 year olds who regularly vape has doubled[9] in the last 5 years, and to crack down on this unacceptable trend, we will also halt the advertising and sponsorship

of vapes and other nicotine products

- launch a moonshot to end the obesity epidemic. We will restrict junk food advertising targeted at children, ban the sale of high-caffeine energy drinks to under 16-year-olds, reform the soft drinks industry levy to drive reformulation; and - in a world first - introduce mandatory health food sales reporting for all large companies in the food sector. We will use that reporting to set new mandatory targets on the average healthiness of sales
- restore the value of Healthy Start from financial year 2026 to 2027, expand free school meals so that all children with a parent in receipt of Universal Credit are eligible, and update school food standards to ensure all schools provide healthy, nutritious food.
- harness recent breakthroughs in weight loss medication and expand access through the NHS. We will negotiate new partnerships with industry to provide access to new treatments on a 'pay for impact on health outcomes' basis
- encourage citizens to play their part, including through a new health reward scheme to incentivise healthier choices. We will also work with the Great Run Company to set up a campaign to motivate millions to move more on a regular basis
- tackle harmful alcohol consumption by introducing new standards for alcohol labelling. We will support further growth in the no- and low- alcohol market
- join up support from across work, health and skills systems to help people find and stay in work. We will work with all ICBs to establish Health and Growth Accelerators models
- expand mental health support teams in schools and colleges – and provide additional support for children and young people's mental health through Young Futures Hubs
- increase uptake of human papillomavirus (HPV) vaccinations among young people who have left school, to support our ultimate aim to eliminate cervical cancer by 2040. We will fully roll out lung cancer screening for those with a history of smoking
- create a new genomics population health service, accessible to all, by the end of the decade. We will implement universal newborn genomic testing and population-based polygenic risk scoring alongside other emerging diagnostic tools, enabling early identification and intervention for individuals at high risk of developing common diseases.

A devolved and diverse NHS: a new operating model

To realise the ambition of this Plan, we will create a new NHS operating model, to deliver a more diverse and devolved health service. Today, power is concentrated in Whitehall, rather than distributed among local providers, staff and citizens.

Our reforms will push power out to places, providers and patients - underpinned by an explicit goal to make the NHS the best possible partner and the world's most collaborative public healthcare provider. To achieve this, we will:

- combine the headquarters of the NHS and the Department of Health and Social Care, reducing central headcount by 50%
- make ICBs the strategic commissioners of local healthcare services. We will build ICB capability, and close commissioning support units
- introduce a system of earned autonomy and, where local services consistently underperform, step in with a new failure regime. Our priority will be to address underperformance in areas with the worst health outcomes. Our ambition over a 10-year period is for high autonomy to be the norm across every part of the country

- reinvent the NHS foundation trust (FT) model for a modern age. By 2035, our ambition is that every NHS provider should be an FT with freedoms including the ability to retain surpluses and reinvest them, and borrowing for capital investment. FTs will use these freedoms and flexibilities to improve population health, not just increase activity
- create a new opportunity for the very best FTs to hold the whole health budget for a defined local population as an integrated health organisation (IHO). Our intention is to designate a small number of these IHOs in 2026, with a view to them becoming operational in 2027. Over time they will become the norm
- set higher standards for leaders, with pay tied to performance, and good work rewarded
- continue to make use of private sector capacity to treat NHS patients where it is available and we will enter discussions with private providers to expand NHS provision in the most disadvantaged areas
- work in closer partnership with local government and other local public services. We will streamline how local government and the NHS work together and make ICBs coterminous with strategic authorities by the end of the Plan wherever feasibly possible
- introduce a new patient choice charter, starting in the areas of highest health need. This will ensure the NHS is receptive and reactive to patient preference, voice and choice
- trial new 'patient power payments', which are an innovative new funding flow in which patients are contacted after care and given a say on whether the full payment for the costs of their care should be released to the provider.

A new transparency and quality of care

The NHS' history is blighted by examples of systematic and avoidable harm. The commonality in these tragedies has been a fundamental lack of transparency. We will make the NHS the most transparent healthcare system in the world.

From this foundation, we will reintroduce a new, rigorous focus on high-quality care for all. Specifically, we will:

- publish easy-to-understand league tables, starting this summer, that rank providers against key quality indicators
- allow patients to search and choose providers based on quality data on the NHS App, including length of wait, patient ratings and clinical outcomes. The App will also show data on clinical teams and clinicians
- use patient reported outcome measures and patient reported experience measures to help patients when choosing their provider on the NHS App
- set up a national independent investigation into maternity and neonatal services. We will also establish a national maternity and neonatal taskforce, chaired by the Secretary of State for Health and Social Care, to inform a new national maternity and neonatal action plan, co-produced with bereaved families
- reform the complaints process and improve response times to patient safety incidents and complaints
- change the time limit for the Care Quality Commission (CQC) to bring legal action against a provider and review how to improve patients' experience of clinical negligence claims
- reform the National Quality Board (NQB) with all other bodies, including Royal Colleges, feeding into it. We will task it with developing a new quality strategy as well as the development of modern

service frameworks. Early priorities will include cardiovascular disease, mental health, frailty and dementia.

- give all providers new flexibilities to make additional financial payments to clinical teams that have consistently high clinical outcomes and excellent patient feedback or are significantly improving care
- reform CQC towards a more data-led regulatory model. When concerns are identified, CQC will rapidly assemble inspection teams of highly qualified staff to assess service quality in greater detail
- make sure persistent poor-quality care results in the decommissioning or contract termination of services or providers, no matter the setting, no matter whether the provider is in the NHS or independent sector, and no matter whether they are a GP practice or an individual NHS trust.

An NHS workforce, fit for the future

It will be through the workforce that our 3 shifts are delivered. Because healthcare work will look very different in 10 years' time, we will need a very different kind of workforce strategy.

While, by 2035, there will be fewer staff than projected in the 2023 Long-Term Workforce Plan, those staff will be better treated, more motivated, have better training and more scope to develop their careers. The NHS will be not only the country's biggest employer but its best. To achieve this, we will:

- ensure every single member of NHS staff has their own personalised career coaching and development plan, to help them acquire new skills and practice at the top of their professional capability
- make AI every nurse's and doctor's trusted assistant - saving them time and supporting them in decision making. Over the next 3 years we will overhaul education and training curricula with the aim of future-proofing the NHS workforce
- work with the Social Partnership Forum to develop a new set of staff standards, which will outline minimum standards for modern employment. We will introduce these standards in April 2026 and publish data on them at the employer level every quarter
- continue to work with trade unions and employers to maintain, update and reform employment contracts and start a big conversation on significant contractual changes that provide modern incentives and rewards for high quality and productive care
- reduce the NHS' sickness rates from its current rate of 5.1%[10] - far higher than the average in the private sector[11] - to the lowest recorded level in the NHS
- give leaders and managers new freedoms, including the power to undertake meaningful performance appraisals, to reward high performing staff, and to act decisively where they identify underperformance
- develop advanced practice models for nurses and other professionals, and work across government to prioritise UK medical graduates for foundation and specialty training
- increase the number of nurse consultants, particularly in neighbourhood settings
- over the next 3 years, create 1,000 new specialty training posts with a focus on specialties where there is greatest need
- accelerate delivery of the recommendations in General Sir Gordon Messenger's review of health and care leadership[12] and establish a new College of Executive and Clinical Leadership to define and drive excellence
- introduce new arrangements for senior managers' pay to reward high performance and to withhold pay increases from executive leadership teams who do not meet public, taxpayer and

patient expectations on timeliness of care or effective financial management

- reorientate the focus of NHS recruitment away from its dependency on international recruitment, and towards its own communities - to ensure sustainability in an era of global healthcare workforce shortages. It is our ambition to reduce international recruitment to less than 10% by 2035
- create 2,000 more nursing apprenticeships over the next 3 years - prioritising areas with the greatest need. Expansion of medical school places will be focused on widening access to talented students from underprivileged backgrounds.

Powering transformation: innovation to drive healthcare reform

Our aim is to be in the driving seat of the biggest industrial revolution since the 19th century as we harness technology to create a new model of care in the NHS. We will use the UK's competitive edge - NHS data, life sciences prowess, world leading universities - to lead the world on the innovation that will most accelerate reform.

We have identified 5 transformative technologies - data, AI, genomics, wearables and robotics - that will personalise care, improve outcomes, increase productivity and boost economic growth. We will:

- create a new Health Data Research Service in partnership with the Wellcome Trust and backed by up to £600 million of joint investment
- make the NHS the most AI-enabled health system in the world with AI seamlessly integrated into clinical pathways
- support the Generation Study as it sequences the genomes of 100,000 newborn babies. This study will inform our longer-term ambition to make genomic sequencing at birth universal
- launch a new large-scale study to sequence the genomes of 150,000 adults this year - and assess how genomics can be used in routine preventive care. A new globally unique set of studies will explore personalised prevention of obesity, applying genomic and other insights to identify people who are at the highest risk of developing obesity
- make wearables standard in preventative, chronic and post-acute NHS treatment by 2035. All NHS patients will have access to these technologies, which will be part of routine care. We will provide devices for free in areas where health need and deprivation are highest
- beginning next year, expand surgical robot adoption in line with National Institute for Health and Care Excellence (NICE) guidelines
- establish new global institutes with the ambition to help the UK lead the world on science and innovation
- speed up clinical trial recruitment. By March 2026, clinical trials setup time will fall to 150 days
- expand NICE's technology appraisal process to cover devices, diagnostics and digital products. NICE will also be given a new role to identify which outdated technologies and therapies can be removed from the NHS to free up resources for investment in more effective ones
- introduce multi-year budgets and require NHS organisations to reserve at least 3% of annual spend for one-time investments in service transformation, to help translate innovations into practice more rapidly
- expand the role life sciences and technology companies can play in service delivery. We will streamline procurement of technology, and we will move to a single national formulary for medicines within the next 2 years.

Productivity and a new financial foundation

Today the NHS accounts for 38% of day-to-day government spending - a figure projected to rise to nearly 40% by the end of the Parliament[13]. While the NHS will need investment in the future, it is now self-evident that more money alone has not always led to better care.

The era of the NHS' answer always being 'more money, never reform' is over. It will be replaced with a new value-based approach focused on getting better outcomes for the money we spend. Our new financial flows will incentivise innovation to support the flow of money from hospital into community and reward best practice across the NHS.

Our three shifts each help secure financial sustainability. More care in the community is cheaper and more effective than care in hospitals. Digitalisation, as in other industries, will deliver far more productively for far lower cost. Prevention bends the demand curve. We will:

- urgently resolve the NHS' productivity crisis. For the next 3 years we have set the NHS a target to deliver a 2% year on year productivity gain
- restore financial discipline by ending the practice of providing additional funding to cover deficits. Over time, our aim is for the NHS to move into surplus, with the majority of providers achieving that by 2030
- break the old, short-term cycle of financial planning, by asking all organisations to prepare robust and realistic five-year plans, demonstrating how financial sustainability will be secured over the medium term
- deconstruct block contracts - paid irrespective of how many patients are seen or how good care is - with the intention of realigning the activity delivered and funding being provided by an ICB. Payment for poor-quality care will be withheld and high-quality care will attract a bonus. In addition, we will introduce new incentives for the best NHS leaders, clinicians and teams
- move from national tariffs based on average costs to tariffs based on best clinical practice that maximises productivity and outcomes. We will also test the development of 'year of care' payments starting in financial year 2026 to 2027. This will drive the shift of activity and resource from hospital to community
- distribute NHS funding more equally locally, so it is better aligned with health need. In the meantime, we will target extra funding to areas with disproportionate economic and health challenges.
- ensure all trusts have the authority to retain 100% of receipts from the disposal of land assets they own, and are able to use the proceeds from disposals across multiple financial years
- develop a business case for the use of Public Private Partnership (PPP) for Neighbourhood Health Centres, ahead of a final decision at the autumn budget
- explore a new mechanism for the NHS to access low risk pension capital
- in the longer-term, move to a new NHS financial model, where money will increasingly follow patients through their lifetime. Providers will be rewarded based on how well they improve outcomes for each individual, as well as how well they involve people in the design of their care, not solely on whether they provide episodic instances of care on demand.

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NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

17th July 2025

Item: 036

Report Title	Integrated Performance Report							
Authors	Phil Sugden, Assistant Director of Quality Samuel Kabiswa, Associate Director, Contracting, Planning and Performance Jennifer Leah, Director of Finance – Strategy and Planning Sukhi Mahil, Associate Director – Workforce Strategy, Planning and Transformation							
Sponsors	Dr Chris Clayton, Chief Executive Officer							
Presenters	Executive Directors Committee Chairs							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices (reports attached)	Appendix 1 – Performance Report							

Recommendations
The ICB Board are recommended to **RECEIVE** the Integrated Performance Report for assurance.
Report Summary

Quality

- DHcFT: NOF 3 Exit Criteria: NoF3 meeting 24/06/25 – Confirmed all Quality end point criteria have been met and improvements across all domains recognised. Agreed that DHcFT will remain in NoF3 until the NHS Performance Assessment Framework (NPAF) is published. Next meeting October 2025.
- NHSE Mental Health Self-Assessment Team: Workshops completed which included Data Quality & Digital Informatics, Access, Waits & Productivity and Culture & Outcomes across May and June 2025. Verbal feedback session held 19th June. Awaiting final written report.
- DHcFT Making Room for Dignity Programme: reported delay in the opening of the new PICU due to reasons outside the Trust control and will now open mid-July 2025. DHcFT linking with service users currently within out of area placements.

Performance

For this month's performance report, we have focused on the first 3 priority areas and used in the main unvalidated data to provide an assessment of how actual performance has fared against plan. A summary of key data points is shown at Appendix 1, for information.

Referral to Treatment

To date, performance between the two Trusts has diverged: UHDB is on track with its RTT trajectory, while CRH is not. A key factor in delivering the RTT plan is improved productivity within core services at both Trusts. On this, the picture is mixed.

- Theatres ('touch time utilisation') – UHDB is performing below expectations, currently in the second quartile at 78%, behind the peer average of 80% and well below top-decile performance of 85%. CRH fares slightly better at 81%, though there is still scope for improvement.
- Outpatients (clinic utilisation) – Utilisation remains 6-7% below target, with the CRH showing the most significant shortfall – first outpatient activity is around 50% lower than peer Trusts.
- Evidence Based Interventions – UHDB is delivering substantially higher volumes of four elective procedures compared to peers, strongly indicating non-compliance with EBI thresholds.

Faster Cancer Diagnosis

At the end of May 2025, both Trusts were behind their planned trajectories and are currently 3-4% behind the national average. The most challenging tumour sites across both Trusts are suspected gynaecological,

gastrointestinal and urological cancers. In addition, the CRH's dermatology service lacks sufficient capacity to meet both general and two-week wait demand. Key cross cutting issues affecting performance across these tumour sites include:

- **First outpatient capacity:** Delays in initial specialist review are limiting timely progression through the cancer pathway.
- **Diagnostic capacity:** Access to imaging and endoscopy remains a critical limiting factor.
- **Histopathology Turnaround:** Delays in pathology reporting, particularly for biopsies and resection specifics, are contributing to pathway breaches.

Cancer Treatment

At the end of May 2025, both Trusts were performing above the national average but remained below their planned trajectories. The CRH's trajectory requires further validation to clarify the assumptions behind the projected improvement from December 2025.

Performance across both Trusts is inconsistent, with significant variation in treatment times by tumour site, particularly at UHDB with lower gastrointestinal, gynaecological and urological cancers showing the greatest delays.

A&E 4hr performance

To date, A&E performance has diverged between the two Trusts: UHDB remains broadly on track to meet its 4-hour trajectory, whilst the CRH continues to fall short. In fact, even, if the CRH delivers its current recovery trajectory, it would only return the Trust to the same position is held at the end of 2023/24 – highlighting a lack of real progress.

While there are opportunities to reduce avoidable demand at both Trusts – particularly in emergency readmissions and end of life hospital utilisation, which remain at upper quartile levels – overall ED demand has not increased. This reinforces the fact that poor A&E performance is not being driven by rising attendances.

The core issue remains flow through beds. Although average length of stay benchmarks reasonably well at both Trusts, there has been no statistically significant reduction in bed occupancy or length of stay over the past 18 months. Within this, delayed discharges remain a critical constraint.

- At CRH, 25% of beds are occupied by patients who are clinically ready for discharge.
- At UHDB, the figure is 19%.

This lack of flow is restricting capacity to admit patients from A&E, directly impacting performance against the 4-hour standard.

Mental health – utilisation of adult acute beds

Average length of stay currently stands at 64 days, with performance averaging 62 days over the past 5 years. Reducing this to 47 days by the end of the period is highly ambitious – but essential. Achieving this target is critical to releasing capacity in a system consistently running at 95%+ bed occupancy. Delivery will require a focused approach in three key areas:

- **Purposeful admission** – with increased investment in community services, admissions must only occur when care or treatment cannot be safely delivered in a non-inpatient setting.
- **Therapeutic inpatient care** – patients must have timely access to the assessments, interventions and treatments they need – ensuring that every day spent in hospital delivers therapeutic value.
- **Purposeful discharge** – Patients should be discharged as soon as their inpatient care objectives are met. There is significant opportunity here, with 12-17% of beds occupied at any one time by patients who are clinically ready for discharge.

Finance

The report summarises the System financial position for the period ending 31st May 2025. It highlights key areas including I&E performance and efficiency achievement across the JUCD system.

Workforce

ICB Total	Reporting Period: May-25					
	Month 2			Trend		
	Plan	Actual	Variance From Plan	Previous Month	Actual - Direction of Change from Previous Month	Actual - Trend (Previous 12 Months)
Workforce						
Total Workforce (WTE)	30,786.34	30,498.13	-288.21	30,526.56	↓	
Substantive (WTE)	29,051.18	28,853.17	-198.01	28,830.00	↑	
Bank (WTE)	1,516.49	1,417.87	-98.62	1,446.08	↓	
Agency (WTE)	218.67	227.09	8.42	250.48	↓	
Pay Cost						
Pay Cost (£'000)	149,145	148,806	-339	148,418	↑	

- As of M2, total workforce across all areas (substantive, bank and agency) was 288.21 WTE under plan. Compared to M1, there was an increase in Substantive positions (23.18 WTE), a reduction in Bank (28.20 WTE) and Agency usage (23.39 WTE).
- The overall workforce pay plan position at M2 was underspent by £339k. There are however overspends in Bank and Agency staffing with the majority of overspend being observed in supporting surge capacity and premium medical locum capacity to support fragile services.
- The Year to Date pay expenditure across the system is £0.2m adverse to plan. This is inclusive of £2.8m adverse in Bank, £1.2m adverse in Agency and £3.9m favourable in other pay including substantive. However, some of this overspend maybe attributed to how other income backed non WTE funding such as WLI, study leave and overtime costs are recorded which is skewing the overall position. In addition, there was some misalignment of financial expenditure, due to 9.4% pension contributions included in outturn which is funded by NHSE. This has now been resolved and should be reflected in future reports.
- Increased focus with Chief Financial Officer's to increase the visibility of non-WTE pay cost alignment on additional funded activities such as WLI, study leave etc to give greater clarity on total workforce pay costs against plan. Joint Chief Finance and Chief People Officer meetings instated to create urgency and clarity of the actual workforce costs position.
- Trusts are continuing and strengthening vacancy and temporary staffing controls.
- Providers have moved all agency staff to on-framework providers, with 0 shifts used in M2.
- In M2 there were 2,258 non-price cap compliant shifts, 52.3% of the total agency shifts. All providers are involved in the price cap compliance workstream which has been established with the NHSE regional team to target efforts to achieve compliance.

How does this paper support the 3 shifts of the NHS 10-Year Plan?					
From hospital to community	☒	From analogue to digital	☒	From sickness to prevention	☒

Integration with Board Assurance Framework and Key Strategic Risks					
SR1	Safe services with appropriate levels of care	☒	**SR2**	Reducing health inequalities, increase health outcomes and life expectancy	☒
SR3	Population engagement	☒	**SR4**	Sustainable financial position	☒
SR5	Affordable and sustainable workforce	☒	**SR7**	Aligned System decision-making	☒
SR8	Business intelligence and analytical solutions	☒	**SR10**	Digital transformation	☒
SR11	Cyber-attack and disruption	☒			

Conflicts of Interest	None identified.

Have the following been considered and actioned?			
Financial Impact	Yes ☒	No ☐	N/A ☐
Impact Assessments	Yes ☐	No ☐	N/A ☒
Equality Delivery System	Yes ☐	No ☐	N/A ☒
Health Inequalities	Yes ☐	No ☐	N/A ☒
Patient and Public Involvement	Yes ☐	No ☐	N/A ☒
ICS Greener Plan Targets	Yes ☐	No ☐	N/A ☒

NHS
Derby and Derbyshire
Integrated Care Board

Integrated Performance Report

July 2025

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

Quality

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

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

Derby and Derbyshire Integrated Care Board

CONCERN OR ISSUE	SPECIALTY/PROGRAMME	DECISION/DISCUSSION OR INFORMATION	ACTIONS/OUTCOMES/RECOMMENDATIONS
3 Year Maternity Delivery Plan - 2025/26 Priorities for Derby and Derbyshire LMNS are based on the themes of the Three-year Delivery Plan and national recommendations requiring investment	Maternity Services	Information	**Key Deliverables** **Perinatal Mortality:** The perinatal mortality rate remains below the national average. **Dashboard Metrics:** At UHDB, the occurrences of third- and fourth-degree tears are rising with assisted deliveries. A review is underway. CRH are sharing learning and experiences from a previous thematic review. Details of the review will be shared via the UHDB and ICB governance routes on completion. **Major Obstetric Haemorrhage:** CRH's major obstetric haemorrhage rate remains above the national average, whilst UHDB have noted a significant reduction since joining the ObsCymru trial. CRH have enrolled on the trial and completed initial benchmarking, with ongoing compliance audits and improvements expected from new measurement techniques. UHDB are sharing learning and experiences from their involvement in the trial. **Neonatal Services Improvements:** UHDB is working on improving data capture for neonatal services with the appointment of a data analyst and the introduction of the Badgernet information system. Progress in monitoring extreme preterm births has been made. **PPHS** – CRH have an operational service in place. UHDB presented a paper internally which was agreed and recruitment for a project lead and clinical lead will commence in July. Trajectory for implementation is Quarter 3, 25/26. **CNST Maternity Incentive Scheme Year 7** – CRH are working towards maintaining compliance with all 10 safety actions. UHDB are aiming to improve compliance from 7 to 10. Challenges remain around safety action 7 and MNVP capacity to attend maternity/neonatal safety meetings. Work is underway for compliance by March 2026. **SBLCBv3 – 2** quarterly assessments required by November 2025 to demonstrate continued improvement to meet MIS Year 7. Aim is to meet 100% compliance by March 2026. **Three Year Delivery Plan** – ICB insight visit in April 2025 has taken place and report shared with UHDB. CRH visit in July 2025. **Areas of Concern** **UHDB CQC** –Trust had recent confirmation of removal of 6 of 8 conditions placed in November 2023. The Trust have applied to CQC removal of the remaining 2 conditions. **CQC Visit from December 2024** - report following revisit reviewed for factual accuracy by UHDB; currently with CQC. **MSSP** reset meeting in July 2025. **UHDB Intrauterine Artery Doppler Pathway** – A policy is in place with training requirements identified for ultrasonographers to progress this work. A trajectory for September 2025 is in place.

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

Derby and Derbyshire Integrated Care Board

CONCERN OR ISSUE	SPECIALTY/PROGRAMME	DECISION/DISCUSSION OR INFORMATION	ACTIONS/OUTCOMES/RECOMMENDATIONS
NHS England established national quality premiums for Continuing Health Care (CHC) teams, requiring 80% of assessments for new referrals to be completed within 28 days and 85% outside of hospitals.	CHC	Information	• The team met these targets in the first two quarters despite a rise in Checklist referrals, compliance dropped to 69% and 59% in the last two quarters. There was a notable increase in Checklist referrals, with 1,178 received, 72% of these were decided within 28 days. Fast Track Referrals increased by 4%, with a significant rise in the Fast Track caseload. • The CCCYP caseload slightly decreased, there were 229 Open PHB patients with 344 PHB packages. • It is important to note the negotiations between ICB and MLCSU to address the contract uplift dispute had an impact on delivery of the service. • The AACC financial year end position has been positive with a £1 million underspend. MLCSU capacity issues have been a significant concern throughout the year. There had been extensive negotiations with the CSU to address the contract dispute, which resulted in a reduction of staffing within the AACC service. **Plan:** • ICB has voluntarily accepted support from NHSE by way of a Transformation Manager who is working with MLCSU with a view to improve Quality Premium compliance. • The service faced a backlog of overdue reviews due to the contractual dispute; a recovery plan is being implemented. • System and Partnership working is underway to support; the appropriate referral route being accessed.

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

Derby and Derbyshire Integrated Care Board

LEARNING AND SHARING - best practices, outcomes
NHSE Mental Health Self-Assessment Team: Workshops completed which included Data Quality & Digital Informatics, Access, Waits & Productivity and Culture & Outcomes across May and June 2025. Verbal feedback session held 19th June. Awaiting final written report. **DHcFT Making Room for Dignity Programme:** reported delay in the opening of the new PICU due to reasons outside the Trust control and will now open mid-July 2025. DHcFT linking with service users currently within out of area placements. **Intensive and Assertive Community Mental Health Treatment - Independent Homicide Review – Nottingham:** DHcFT provided progress report to the Board of Directors into meeting the recommendations from the independent review and The Care Quality Commission (CQC) Section 48 review of Nottinghamshire Healthcare NHS Foundation Trus on the 3rd June 2025. Update will be provided at next DDICB Board. **Derbyshire Healthcare Foundation Trust - NOF 3 Exit Criteria:** NoF3 meeting 24/06/25 – Confirmed all Quality end point criteria have been met and improvements across all domains recognised. Agreed that DHcFT will remain in NoF3 until the NHS Performance Assessment Framework (NPAF) is published. Next meeting October 2025.

Operational Plan Performance

Michelle Arrowsmith, Chief Strategy & Delivery Officer
Nigel Smith, Non-Executive Member

Reduce the time people wait for elective care

Derby and Derbyshire Integrated Care Board

The level of improvement we have set out to achieve in 2025/26:

Area	2024/25 acutal	2025/26 plan	We set out a trajectory to...
Referral to Treat ment (RTT) 18 weeks	55%	60%	increase the proportion of incomplete RTT pathways within 18 weeks by 6%
Referral to Treatment (RTT) 52 weeks	2%	1%	reduce the proportion of incomplete RTT pathways of 52 weeks or more, 1%
The number of incomplete RTT pathways	137,624	126,587	Reduce the size of the total patient waiting list, by 8%
Incomplete outpatient pathways	60%	67%	Increase the proportion of outpatient pathways within 18 weeks, by 7%
28 day Faster Cancer Diagnosis	76%	80%	Iincrease in the proprtion of suspected cancers ruled out or diagnosed within 28 day, by 5%
62 day Cancer treatment	71%	75%	Increase in the proprtion of patients recieveing a first definative treatment within 62 days, 4%

By taking the following action:

Action	
• **Improve outpatient productivity,** by reducing Did Not Attend (DNA) rates; increasing the use of Patient Initiated Follow-ups (PIFU); and increasing clinical utilisation. • **Enhance theatre productivity,** by increasing uncapped touch time utilisation; and increasing the number of cases per list. • **Moderate the growth in new demand**, by increasing the use of pre-referral specialist advice, which is estimated to divert 10-15% of "unnecessary" outpatient first attendances; and adhering to the ICB's clinical policies in relation to evidence-based interventions. • **Undertake validation (clinical, administrative or technical) of the waiting list**, to ensure that Referral to Treatment (RTT) rules are being applied consistent and access policies are being adhered to.	• **Insource medical and surgical services,** to provide care within existing structures to utilise spare, out-of-hours capacity, typically at weekends and evenings. • **Expand diagnostic capacity,** with the additional Community Diagnostic Centres providing faster access. • **Recruit more cancer specialists,** to bolster UHDB's provision. • Focus on more sustainable service offering for **suspected skin cancer pathway**, across both Trusts. • Ensure a comprehensive roll-out and implementation of **Targeted Lung Health Checks**. • **Upgrade key capital assets,** to support single-photon emission computed tomography and medical linear accelerator capacity.

Improve A&E waiting times and ambulance response times

Derby and Derbyshire Integrated Care Board

The level of improvement we have set out to achieve in 2025/26

Area	2024/25 acutal	2025/26 plan	We set out a trajectory to...
A&E 4 hour - *University Hospitals of Derby and Burton NHSFT*	65%	73%	Increase the proportion of A&E attendances admitted, discharged or transferred within 4 hrs, by 8%
A&E 4 hour - *Chesterfield Royal Hospital NHSFT*	58%	67%	Increase the proportion of A&E attendances admitted, discharged or transferred within 4 hrs, by 9%
A&E 4 hour - *all commissioned UEC provision*	74%	80%	Increase the proportion of A&E attendances admitted, discharged or transferred within 4 hrs, by 6%
A&E 12+ hour waits - *University Hospitals of Derby and Burton NHSFT*	11%	8%	Reduce the proportion of type 1 A&E attendances where the patient spent more than 12 hours from time of arrival to time of admission, discharge, or transfer, by 3%
A&E 12+ hour waits - *Chesterfield Royal Hospital NHSFT*	5%	5%	No change
Ambulance handover - *University Hospitals of Derby and Burton NHSFT*	00:43:30	00:33:03	Reduce ambulance handover times by 10% on average
Ambulance handover - *Chesterfield Royal Hospital NHSFT*	00:17:48	00:17:57	No change

By taking the following action:

Action

- **Enhance general and acute bed productivity**, by reducing delayed discharges due to a range of "internal" factors.
- **Bring online the "winter" capacity, all year round if required at the Royal Derby Hospital** and consider opening ward 6 at the Florence Nightingale Community Hospital to bolster winter provision as a contingency.
- **Deliver a new streaming model to maximise the utilisation of the co-located Urgent Treatment Centre** at the Royal Derby Hospital and open a UTC at Queen's Hospital Burton.
- **Expand the use of Same Day Emergency Care provision,** to avoid unnecessary admissions and thus help nullify growth.
- **Ambulance response** - deal with more ambulance calls via hear and treat and see and treat.
- **Implement a new Mental Health Urgent Assessment Centre,** to assess and manage the needs of service users, providing an easy to access service that provides timely assessment for people suffering from a mental health crisis.
- **Deliver more urgent treatment centre capacity,** relative to 2024/25, with a particular focus on consistently delivering the commissioned model of care (appointment and walk-in) at the Ilkeston Urgent Treatment Centre.
- **Repurpose the use of virtual ward capacity,** with a greater focus on bolstering admission avoidance (step-up) in the community and thus achieve greater impact.
- **Increase the level of community nursing activity** (delivered via productivity and reduced staff absence) and **increase Community Response Team and Care Transfer Hub** capacity.
- **Deliver a significant financial ICS investment** to bolster our community-based change management capability and capacity, by sourcing a strategic partner to enhance the co-ordination and effectiveness of primary and community care services.
- **Continuing with the plan to improve access of Primary Care,** particularly GP services facilitated by the new GP contract.

Improve mental health and learning disability care

Derby and Derbyshire Integrated Care Board

The level of improvement we have set out to achieve in 2025/26:

Area	2024/25 acutal	2025/26 plan	We set out a trajectory to...
Inappropriate out of area placements	24	5	Reduce the number of inappropriate out of area placements by 80%.
Average length of stay - adult acute inpatient beds (days)	60	53	Reduce the average length of stay by 13%
Children and Young People's access to mental health services - number of CYPs receiving at least one contact	14,515	14,565	Maintain the support provided to CYPs
Reliance on inpatient care for adults with autism and/or a learning disability	34	28	reduce the number of adults in an inpatient facility by 18%.
Reliance on inpatient care for children with autism and/or a learning disability or both	3	3	maintain the support provided to children in an inpatient facility

By taking the following action:

Action	
Children and Young Person • Continue investment into **mental health support in schools and colleges**, to build on the 13 teams currently in place to support approximately 90,000 young people in an educational setting. • Develop a business case for in-year investment to **enhance core CAMHS capacity** to reduce waiting times. *Reducing reliance on inpatient care for people with a learning disability and/or autism* • Work with partners to create an effective care and accommodation offering in the community for the **17 long stay citizens** that we plan to discharge in 2025/26. • **Source capital from NHS England** to support the discharge of 2 people who are clinically fit for discharge, but accommodation is an issue. • Work closely with the CAMHS T4 Provider Collaborative, to support the delivery of the National framework and **strengthen our local crisis services** with a focus on LD/A needs.	• Progress two major service change programmes – 1) Short Breaks 2) Inpatients. This includes consideration of initiatives which can enhance the local LD care pathway such as Step Up/Down. *Length of stay* • Continue to focus on enhancing the effectiveness of **crisis resolution and home treatment teams,** to prevent unnecessary admissions. • Work with local authority partners to increase access to **supported housing and social care**, to facilitate recovery. • Optimise patient flow – by focussing on consistent delivery of **10 high impact actions**. • Improve the care pathway for adults with **emotionally unstable personal disorder**, to reduce avoidable admissions and support shorter length of stay where admission is necessary. *Psychiatric Intensive Care Unit (PICU)* • We will **bring online the 14-bedded male PICU** on the Kingsway Hospital Site.

Improve access to general practice and urgent detail care

Derby and Derbyshire Integrated Care Board

Objective
• Increase the proportion of the adult and child population seen by an NHS dentist by 2% over the next 12 months and within this deliver more urgent appointments to deal with the unmet need. • NHS Operational Planning Guidance sets patient experience of access, as measured by the ONS' Health Insights Survey, as a key measure of success in 2025/26. At the time of writing, no further detail has been received on the level of improvement required, nor detail of the baseline level of performance.

Action	
Dental • We will **commission an additional 16,298 urgent dental appointments.** • We are also planning ongoing patient engagement to promote the availability of the urgent appointments and monitor demand. • We will work with key stakeholders including Healthwatch to promote the availability of urgent appointments.	General Practice We will continue to support the delivery of modern general practice, with the following action planned: • Pending SDF monies, we will implement a new digital triage system that will provide online consultation, video consultation, patient messaging, sending out individual booking links – for on the day appointments and QOF/vaccines appointment. • We will convene a task and finish group to build on the rollout of the NHS App to ensure that all practices are using all the functionalities available including access to records, booking appointments, ordering repeat prescriptions and patient messaging. We will also work with the comms team to increase the awareness to the public about the benefits of using the NHS App. • We will continue to work with practices and pharmacies to increase the use of pharmacy first and reduce variation.

Address inequalities and shift towards prevention

Derby and Derbyshire Integrated Care Board

Objective
• Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people. • Increase the proportion of patients with hypertension treated according to NICE guidance, and the proportion of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance.
Action
We will continue to improve the **clinical areas within the Core20Plus 5 Framework** for both adults and children. In previous sections of this document, we have covered specific aspects of the Framework: • For children, we detail how we plan to improve access to mental health services and dentistry. • For adults, we detail how we will increase the faster diagnosis of cancer, which is critical to ensure that more cancers are caught earlier. As part of our wider effort to reduce unwarranted variation for a range of quality metrics, we will work with General Practice and other partners to form an action plan, by the end of quarter one 2025/26, to bring about improvements to other areas of the Framework – specifically:

Adults	***Children***
• **Physical Health Checks and Care Planning** – for people with a Severe Mental Illness; and people with Learning Disabilities and/or autism. • **Chronic Respiratory Disease** – working with the 28 practices where the COPD admission rate is above upper quartile performance. • **Hypertension and cholesterol management** – using QoF to incentivise an increase in overall compliance to NICE guidelines.	• **Asthma** – working with the 28 practices where admission rates for asthma are above upper quartile performance.

Referral to Treatment

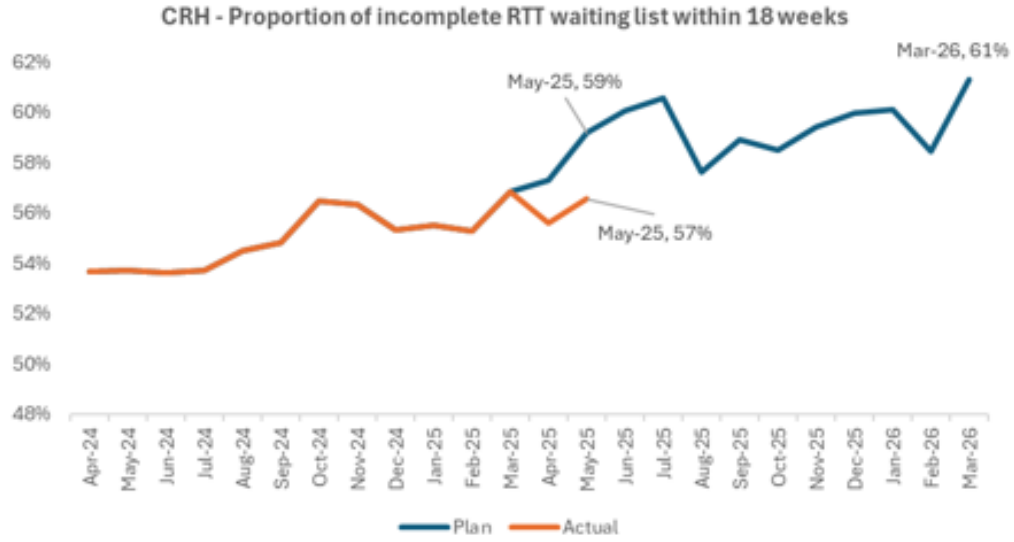
To date, performance between the two Trusts has diverged: UHDB is on track with its RTT trajectory, while CRH is not.

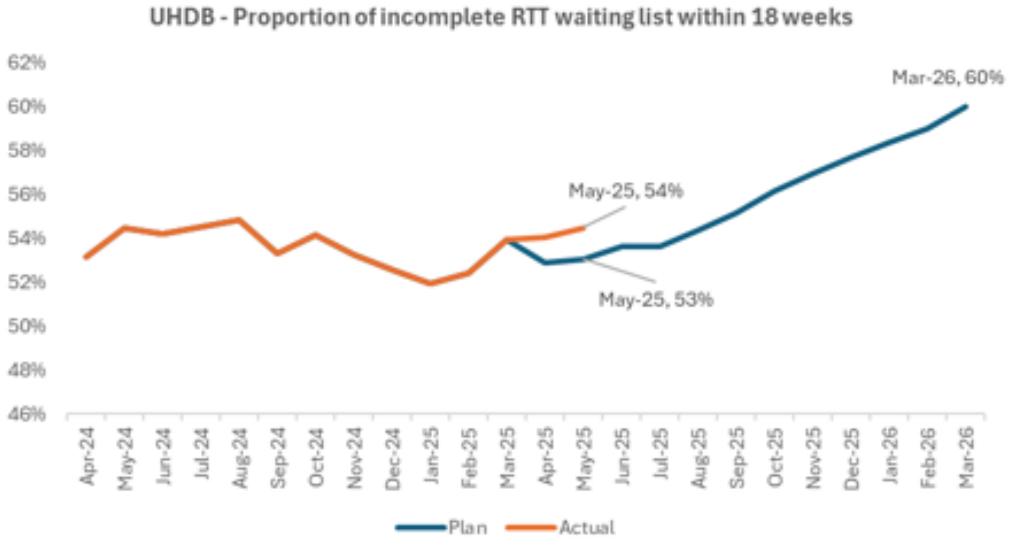
A key factor in delivering the RTT plan is improved productivity within core services at both Trusts. On this, the picture is mixed.

- **Theatres ('touch time utilisation')** – UHDB is performing below expectations, currently in the second quartile at 78%, behind the peer average of 80% and well below top-decile performance of 85%. CRH fares slightly better at 81%, though there is still scope for improvement.

- **Outpatients (clinic utilisation)** – Utilisation remains 6-7% below target, with the CRH showing the most significant shortfall – first outpatient activity is around 50% lower than peer Trusts.

- **Evidence Based Interventions –** UHDB is delivering substantially higher volumes of four elective procedures compared to peers, strongly indicating non-compliance with EBI thresholds.





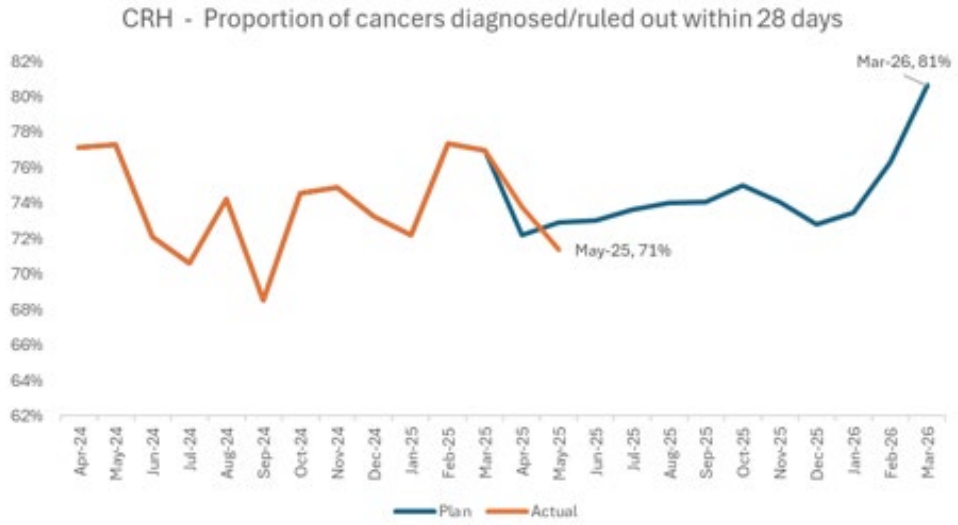
Faster Cancer Diagnosis

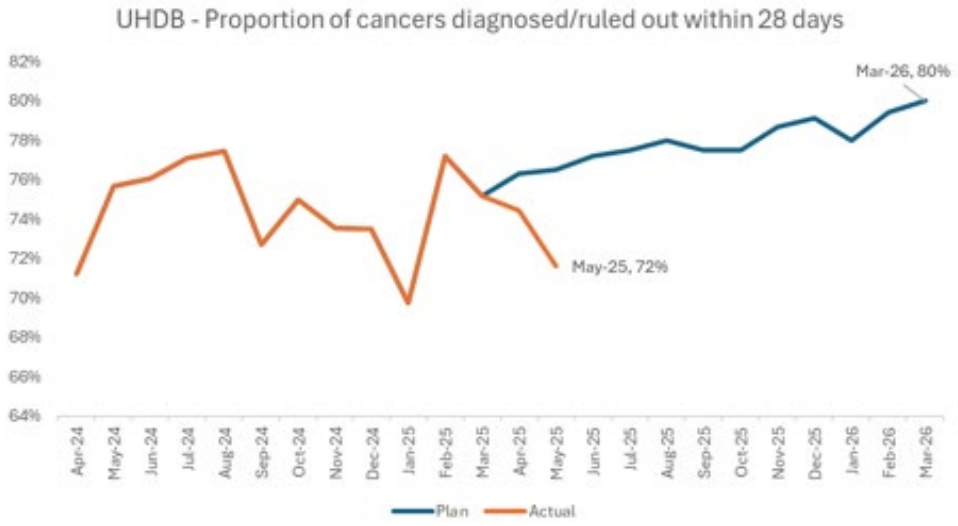
At the end of May 2025, both Trusts were behind their planned trajectories and are currently 3-4% behind the national average.

The most challenging tumour sites across both Trusts are suspected **gynaecological**, **gastrointestinal** and **urological** cancers. In addition, the **CRH's dermatology service** lacks sufficient capacity to meet both general and two-week wait demand.

Key cross cutting issues affecting performance across these tumour sites include:

- **First outpatient capacity:** Delays in initial specialist review are limiting timely progression through the cancer pathway.
- **Diagnostic capacity:** Access to imaging and endoscopy remains a critical limiting factor.
- **Histopathology Turnaround:** Delays in pathology reporting, particularly for biopsies and resection specifics, are contributing to pathway breaches.

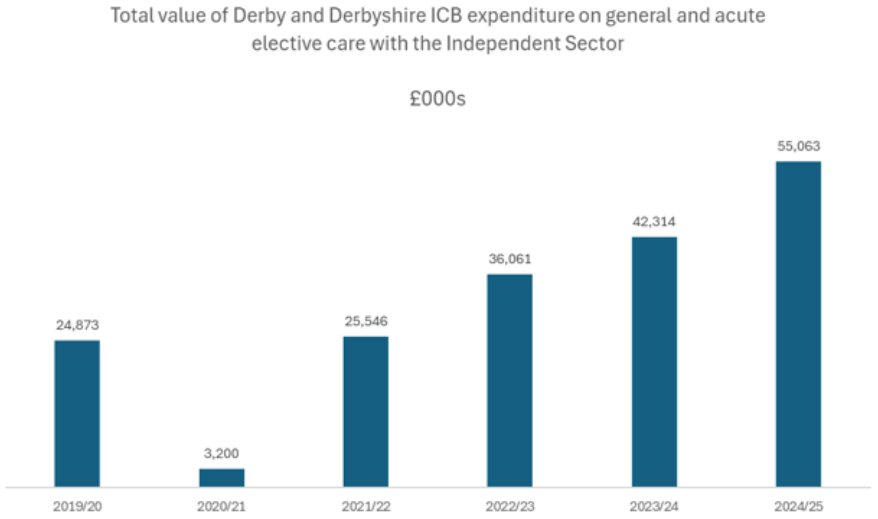




Utilisation of the Independent Section – general and acute elective care

Derby and Derbyshire Integrated Care Board

- The volume of activity delivered by the Independent Sector (IS) has doubled compared to the pre-pandemic baseline level.
- While growth was anticipated in the immediate post-pandemic period, there has been no levelling off with 2024/25 outturn 30% higher than 2023/24.
- Most of the activity consists of high volume, low complexity procedures within orthopaedics and ophthalmology, leading to (i) distortion of NHS vs. non-NHS provider access performance and (ii) lost margin opportunities that could otherwise support the financial sustainability of NHS provider operations.
- In 2025/26, tighter control over IS expenditure is essential. Key actions include:
  - **NHS Trust accountability for reimbursement of IS-transferred care**: This will help disincentive the outsourcing of long-wait patients and encourage provider-side efficiency.
  - **Strengthening contract management:** Leverage enhanced activity controls within the NHS Standard Contract.
  - **Setting clear expectations:** Accept that median wait times in the IS will increase, but patient choice will still be maintained.



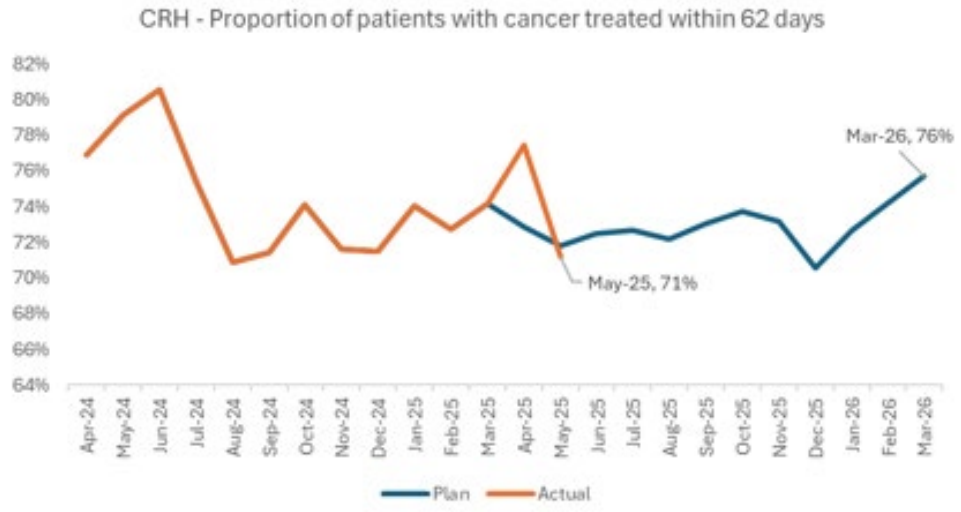
Median waiting times for treatment (March 2025)					
Orthopaedics			Opthalmology		
	admitted	non-admitted		admitted	non-admitted
NHS	26-32 weeks	19-27 weeks	NHS	17 weeks	17-26 weeks
IS	18-27 weeks	11-15 weeks	IS	3-4 weeks	2-4 weeks

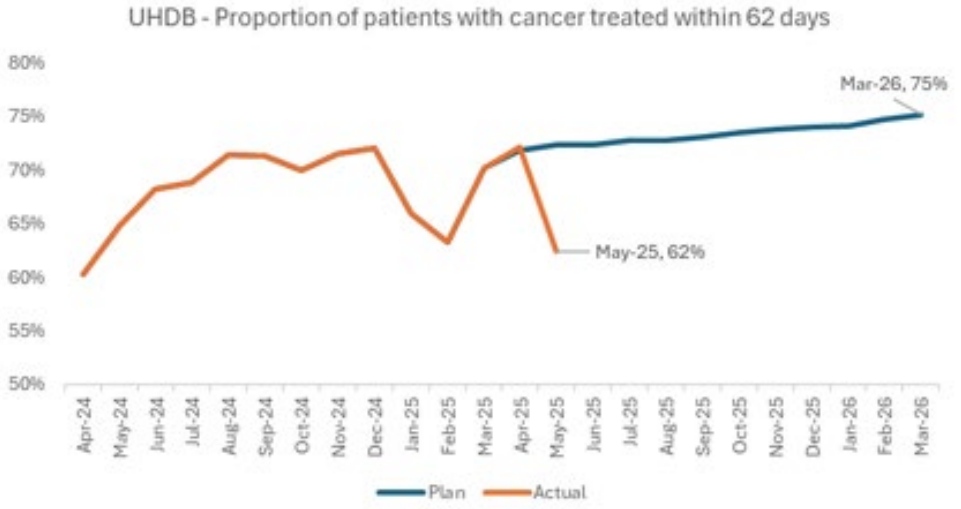
Cancer Treatment

At the end of May 2025, both Trusts were performing above the national average but remained below their planned trajectories. The CRH's trajectory, in particular, requires further validation to clarify the assumptions behind the projected improvement from December 2025.

Performance across both Trusts is inconsistent, with significant variation in treatment times by tumour site, particularly at UHDB with lower gastrointestinal, gynaecological and urological cancers showing the greatest delays.

tumour_site	Feb 2025	Mar 2025	Apr 2025	May 2025	Total
Brain/Central Nervous System	100.0%	100.0%	85.7%	100.0%	**93.3%**
Breast	78.7%	79.1%	72.7%	56.7%	**72.3%**
Gynaecological	36.7%	31.4%	57.1%	26.1%	**38.6%**
Haematological	61.5%	76.9%	71.4%	58.6%	**68.2%**
Head & Neck	64.7%	81.8%	68.8%	81.8%	**74.2%**
Lower Gastrointestinal	31.5%	55.1%	46.3%	33.3%	**42.1%**
Lung	57.7%	62.7%	78.0%	93.7%	**75.8%**
Other	33.3%	100.0%	100.0%	100.0%	**71.4%**
Sarcoma	100.0%	100.0%	0.0%	50.0%	**53.3%**
Skin	89.1%	84.8%	84.5%	69.4%	**83.6%**
Upper Gastrointestinal	68.9%	68.0%	68.4%	68.8%	**68.5%**
Urological	55.8%	67.4%	66.7%	69.3%	**64.5%**
Total	**63.2%**	**70.2%**	**70.0%**	**62.4%**	**66.8%**





4-hour A&E

NHS and Derbyshire Integrated Care Board

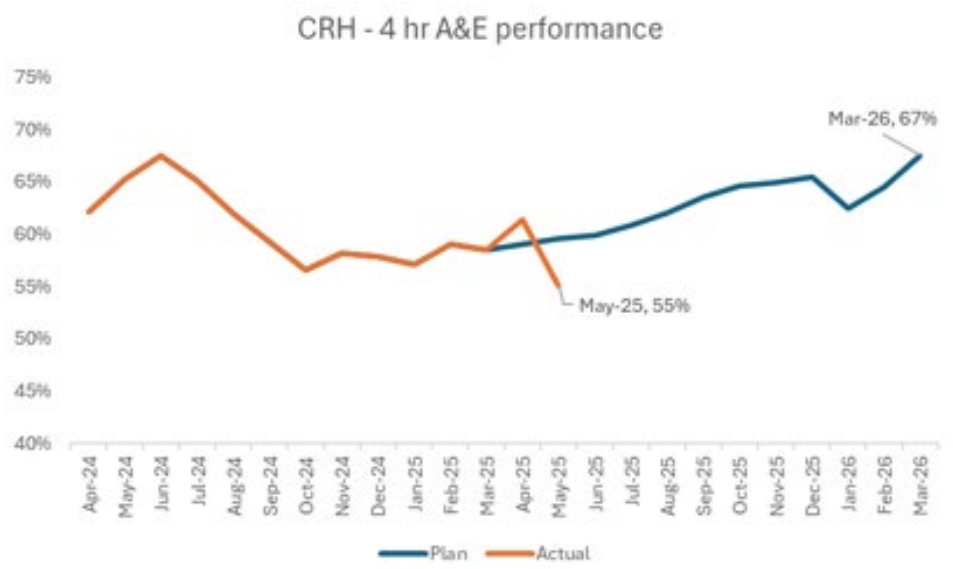
To date, A&E performance has diverged between the two Trusts: UHDB remains broadly on track to meet its 4-hour trajectory, whilst the CRH continues to fall short. In fact, even, if CRH delivers its current recovery trajectory, it would only return the Trust to the same position is held at the end of 2023/24 – highlighting a lack of real progress.

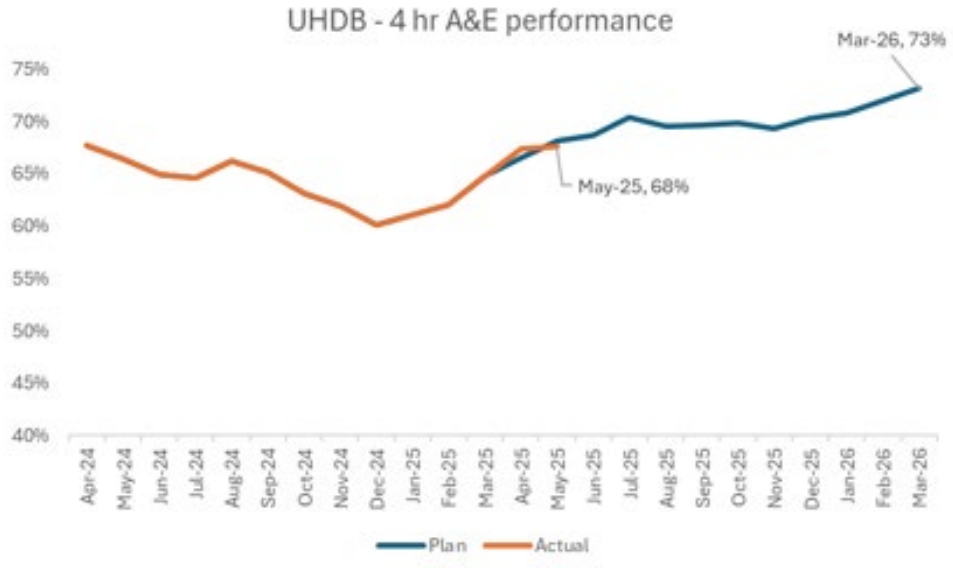
While there are opportunities to reduce avoidable demand at both Trusts – particularly in emergency readmissions and end of life hospital utilisation, which remain at upper quartile levels – overall ED demand has not increased. This reinforces the fact that poor A&E performance is not being driven by rising attendances.

The core issue remains flow through beds. Although average length of stay benchmarks reasonably well at both Trusts, there has been no statistically significant reduction in bed occupancy or length of stay over the past 18 months. Within this delayed discharges remain a critical constraint.

- At CRH, 25% of beds are occupied by patients who are clinically ready for discharge.
- At UHDB, the figure is 19%.

This lack of flow is restricting capacity to admit patients from A&E, directly impacting performance against the 4-hour standard.





Mental Health

Derby and Derbyshire
Integrated Care Board

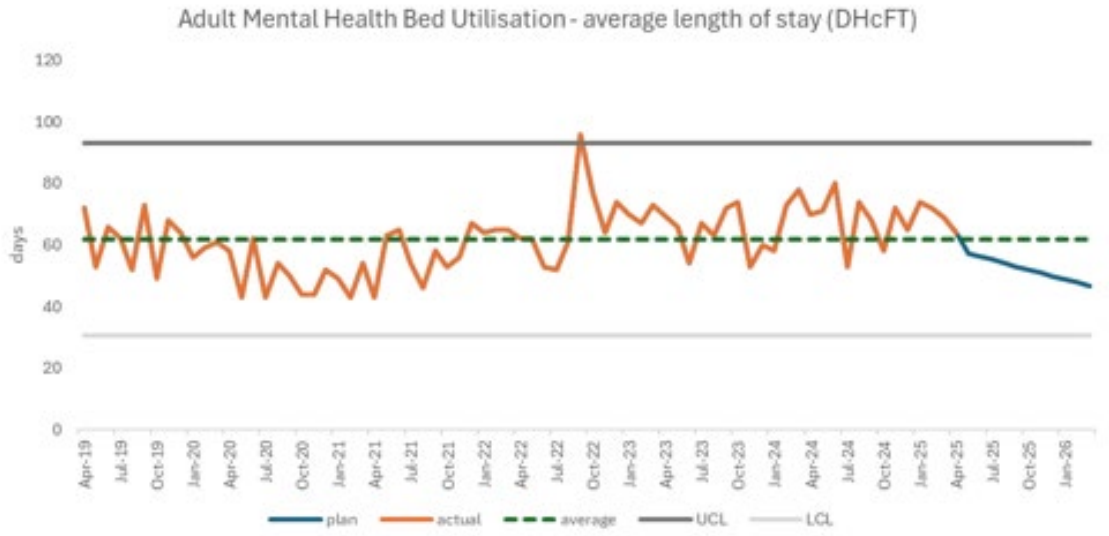
Achieving an average length of stay of 47 days by the end of the period is highly ambitious – particularly given performance has remained at 62 days on average for the past five years. However, meeting this target is critical to creating capacity in a system currently operating at a bed occupancy of 95%+.

Delivery will require a focused approach in three key areas:

Purposeful admission – with increased investment in community services, admissions must only occur when care or treatment cannot be safely delivered in a non-inpatient setting.

Therapeutic inpatient care – patients must have timely access to the assessments, interventions and treatments they need – ensuring that every day spent in hospital delivers therapeutic value.

Purposeful discharge – Patients should be discharged as soon as their inpatient care objectives are met. There is significant opportunity here, with 12-17% of beds occupied at any one time by patients who are clinically ready for discharge.



Finance

Bill Shields, Chief Finance Officer
Nigel Smith, Non-Executive Member

Month 2 System Finance Summary – Financial Position

NHS
Derby and Derbyshire
Integrated Care Board

JUCD submitted a break-even plan inclusive of £45m Deficit Support Funding (DSF). With the phasing of the plan, as at M2 the system has planned for a deficit of £13.1m after receipt of DSF.

At month 2, the system is reporting a year to date position of £0.6m favourable to the planned deficit of £13.1m.

Key variances within the financial position include an adverse variance on pay relating to bank and agency costs. This variance is being offset by favourable variances including over-achievement of efficiencies to date.

All organisations are forecasting to be in line with the plan for the financial year.

	Inclusive of Deficit Support Funding			Excluding Deficit Support Funding			
	YTD Plan £'m	YTD Actual £'m	YTD Variance £'m	YTD Plan £'m	YTD Actual £'m	YTD Variance £'m	YTD DSF £'m
ICB	0.0	0.1	0.1	0.0	0.1	0.1	0.0
CRH	(3.5)	(2.8)	0.7	(5.9)	(5.2)	0.7	2.4
DCHS	(1.0)	(1.0)	0.0	(1.0)	(1.0)	0.0	0.0
DHcFT	(1.3)	(1.2)	0.0	(1.3)	(1.2)	0.0	0.0
EMAS	0.6	0.6	0.0	0.6	0.6	0.0	0.0
UHDB	(7.8)	(8.0)	(0.2)	(12.9)	(13.1)	(0.2)	5.1
JUCD Total	**(13.1)**	**(12.5)**	**0.6**	**(20.6)**	**(20.0)**	**0.6**	**7.5**

Month 2 System Finance Summary – Efficiencies

Derby and Derbyshire Integrated Care Board

At month 2 efficiency delivery is £18.9m, a variance of £0.1m ahead of the planned £18.8m.

The level of recurrent efficiencies is £0.8m behind plan, offset by achievement on non-recurrent schemes. This puts pressure on future financial years.

All organisations are forecasting to achieve the full year plan of £181.7m. However, a risk-adjusted assessment of efficiency delivery shows a risk adjusted gap of up to £54.3m (29.9%) against the annual plan target.

Organisation	YTD Plan £'m	YTD Actual £'m	YTD Variance £'m	Full Year Plan £'m	Forecast Outturn £'m	Forecast Variance £'m	Total Forecast £'m	Risk Weighting %	Risk Adjusted Forecast £'m
ICB	5.8	5.8	0.0	44.0	44.0	0.0	44.0	86%	38.0
CRH	1.8	1.9	0.1	21.9	21.9	0.0	21.9	51%	11.3
DCHS	1.8	2.0	0.3	17.0	17.0	0.0	17.0	70%	11.9
DHcFT	1.9	1.9	0.0	14.8	14.8	0.0	14.8	83%	12.3
EMAS	2.8	2.6	(0.2)	16.9	16.9	0.0	16.9	88%	15.0
UHDB	4.8	4.7	(0.1)	67.0	67.0	0.0	67.0	58%	38.9
JUCD Total	**18.8**	**18.9**	**0.1**	**181.7**	**181.7**	**0.0**	**181.7**	**70%**	**127.4**

Month 2 System Finance Summary – Capital

Derby and Derbyshire Integrated Care Board

Capital expenditure year to date at M2 is a total of £8.2m, this is £7.8m behind plan.

M2 capital expenditure is behind planned levels in all but EMAS who signed a lease on 1 April. Schemes behind plan include £2.3m Site Wide Power, £1.6m Making Room for Dignity and £1m CDC's.

Capital funding for 2025/26 for the system is a total of £144.0m, consisting of system capital, provider internally generated funding, PFI schemes and central allocations. The system has not received any changes to allocations since the plan was set.

The system has plans to spend £145m, which is over the total allocation but within the allowable 5% planning tolerance. This additional £1m cannot be spent and must be managed through system slippage and underspends.

	YTD Plan £'m	YTD Actual £'m	YTD Variance £'m	Original Annual Plan £'m	Revised Spending Limit £'m	Forecast Annual Amount £'m	Forecast Variance £'m
CRH	1.8	0.1	1.6	23.5	23.5	23.5	0.0
DCHS	2.7	1.6	1.1	18.1	18.1	18.1	0.0
DHcFT	3.3	1.1	2.2	18.6	18.6	18.6	0.0
EMAS	2.9	3.1	(0.2)	22.1	22.1	22.1	0.0
UHDB	5.4	2.3	3.1	58.5	58.5	58.5	0.0
Provider Total	**16.0**	**8.2**	**7.8**	**140.8**	**140.8**	**140.8**	**0.0**
DDICB	0.0	0.0	0.0	4.2	4.2	4.2	0.0
Overcommitment	(0.2)	0.0	(0.2)	(1.0)	(1.0)	0.0	(1.0)
Total Capital	**15.8**	**8.2**	**7.6**	**144.0**	**144.0**	**145.0**	**(1.0)**

Workforce

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

2025/26 Workforce Plan Position Month 2 - Provider Summary

NHS Derby and Derbyshire Integrated Care Board

2025/26v		M2 Plan	M2 Actual	Variance from plan	YTD Plan M1 - M2 (WTE as Average)	YTD Actual M1 - M2 (WTE as Average)	Variance
ICB	Workforce (WTE)						
	Total Workforce	30,786.34	30,498.13	-288.21	30,401.41	30,074.84	-326.57
	Substantive	29,051.18	28,853.17	-198.01	28,546.28	28,256.87	-289.40
	Bank	1,516.49	1,417.87	-98.62	1,568.45	1,590.03	21.58
	Agency	218.67	227.09	8.42	286.68	227.94	-58.74
	Cost (£)						
	Pay Cost (£'000) ^	149,145	148,806	-339	297,058	297,224	165
CRH	Workforce (WTE)						
	Total Workforce	5,002.96	4,998.96	-4.00	5,039.21	4,984.86	-54.35
	Substantive	4,657.21	4,666.81	9.60	4,621.58	4,631.72	10.14
	Bank	266.89	240.76	-26.13	310.86	267.95	-42.91
	Agency	78.86	91.39	12.53	106.77	85.19	-21.58
	Cost (£)						
	Pay Cost (£'000) ^	25,231	24,399	-832	49,305	49,125	-180
DCHS	Workforce (WTE)						
	Total Workforce	3,979.00	3,900.46	-78.54	3,907.73	3,867.46	-40.27
	Substantive	3,874.00	3,792.94	-81.06	3,779.14	3,763.59	-15.55
	Bank	80.00	87.26	7.26	95.16	85.53	-9.63
	Agency	25.00	20.26	-4.74	33.43	18.34	-15.09
	Cost (£)						
	Pay Cost (£'000) ^	15,860	16,217	357	31,781	32,448	667
DHcFT	Workforce (WTE)						
	Total Workforce	3,378.34	3,221.11	-157.23	3,216.61	3,202.78	-13.83
	Substantive	3,202.08	3,067.70	-134.38	3,006.88	2,963.54	-43.34
	Bank	158.56	140.74	-17.82	164.16	214.62	50.46
	Agency	17.70	12.67	-5.03	45.57	24.63	-20.95
	Cost (£)						
	Pay Cost (£'000) ^	15,807	15,049	-758	31,613	30,299	-1,314
EMAS	Workforce (WTE)						
	Total Workforce	4,580.64	4,493.87	-86.77	4,442.74	4,262.38	-180.36
	Substantive	4,514.64	4,428.45	-86.19	4,366.08	4,185.01	-181.07
	Bank	47.00	52.18	5.18	52.66	59.31	6.65
	Agency	19.00	13.24	-5.76	24.00	18.07	-5.94
	Cost (£)						
	Pay Cost (£'000) ^	20,575	20,233	-342	41,141	40,213	-928
UHDB	Workforce (WTE)						
	Total Workforce	13,845.40	13,883.73	38.32	13,795.13	13,757.37	-37.76
	Substantive	12,803.25	12,897.26	94.01	12,772.61	12,713.02	-59.59
	Bank	964.04	896.93	-67.11	945.61	962.63	17.02
	Agency	78.11	89.53	11.42	76.91	81.72	4.81
	Cost (£)						
	Pay Cost (£'000) ^	71,672	72,908	1,236	143,219	145,139	1,920

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

17th July 2025

Item: 037

Report Title	One Workforce People Plan Update Report
Author	Lee Radford – ICB Chief People Officer
Sponsor	Lee Radford – ICB Chief People Officer
Presenter	Lee Radford – ICB Chief People Officer
Paper purpose	Decision ☐ Discussion ☐ Assurance ☒ Information ☐
Appendices (reports attached)	Appendix 1 - One Workforce Update Report July 2025

Recommendations

The ICB Board are recommended to **RECEIVE** the current update report on the development of the ICB's One Workforce approach across the NHS, Social Care, VCFSE and Local Authority sectors in Derby and Derbyshire.

Report Summary

This report provides an update to the ICB Board on the progress of the ICB's One Workforce strategy and approach.

The timelines for developing the system One Workforce strategy, approach and ethos remains on plan.

From March 2025 to June 2025, an extensive system wide engagement exercise took place across health, care, local authority, higher education, and VCFSE sectors to understand the current state of the workforce, areas of under representation, social mobility cold spots, culture, workforce challenges and risks.

Over 350 people from 56 different organisations across Derbyshire attended a range of engagement sessions resulting in over 2,000 pieces of feedback being given to steer the development of this important strategy.

During July and August, this feedback will be analysed, findings will be played back to the system, opportunities identified for collaboration and to test recommendations with our partners. The next steps will be then to co-produce with partners a draft strategy, test approaches and define our future desired workforce state.

This report also presents an overview of how our One Workforce approach will strengthen the future ICB model blueprint aligned to strategic commissioning, reducing health inequalities, and support the new national NHS Ten Year Plan through a strategic partnership and whole workforce development approach.

How does this paper support the 3 shifts of the NHS 10-Year Plan?

From hospital to community	☒	From analogue to digital	☐	From sickness to prevention	☒

Integration with Board Assurance Framework and Key Strategic Risks

SR1	Safe services with appropriate levels of care	☒	**SR2**	Reducing health inequalities, increase health outcomes and life expectancy	☒
SR3	Population engagement	☒	**SR4**	Sustainable financial position	☐

SR5	Affordable and sustainable workforce	☒	**SR7**	Aligned System decision-making	☐
SR8	Business intelligence and analytical solutions	☐	**SR10**	Digital transformation	☐
SR11	Cyber-attack and disruption	☐			☐

Conflicts of Interest	None identified

Have the following been considered and actioned?			
Financial Impact	Yes ☐	No ☐	N/A ☒
Impact Assessments	Yes ☐	No ☐	N/A ☒
Equality Delivery System	Yes ☒	No ☐	N/A ☐
Health Inequalities	Yes ☒	No ☐	N/A ☐
Patient and Public Involvement	Yes ☒	No ☐	N/A ☐
ICS Greener Plan Targets	Yes ☐	No ☐	N/A ☒

Derby and Derbyshire Integrated Care Board

One Workforce Update Report July 2025

Background

As previously agreed by the ICP Board in July 2024, a mandate was established to develop a system vision through a One Workforce approach of “anyone working in health and care within Derby and Derbyshire feels part of ‘one workforce’ which is focused on enabling our population to have the best start in life, to stay well, age well and die well.

Our workforce will feel valued, supported and encouraged to be the best they can be and to achieve the goals that matter to them wherever they work in the system.”

Our One Workforce strategy, approach and ethos also strongly aligns to the East Midlands Combined Authority's vision on developing skills and employment for local communities and the National Get Britain Working Campaign.

Strategic Partnership and Whole Workforce Development Approach for the Future

Over the last few years, Derby and Derbyshire have been at the forefront of developing its Anchor ambition with a particular focus on attracting our future workforce into the system by working with all of our partners and increasing social mobility to reduce health inequalities.

Building partnerships across our system through our One Workforce development work has positioned Derby and Derbyshire into a pivotal position to respond to the new workforce challenges set out in the recent ICB model blueprint and new NHS Ten Year Plan.

Providing a comprehensive view of the whole system workforce, allows the ICB to be at the forefront of supporting strategic commissioning intentions through an inclusive strategic whole workforce development approach. This approach facilitates our system workforce to become a strategic enabler through sustainable system workforce capability and capacity that will successfully deliver our commissioning plans.

It also enables the ICB to support the development of future neighbourhood models of care with a multi-sector workforce, partnering with education institutions to cultivate future talent pipelines, empowering system leadership to support new models of care, reducing health inequalities and increasing social mobility through strategic partnership working. Developing effective multi-sector workforce models will be a critical component in supporting the shift of care from acute to community as it will require new ways of working and a different type of workforce.

Having built a strong multi-sector strategic partnership through our One Workforce approach across Derbyshire, provides us with a critical interface to further develop and work with our partners to better understand system working, which will support strategic commissioning and national priorities. Bringing system working to life for some of our workforce communities through our One Workforce approach has provoked many positive suggestions as to how different sector workforces could support strategic commissioning and innovation, align programmes of work to promote prevention and improve collaboration in becoming system leaders.

Our existing Anchor development programme plays a key part in improving the wider determinants of health and social mobility by targeting underrepresented communities into education and employment. In the new Ten Year Health Plan for England, there is a clear reference to joined up support from across work, health and skills systems to help people find and stay in work.

Strategic partnership working is also identified as a growth area in the new ICB model blueprint and our whole workforce approach will underpin the delivery of the new NHS Ten Year Plan.

The diagram below presents an overview of our strategic partnership and whole workforce development approach for Derby and Derbyshire and alignment to the NHS Ten Year Plan.

NHS
Derby and Derbyshire
Integrated Care Board

Strategic Workforce Partnership and Anchor Development – Improving Today and Building for Tomorrow

Baseline Current State

Current Workforce
- Sector baseline analysis
- WTEs
- Trend analysis
- Reasons for leaving
- Hard to recruit posts

Current Culture
- Staff Surveys
- Well Being
- EDI – WRES/WDES
- Neurodiversity
- OD maturity

Talent Management
- Succession Planning Risks
- Training and Development
- Trend analysis and EDI
- Reasons for leaving

Workforce Supply
- Build cross sector partnerships and relationships
- HEI & FEI application trends
- Understanding young peoples needs
- Building social mobility
- Careers program alignment to hard to recruit posts across sectors

Journey to Future State Through a Whole Strategic Partnership and Workforce Development Approach

Strategic Commissioning

Workforce as a strategic lever to deliver population health improvements by:
- Holding the system whole workforce view to support strategic commissioning.
- Developing strategic system workforce capability and capacity to deliver our plans.
- Develop the whole workforce vision for where the system is and wants to be.
- Develop future multi sector workforce models to support commissioning to enable transformation from **acute to community**.
- Build partnerships with HEI to develop future talent pipelines and systems leadership.
- Educate our system workforce on system working, **prevention** and commissioning.

Anchor and Social Mobility
- Bridging the gap between workforce, health, skills and economic inclusion to ensure that workforce is leveraged as a determinant of health.
- Use population health data to focus on underrepresented communities and social mobility cold spots to reduce health inequalities.
- Develop career pathways across all sectors to increase progression opportunities for local communities.
- Develop the Anchor brand to enable attraction opportunities across the Derbyshire system.
- Using Anchor partnerships to promote **digital access** to the NHS front door.

Neighbourhood Heath Teams
- Project OD to support by:
  - ✓ Building leadership capability
  - ✓ Wrap around change management
  - ✓ Support new ways of working
- Develop future multi-sector workforce models to support new models of care.
- Partnership with HEI's to develop professional training and talent pipelines.
- Align widening access programmes to recruit new future workforce..
- Supporting Pathway redesign from acute to community with OD to support change, new ways of working and embedding new workforce models.

NHS 10 Year Plan
- Strategic partnership working with multi sectors.
- Creation of neighbourhood health services.
- Cross-societal energy on prevention
- Join up support from across work, health and skills systems to help people find and stay in work. We will work with all ICBs to establish Health and Growth Accelerators models.
- Reduce international recruitment and focus on recruiting from our communities.
- Widening access to talented students from underprivileged backgrounds.

Delivering Strategic Commissioning and Reducing Health Inequalities Through a Whole System Strategic Partnership and Workforce Development Approach

- Workforce as a strategic lever to reducing health inequalities
- Creating inclusive and compassionate system culture
- Improving wider determinants of health through Social Mobility
- Acute to community shift through multisector workforces
- Promoting prevention through partnerships
- Attraction through Anchor

Update July 2025

1. The table below outlines the timelines for developing the system One Workforce strategy and approach which remains on plan.

Feb 25	Establishment of a One Workforce Steering group. - **Completed**
Mar – Jun 25	Engagement and diagnostic phase to understand the current system workforce, areas of under representation, social mobility cold spots, culture, areas of best practice, challenges and risks. - **Completed**
Jul-Aug 25	Analysing results of diagnostic phase, play back findings to the system, to identify opportunities for collaboration and to test recommendations.
Sept - Nov 25	Co-produce with partners a draft strategy, test approaches and define the future desired state.
Jan 26	Present the One Workforce Strategy, approach and ethos to ICB People and Culture Committee and ICB/ICP Boards for approval.

2. From March 2025 to June 2025, an extensive system wide engagement exercise took place across health, care, local authority, education establishments, and VCFSE sectors to understand the **current state** of the workforce, areas of under representation, social mobility cold spots, culture, workforce challenges and risks.

3. Over 350 people from across 56 different organisations across Derby and Derbyshire attended a range of face to face, online and bespoke team engagement sessions.

4. Alongside the system wide engagement events, bespoke, focussed engagement was carried out with VCFSE colleagues and students. The VCFSE engagement has been designed in partnership with the VCFSE Alliance and is being delivered by local VCFSE infrastructure organisations. The aim is to gather comprehensive baseline data on workforce issues and trends within the VCFSE sector to support development of the One Workforce approach. This will be critical as the system is currently lacking any VCFSE workforce data information and will enable us to consider future strategic commissioning priorities, along with the support needed from the VCFSE sector to deliver these programmes of work.

5. Tailored engagement using surveys, focus group approaches and in-person sessions are also took place with college students as our future workforce. The differing questions for the different key stages aim to identify what matters most to students when it comes to choosing a job or career which will help to support future supply pipeline development.

6. We have received over 2,000 pieces of feedback from this engagement exercise which will be analysed in more detail over the next few months. The main high level themes to emerge from this engagement exercise focused on:

Workforce Planning	Skill gaps
Hard to recruit roles and supply pipelines	Apprenticeships
Workforce recruitment and retention	Learning/ development & training
Leadership development	Staff Wellbeing
Culture	Digital/ IT

Next Steps

7. Over the next few months, the ICB Chief People Officers Directorate will undertake an in depth and comprehensive analysis of the feedback in order:

- To understand 'left shift' priorities and sector specific strategic drivers to identify commonality, enable mutual understanding and what this means for a future workforce.
- To consider how a whole workforce approach can be developed to support strategic commissioning intentions to reduce health inequalities, develop neighbourhood health centres with multi-sector workforces and improve social mobility.
- To identify system collaboration opportunities and learning from all sectors to develop shared approaches to attract, develop and retain a workforce and talent supply as part of a strategic whole workforce approach.
- To identify and deploy widening participation programmes of work to recruit our local population and to create career pathways across all sectors that will enable social mobility.
- To create new innovative routes and approaches into employment from care or college to work and remove barriers in applying to join the system workforce as part of our Anchor ambition.
- To identify ways to create a consistent and inclusive and compassionate culture to attract and retain our people across Derby and Derbyshire supported by a system EDI approach to feel part of the system workforce.
- To identify opportunities to develop and deploy people digital solutions that will enhance workforce productivity and capacity.
- To engage with system partners to test recommendations and findings and co-design our desired **future** workforce state.

8. The learning and implementation of this model and approach is also scalable which means that it can be further deployed across the Derbyshire, Nottinghamshire and Lincolnshire cluster to enable our cluster workforce to become a strategic lever to support commissioning, reduce health inequalities and improve social mobility for all our communities and implement the workforce requirements of the new NHS Ten Year Plan.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

17th July 2025

Item: 038

Report Title	Fit and Proper Person Test							
Author	Suzanne Pickering, Head of Governance Helen Dillistone, Chief of Staff							
Sponsor	Dr Kathy McLean, ICB Chair							
Presenter	Dr Kathy McLean, ICB Chair							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices (reports attached)	Appendix 1 – Annual FPPT Reporting Submission Appendix 2 – FPPT Checklist							

Recommendations

The ICB Board are recommended to **NOTE** the ICB position in relation to the Fit and Proper Person Test submission and approval of the process by the ICB Chair.

Report Summary

The report provides assurance to the ICB Board that the ICB has met the requirements of the Fit and Proper Persons Test (FPPT) Framework.

On 1st April 2025 NHS England launched a new Board Member Appraisal Framework which applies to Chairs, Chief Executives, Executives and Non-Executive Directors. The framework has been produced in response to the Messenger Review recommendations and stakeholder feedback, including the existing Chair Appraisal Framework, which it replaces.

The new framework incorporates the 6 domains of the leadership competency framework (https://www.england.nhs.uk/long-read/nhs-leadership-competency-framework-for-board-members/) into a single approach for all Executive and Non-Executive roles and aligns with the fit and proper person test (FPPT) framework (https://www.england.nhs.uk/publication/nhs-england-fit-and-proper-person-test-framework-for-board-members). It establishes clear expectations and enhances consistency in standards for board-level appraisals across the NHS, with the flexibility to adapt the process depending on whether the appraisee is an Executive or Non-Executive Director and enables integration into local policies.

Organisations were asked either to incorporate the framework principles into their own local processes or use the processes and editable forms NHSE provided. The ICB has incorporated the new framework and forms into its 2024/25 appraisal and FPPT process.

The appraisals for Chairs of NHS Trusts and Integrated Care Boards were required to be shared with NHS England by 27th June 2025 via england.chairsappraisal@nhs.net to facilitate Regional Director sign-off.

Appraisal forms a key part of the Fit and Proper Persons annual process. As per the prior year, Integrated Care Boards, NHS Trusts and Foundation Trusts were required to submit the FPPT annual reporting template by 27th June 2025.

FPPT and Appraisal Process

The FPPT and appraisal process has been completed by all ICB Board members. The FPPT Checklist (Appendix 2) details the process undertaken and confirms the completion of the ICB Board appraisals, self-attestation forms and the required checks.

Each Board member was required to:

- Complete the Fit and Proper Person Self Attestation Form;
- Complete a 360 self-assessment against the LCF; and
- Have an annual appraisal to include areas for self-development (as identified via the self-assessment against the LCF).

The ICB Chair and Chief Executive have confirmed that the above have been completed for Executive Officers and Non-Executive Members. The Senior Independent Director completed the process for the ICB Chair, and the process for ICB Board Partner Members are completed by their own organisations. All Board self-attestation forms have been formally signed off by the ICB Chair.

All recent appointments to the ICB Board, for example Chief Finance Officer, have complied with the requirements of the FPPT Framework.

Fit and Proper Person Test Annual Submission

The Chair's appraisal documentation was submitted to NHS England on 4th June 2025; and in accordance with the NHS England Fit and Proper Person Framework, the ICB was required to submit the Annual FPPT Reporting template; this can be found at Appendix 1.

The annual reporting template, the review of the self-attestation forms and confirmation of required checks as detailed in the FPPT checklist were to be signed off and approved by the ICB Chair on 19th June. This was submitted on the 20th June to NHS England, ahead of the deadline for submission of 27th June 2025.

The ICB are awaiting the final template following sign-off from Dale Bywater, Regional Director.

How does this paper support the 3 shifts of the NHS 10-Year Plan?					
From hospital to community	☒	From analogue to digital	☒	From sickness to prevention	☒

Integration with Board Assurance Framework and Key Strategic Risks					
SR1	Safe services with appropriate levels of care	☐	**SR2**	Reducing health inequalities, increase health outcomes and life expectancy	☐
SR3	Population engagement	☐	**SR4**	Sustainable financial position	☒
SR5	Affordable and sustainable workforce	☒	**SR7**	Aligned System decision-making	☒
SR8	Business intelligence and analytical solutions	☐	**SR10**	Digital transformation	☐
SR11	Cyber-attack and disruption	☐			☐

Conflicts of Interest	None identified

Have the following been considered and actioned?			
Financial Impact	Yes ☐	No ☐	N/A ☒
Impact Assessments	Yes ☐	No ☐	N/A ☒
Equality Delivery System	Yes ☐	No ☐	N/A ☒
Health Inequalities	Yes ☐	No ☐	N/A ☒
Patient and Public Involvement	Yes ☐	No ☐	N/A ☒
ICS Greener Plan Targets	Yes ☐	No ☐	N/A ☒

Appendix 5: NHS FPPT submission reporting template

This is a submission form. If anything changes during the year, submit a new form and notify an RD immediately. Do not alter the form.

NAME OF ORGANISATION	TYPE OF ORGANISATION *Select organisation*		NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
NHS Derby and Derbyshire Integrated Care Board		Trust	Dr Kathy McLean	1st April 2024 to 31st March 2025
		Foundation Trust		
	✓	ICB		

Part 1: FPPT outcome for board members including starters and leavers in period

Role**	Total Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	6	6	0	0	1	1
Executive board members	7	7	0	0	2	2
Partner members (ICBs)	7	7	0	0	2	0
Total	20	20	0	0	5	3

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

***** Do not enter names of board members.***

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	Yes	

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC	N/A	N/A	N/A	N/A
Other, e.g., internal audit, review board, etc.	N/A	N/A	N/A	N/A

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR NHS DERBY AND DERBYSHIRE ICB – 2024/25				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
	Senior Independent Director & Deputy Chair	Margaret Gildea	19th June 2025	Yes

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
	Yes	Not applicable
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:
	No	Not applicable
As Chair of NHS Derby and Derbyshire ICB, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.		
Chair signature:	Dr Kathy McLean	
Date signed:	19th June 2025	
For the regional director to complete:		
Name:		
Signature:		
Date:		

Derby and Derbyshire Integrated Care Board

FPPT Submission Checklist

Board Member	Professional qualifications/ registration	Disciplinary, Grievance, Whistleblowing, Behaviour	Insolvency check	Disqualified director, charity trustee check	Employment Tribunal Judgement check	DBS check	Social media check	Self-Attestation Received	Reference, if applicable	Annual Appraisal Date
Chair										
Kathy McLean		✓	✓	✓	✓	✓	✓		NHSE	17th April
Non Executive Members										
Richard Wright										
Adedeji Okubadejo		✓	✓	✓	✓	✓	✓	✓		7th May
Margaret Gildea		✓	✓	✓	✓	✓	✓	✓		23rd April
Sue Sunderland	✓	✓	✓	✓	✓	✓	✓	✓		28th May
Jill Dentith		✓	✓	✓	✓	✓	✓	✓		15th April
Nigel Smith	✓	✓	✓	✓	✓	✓	✓	✓	✓	15th May
Executive Directors										
Dr Chris Clayton		✓	✓	✓	✓	✓	✓	✓		8th May
Michelle Arrowsmith		✓	✓	✓	✓	✓	✓	✓		12th May
Keith Griffiths									✓	
Bill Shields	✓	✓	✓	✓	✓	✓	✓			
Dr Chris Weiner	✓	✓	✓	✓	✓	✓	✓	✓		20th May
Prof Dean Howells	✓	✓	✓	✓	✓	✓	✓	✓		16th May
Helen Dillistone		✓	✓	✓	✓	✓	✓	✓		16th May
Linda Garnett									✓	
Lee Radford	✓	✓	✓	✓	✓	✓	✓	✓	✓	9th May
Partner Members										
Stephen Posey								✓		4th August
Mark Powell								✓		28th August
Dr Andrew Mott								✓		15th July
Perveez Sadiq										
Paul Simpson								✓		16th July
Ellie Houlston								✓		18th June
Participant Members										
Tracy Allen										
James Austin								✓		15th July
Dr Avi Bhatia								✓		18th June

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

17th July 2025

Item: 039

Report Title	Board Assurance Framework (BAF) Quarter 1 2025/26						
Author	Rosalie Whitehead, Risk Management & Legal Assurance Manager						
Sponsor	Helen Dillistone, Chief of Staff						
Presenter	Helen Dillistone, Chief of Staff						
Paper purpose	Decision	☒	Discussion	☐	Assurance	☒	Information ☐
Appendices (reports attached)	Appendix 1 – ICB Board BAF Strategic Risk Report Appendix 2 – BAF Summary of all Strategic Risks Quarter 1 Appendix 3 – BAF Strategic Risks 1 to 11						

Recommendations

The ICB Board are requested to:

- **RECEIVE** the Quarter 1 2025/26 BAF strategic risks 1 to 11;
- **NOTE** the risk score decreases in respect of strategic risk:
  - Strategic Risk 11, owned by Finance and Performance Committee has been decreased from a very high score of 16 to a high score of 12.

Report Summary

This report provides the 2025/26 final quarter 1 position of the Board Assurance Framework. The strategic risks have been reviewed, updated and approved by each responsible Committee and the current risk scores considered and rationale provided.

The Board Assurance Framework (BAF) is presented in a new format from quarter 1 2025/26, this is following the agreement at the Board Risk Management seminar session in October 2024 to update and simplify the format of the BAF. The strategic risks have been further streamlined and the detail refreshed into a strategic concise level format.

Changes made during quarter 1 are highlighted on the BAF in blue text. Please see Appendix 3, included as a separate PDF document to the agenda and paper pack.

The Board Assurance Framework Strategic Risk Report (Appendix 1) provides the detail of the final quarter 1 position strategic risks, risk movement, rationale and actions completed during quarter 1. The BAF summary (Appendix 2) provides the overall assurance rating, target and risk tolerance scores for each strategic risk.

Strategic Risk score changes

During quarter 1, one strategic risk, owned by the Finance and Performance Committee, has decreased in risk score:

Strategic Risk 11: *There is a risk that the core patient care and business functions of Derbyshire system partners could be compromised or unavailable if there were a successful cyber-attack/disruption, resulting in threats to patient care and safety, and loss or exploitation of personal patient information, amongst others.*

This strategic risk has decreased from a very high score of 16 to a high score of 12. This reduction was approved at the Finance and Performance Committee meeting held on 24th June 2025.

All other strategic risk scores have not changed. Committee have reviewed and scrutinised the risk scores and they have agreed for the risk scores to remain the same.

How does this paper support the 3 shifts of the NHS 10-Year Plan?					
From hospital to community	☒	From analogue to digital	☒	From sickness to prevention	☒

Integration with Board Assurance Framework and Key Strategic Risks					
SR1	Safe services with appropriate levels of care	☒	**SR2**	Reducing health inequalities, increase health outcomes and life expectancy	☒
SR3	Population engagement	☒	**SR4**	Sustainable financial position	☒
SR5	Affordable and sustainable workforce	☒	**SR7**	Aligned System decision-making	☒
SR8	Business intelligence and analytical solutions	☒	**SR10**	Digital transformation	☒
SR11	Cyber-attack and disruption	☒			☐

Conflicts of Interest	None identified

Have the following been considered and actioned?			
Financial Impact	Yes ☐	No ☐	N/A ☒
Impact Assessments	Yes ☐	No ☐	N/A ☒
Equality Delivery System	Yes ☐	No ☐	N/A ☒
Health Inequalities	Yes ☐	No ☐	N/A ☒
Patient and Public Involvement	Yes ☐	No ☐	N/A ☒
ICS Greener Plan Targets	Yes ☐	No ☐	N/A ☒

Derby and Derbyshire Integrated Care Board

Board Assurance Framework Strategic Risk Report
Quarter 1 – 2025/26

This report provides a description of the strategic risks currently facing the Derbyshire system and provides the final position for each at Quarter 1 2025/26 including the decisions of the relevant committees in relation to any changes in risk scores, risk description and threats.

The ICB has nine strategic risks in total. Four strategic risks are scored very high and five strategic risks are scored high.

Risk No	Description	Q4 2024/25 closing risk score	Q1 2025/26 closing risk score	Risk Movement	Rationale	Additional Comments
SR1 *Quality, Safety and Improvement Committee*	There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and both upper tier Councils to deliver consistently safe services with appropriate standards of care.	**16**	**16**	⟺	Due to the ongoing pressures within the system, along with zero growth in the workforce due to the vacancy freeze, this impacting capacity, the risk score remains at a very high 16.	The description for Threat 2 has been revised to align to the three shifts in the NHS. There are no completed actions for quarter 1.
SR2 *Strategic Commissioning and Integration Committee*	There is a risk that short term operational needs hinder the pace and scale required for the system to maximise the collaborative contribution of partners and achieve the long-term strategic objectives to reduce health inequalities, improve health outcomes and life expectancy.	**16**	**16**	⟺	Following discussion by the committee, the risk score remains at a very high 16.	The risk description has been amended to incorporate *the collaborative contribution of partners.* There are no completed actions for quarter 1.
SR3 *Strategic Commissioning and Integration Committee*	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to	**12**	**12**	⟺	Following discussion by the committee, the risk score remains at a high 12.	There are no completed actions for quarter 1.

	inequitable access to care and poorer health outcomes.					
SR4 *Finance and Performance Committee*	There is a risk that the NHS in Derbyshire is unable to deliver a sustainable financial position in the medium term and achieve the best value from the available funding for the population of Derby and Derbyshire.	**20**	**20**	⟷	The risk description has been revised for 2025/26.	One additional threat has been added to Strategic Risk 4, this relates to the ICBs requirement to cut running costs.
SR5 *People and Culture Committee*	There is a risk that the system is not able to maintain an affordable and sustainable workforce supply pipeline and to retain staff through a positive staff experience.	**16**	**16**	⟷	The score remains at a very high 16. Due to the lack of information available from non NHS wider workforce sectors, a full review of Strategic Risk 5 will take place during quarter 2 2025/26 once the analysis and testing of the 'One Workforce' Strategy detailing wider workforce statistics is carried out.	No actions were completed during quarter 1.
SR7 *Strategic Commissioning and Integration Committee*	There is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	**12**	**12**	⟷	Following discussion by the committee, the risk score remains at a high 12.	There were no completed actions during quarter 1.
SR8 *Strategic Commissioning and Integration Committee*	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	**12**	**12**	⟷	Following discussion by the committee, the risk score remains at a high 12.	There were no completed actions during quarter 1.

SR10 *Finance and Performance Committee*	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	**12**	**12**	⟷	The risk score remains at a high 12. This is due to the continued uncertainty of national funding and resources to support digital enablement along with pending changes to the ICBs role in relation to strategic digital leadership and delivery.	No actions were completed during quarter 1.
SR11 *Finance and Performance Committee*	There is a risk that the core patient care and business functions of Derbyshire system partners could be compromised or unavailable if there were a successful cyber-attack/disruption, resulting in threats to patient care and safety, and loss or exploitation of personal patient information, amongst others.	**16**	**12**	↓	The impact score has decreased from 4 to 3 due to a Cyber Resilience Plan for the system and the ICB currently being in the final stages of approval. A cyber resilience exercise for the system is also planned. Work has been undertaken in the system to understand co-dependencies and how we would manage cyber incidents and positive assurance has been seen from partners.	Two actions were completed during quarter 1.

Item 039 - Appendix 2

ICB – Board Assurance Framework (BAF) Quarter 1 2025/26

The purpose of the Derby and Derbyshire Integrated Care System is to:

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

The 2025/26 Strategic Aims of Derby and Derbyshire Integrated Care Board are:

1. To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.
2. To improve health and care gaps currently experienced in the population and ensure best value, improve productivity and financial sustainability of health and care services across Derby and Derbyshire.
3. Reduce inequalities in health and be an active partner in addressing the wider determinants of health.

The key elements of the BAF are:

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

Key to lead committee assurance ratings:

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

- no gaps in assurance or control AND current exposure risk rating = target OR
- gaps in control and assurance are being addressed, in a timely way.

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

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

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

Risk scoring = Probability x Impact (P x I)

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

Reference	Strategic risk	Responsible committee	Executive lead	Target risk score	Previous risk score	Current risk score	Tolerance score	Movement in risk score	Overall Assurance rating
SR1	There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and both upper tier Councils to delivery consistently safe services with appropriate levels of care.	Quality, Safety and Improvement Committee	Prof Dean Howells	8	16	16	12	⟷	Partially Assured
SR2	There is a risk that short term operational needs hinder the pace and scale required for the system to maximise the collaborative contribution of partners and achieve the long term strategic objectives to reduce health inequalities, improve health outcomes and life expectancy.	Strategic Commissioning and Integration Committee	Dr Chris Weiner	8	16	16	12	⟷	Adequate
SR3	There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	Strategic Commissioning and Integration Committee	Helen Dillistone	9	12	12	12	⟷	Adequate
SR4	There is a risk that the NHS in Derbyshire is unable to deliver a sustainable financial position in the medium term and achieve the best value from the available funding for the population of Derby and Derbyshire.	Finance and Performance Committee	Bill Shields	9	20	20	12	⟷	Partially Assured
SR5	There is a risk that the system is not able to maintain an affordable and sustainable workforce supply pipeline and to retain staff through a positive staff experience.	People and Culture Committee	Lee Radford	12	16	16	16	⟷	Partially Assured
SR7	There is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	Strategic Commissioning and Integration Committee	Michelle Arrowsmith	9	12	12	9	⟷	Adequate
SR8	There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.	Strategic Commissioning and Integration Committee	Prof Chris Weiner	8	12	12	12	⟷	Adequate
SR10	There is a risk that the system does not identify, prioritise and adequately resource digital transformation in order to improve outcomes and enhance efficiency.	Finance and Performance Committee	Andrew Fearn	9	12	12	12	⟷	Partially Assured

Reference	Strategic risk	Responsible committee	Executive lead	Target risk score	Previous risk score	Current risk score	Tolerance score	Movement in risk score	Overall Assurance rating
SR11	There is a risk that the core patient care and business functions of Derbyshire system partners could be compromised or unavailable if there were a successful cyber-attack/disruption, resulting in threats to patient care and safety, and loss or exploitation of personal patient information, amongst others.	Finance and Performance Committee	Dr Chris Weiner	9	16	12	15		Adequate

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Strategic Risk 1 – Quality, Safety and Improvement Committee

Strategic Risk: There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and both upper tier Councils to deliver consistently safe services with appropriate standards of care.	Current Risk score **16**

If healthcare intervention is not met in a timely way and capacity is inadequate	***Then*** this impacts the ability of the ICB and both upper tier Councils	***Resulting*** in a risk to delivering consistently safe services with appropriate standards of care

Overall Assurance Level **Partially Assured**	***Strategic threats*** (what might cause this risk to materialise) 1. Lack of timely data to improve healthcare intervention 2. Lack of system ownership and capacity across JUCD including first tier Local Authorities, Provider Board and neighbourhood working to deliver the three shifts: from hospital to community services, from treating sickness to preventing it, from analogue to digital. 3. Risk to clinical quality and safety due to the significant financial constraints across all partners within JUCD.

Strategic Aim: To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.

	Probability	Impact	Score
Current	**4**	**4**	**16**
Risk Target	**4**	**2**	**8**
Risk Tolerance	**4**	**3**	**12**

Risk Trend

Executive Officer	Prof Dean Howells, Chief Nursing Officer	Assurance committee	Quality, Safety and Improvement

System Controls	System Sources of Assurances
• Deep dives are identified where there is lack of performance/ or celebration of good performance. • Health inequalities programme of work supported by the strategic intent function of the ICS, the anchor institution and the plans for data and digital management. This reports to the Strategic Commissioning and Integration Committee. • Maternity surveillance is ongoing and being jointly led by the ICB Chief Nurse Officer and the Regional Chief Nurse. • Derbyshire Cost Improvement Programme (CIP) in progress and Service Benefit Reviews challenge process is in place to support efficiencies. • Agreed Prioritisation tool is in place. • Robust Citizen engagement across Derbyshire and reported through Strategic Commissioning	• The Integrated Assurance and Performance Report has been developed and is reported to public ICB Board bimonthly. Specific section focuses on Quality. • Quality, Safety and Improvement Committee assurance to the ICB Board via the Performance Report. • System Quality Group update and escalations on System risks. • Agreed ICB Quality Risk escalation Policy. • Quality, Safety and Improvement Forum provides assurance into the System Quality Group and meets bi-monthly. This provides the detailed sense check of reporting. • Maternity Reporting into the Local Maternity and Neo natal System (LMNS). • Maternity reporting at CRH and UHDB. • Agreed System Quality infrastructure meeting in place across Derbyshire. • National Quality Board guidance.

System Controls	System Sources of Assurances
and Integration Committee. • Deep dives focussing on improvement actions, as identified by the JUCD Delivery Boards featured in the Quality Framework.	• County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Agreed Core20PLUS5 approach across Derbyshire. • Strategic Commissioning and Integration Committee assurance to the ICB Board via the Assurance Report. Also provides clinical oversight of commissioning and de-commissioning decisions. • NHSE Assurance Reviews and Assurance Letters provide evidence of compliance and any areas of concern. • Local Authority and ICB Public consultation processes where significant service change is planned due to system financial constraints. • QEIA report to the Quality, Safety and Improvement Committee. Monthly meetings of the QEIA group are in place and escalation to the Chief Nursing Officer and Strategic Commissioning and Integration Committee as required. • Delivery of the Quality Framework. • Internal Audit reports relating to Quality Governance. • Reporting and escalation from Delivery Boards as required.

Gaps in Controls and Assurances	Action Ref
• Intelligence and evidence are required to understand health inequalities, make decisions and review ICS progress.	1.1
• Plan for data and digital need to be developed further.	1.2
• Lack of real time data collections.	1.3
• Requirement for streamlining Data and Digital needs of all Partners (Including LAs).	1.4
• Not currently using Statistical Process Control Charts (SPCC) across the system to allow effective analysis of performance data to identify trends relating to quality and clinical safety.	1.5
• Awaiting publication of the NHS 10-year plan is delaying the final version of the Quality Strategy being completed and the subsequent approval by the Quality, Safety and Improvement Committee.	1.6

Actions	Action Ref	Owner(s)	Timescale	Assurance Level
• Operation Periscope initial version is currently live in the ICB. Processes are now being created to routinely use this data in decision making.	1.1 1.2 1.3 1.4 1.5	Prof Chris Weiner	Quarter 2 2025/26	Partial
• Once the NHS 10-year plan is published, a final review of the Quality Strategy will take place followed by its presentation at the Quality, Safety and Improvement Committee, for approval.	1.6	Prof Dean Howells	Quarter 2 2025/26	Partial

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Strategic Risk 2 – Strategic Commissioning and Integration Committee

Strategic Risk: There is a risk that short term operational needs hinder the pace and scale required for the system to maximise the collaborative contribution of partners and achieve the long-term strategic objectives to reduce health inequalities, improve health outcomes and life expectancy.	Current Risk score **16**

If short term operational needs hinder the pace and scale required	***Then*** the long-term strategic objectives of the system will be hindered	***Resulting in*** the pace and scale required to reduce health inequalities, improve health outcomes and life expectancy not being met

Overall Assurance Level **Adequately Assured**	***Strategic threats*** (what might cause this risk to materialise) 1. Lack of system ownership and collaboration 2. The ICS short term needs are not clearly determined 3. The breadth of requirements on the system outstrips/surpasses our ability to prioritise our resources (financial/capacity) and coordination across the system towards reducing health inequalities. 4. The population may not engage with prevention programmes.

Strategic Aim: To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.

	Probability	Impact	Score
Current	**4**	**4**	**16**
Risk Target	**4**	**2**	**8**
Risk Tolerance	**4**	**3**	**12**

Risk Trend

Executive Officer	Michelle Arrowsmith, Chief Strategy and Delivery Officer	Assurance committee	Strategic Commissioning and Integration Committee

System Controls	System Sources of Assurances
• JUCD Transformation Co-ordinating Group has responsibility for delivery of transformation plans across system. • Provider Collaborative Leadership Board overseeing Delivery Boards and other delivery groups. • System Delivery Boards provide a mechanism to share decisions and challenge actions enhancing transparency and shared understanding of impact. • All Providers are undertaking clinical harm reviews linked to long waiting lists and waits at the Emergency Department. Tier 1 oversight is in place for UHDB and processes are in place. • ICS 5 Year Strategy sets out the short and medium term priorities.	• Quality, Safety and Improvement Committee assurance to the ICB Board via the Assurance Report and Integrated Performance Report. • System Quality Group assurance on System risks and ICB risks. • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • NHSE Assurance Reviews and Assurance Letters provide evidence of compliance and any areas of concern. (EA) • Quality sub group of MHLDA Delivery Board established. Regular Integrated Assurance report is in place and reported to the Delivery Board. • UEC Board include Quality as a regular agenda item.

System Controls	System Sources of Assurances
• System planning & co-ordination group managing overall approach to planning. • Agreed Commissioning Intentions in place. • Agreed System dashboard to include inequality measures. • Core 20 Plus 5 work programme. • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis inclusive of access and inequality considerations. • Existing in-ICB and in-system clinically led prioritisation framework is being revisited to ensure suitability for recent (March 2025) changes to healthcare system design. • Commencement of Director of Population Health in April 2025 with remit to self-review DDICB against CQCs 'addressing health inequalities through engagement with people and communities' framework. • 'Winter wash up' meeting held on 2nd April 2025 to collate learning. • First draft of winter plan has been brought forward and will aim to be completed by June 2025. • Urgent Emergency Care Board, Community Transformation Programme expected to relieve pressure on UECB, 40% benefits expected to be delivered in 2025/26.	• MH LDA Delivery Board Terms of Reference (ToR) and Children's Delivery Board terms of reference are drafted, standardised in format across all ICB System Delivery Boards. The ToRs will be submitted to the June 2025 Delivery Boards with a proposed/revised structure of subgroups to reflect the Operational Plan priorities for 2025/26. • The ICB Board Seminar Sessions provide dedicated time to agree ICB/ ICS Priorities. • System-wide EQIA process supports identification of equalities risks and mitigations and reduces risk of projects/ programmes operating in • isolation – and specifically decommissioning decisions. • County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Delivery Boards remit to ensure work programme supports health inequalities. • SCIC assurance to the ICB Board via the Assurance Report and Integrated Performance Report. • Provider Collaborative Leadership Board. • Health and Well Being Board. • Audit and Governance Committee oversight and scrutiny. • Health Overview and Scrutiny Committee (HOSC). • Derbyshire ICS Greener Delivery Group. • Performance Data from MHSDB. • Alignment between the ICS and the City and County Health and Wellbeing Boards. • Integrated Care Partnership (ICP) and ICP Strategy in place which will support improving health outcomes and reducing health inequalities.

Gaps in Controls and Assurances	Action Ref
• Intelligence and evidence to understand health inequalities, make decisions and review ICS progress.	2.1
• The Integrated Performance Report will continue to be developed further as reported to ICB Board.	2.2
• Under performance against key national targets and standards (Core 20 Plus 5 work programme).	2.3
• Public Health Summary Report to be developed and report into Quality, Safety and Improvement Committee.	2.4

Actions	Action Ref	Owner(s)	Timescale	Assurance Level
• Use of the Data Platform has commenced, however, there is no General Practice or acute detail and a Data Sharing Agreement is required/in progress. The intention is that GP practice data and acute detail will be incorporated by the end of October 2025.	2.1	Prof Chris Weiner	Quarter 3 2025/26	Partial
• The Integrated Performance report continues to be developed and refined. The report has been updated and further integration is in development	2.2 2.3	Michelle Arrowsmith	Quarter 2 2025/26	Partial

Actions	Action Ref	Owner(s)	Timescale	Assurance Level
which will include performance through both contract and Delivery Board routes.				
• Periscope initial version is currently live in the ICB. Processes are now being created to routinely use this data in decision making.	2.4	Prof Chris Weiner	Quarter 2 2025/26	Partial

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Strategic Risk 3 – Strategic Commissioning and Integration Committee

Strategic Risk: There is a risk that the population is not sufficiently engaged and able to influence the design and development of services, leading to inequitable access to care and poorer health outcomes.	Current Risk score **12**

If the population is not sufficiently engaged	***Then*** the design and development of services will be unable to be influenced	***Resulting in*** inequitable access to care and poorer health outcomes

Overall Assurance Level	***Strategic threats*** (what might cause this risk to materialise)
Adequately Assured	1. The public are not being engaged and included in the strategy development and early planning stage of service development therefore the system will not be able to suitably reflect the public's view and benefit from their experience in its planning and prioritisation. 2. Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised. 3. The complexity of change required, and the speed of transformation, potential decommissioning and other cost improvement programmes required leads to patients and public being engaged too late in the planning stage, or not at all leading to legal challenge where due process is not being appropriately followed. 4. The system does not adopt the ethos of the Insight or Co-Production Frameworks, public views do not routinely influence decisions and the power balance across the NHS system resides with decision-makers.

Strategic Aim: To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.

	Probability	Impact	Score	Risk Trend
Current	**4**	**3**	**12**	
Risk Target	**3**	**3**	**9**	
Risk Tolerance	**4**	**3**	**12**	

Executive Officer	Helen Dillistone Chief of Staff	Assurance committee	Strategic Commissioning and Integration Committee

System Controls	System Sources of Assurances
• Agreed system Communications & Engagement Strategy and agreed Guide to Public Involvement, published and available to the system to guide good practice. • PPI log developed to list all potential services changes and the appropriate level of engagement required. • A suite of guidance is available to support the	• Senior managers have membership of IC Strategy Working Group to influence. • PPI assessment processes routinely shared with Health Overview & Scrutiny Committees. • Comprehensive legal duties training programme for engagement professionals. • ePMO gateway structure ensures compliance with PPI process.

System Controls	System Sources of Assurances
application of the public involvement duty in service change, and assessment process. • Guidance available around consulting with the Health Overview and Scrutiny Committee. • A range of methods and tools available to all our system partners to support involvement of people and communities in work to improve, change and transform the delivery of our health and care provision. • Insight Framework proof of concept. • Developed Insight Library to house all insight available in the system. • Agreed gateway for PPI form on the ePMO system. • Membership of key strategic groups, including Executive Team, Delivery Board, Senior Leadership Team and others to ensure detailed understanding of progression. • Functional and well-established system communications and engagement group. • Digital engagement infrastructure in place across partners to ensure transparency around decisions being made. • Training programme underway with managers on PPI governance requirements and process. • Insight Framework approach firmly embedded in the work of the Engagement Team, and promoted in all interactions with commissioners and system partners as the way we should be working. • Working effectively with VCSE infrastructure, organisations and representatives to reach and engage communities of place, condition and interest from the outset and at all points of the commissioning cycle.	• National Oversight Framework ICB annual assessment evidence and emerging CQC reviews. • Benchmarking against comparator ICS approaches. • The CQC self-assessment and improvement framework has been co-designed to help Integrated Care Systems (ICSs) improve their engagement with people and communities. DDICB is a pilot site. • NHS/ICS ET membership and ability/requirement to provide updates. • ePMO progression and gateway structure ensures compliance with PPI process. • Comprehensive legal duties training programme for engagement professionals. • PPI Governance Guide training for project/programme managers. • Establishment of ICB Procurement Group supports future planning and engagement timetable. • Anticipated national guidance on strategic commissioning, including commissioning cycle approach. • Public Health and Local Authorities contribute expertise and experience in engaging patients, users and communities.

Gaps in Controls and Assurances	Action Ref
• All aspects of the Engagement Strategy need to continue to be developed and implemented, and then evaluated. All are in progress.	3.1
• Continue to advise providers on good PPI practice, especially around system transformation programmes.	3.2
• Ensuring transformation programmes are providing sufficient time to factor in the inputs to and outcomes from involvement activity, including prioritising the utilisation of insight alongside other evidence sources.	3.3
• Ongoing learning of skills relating to cultural engagement and communication across all JUCD partners, including health literacy approach.	3.4
• Insight Framework proof of concept continues to be developed to embed it as 'Business as Usual', ensuring we share power with people and communities routinely, supporting them to have a voice, and input into priority setting.	3.5
• Model ICB and Cost Reduction programme to impact on approaches and capacity to deliver.	3.6
• Development of system stakeholder communication methodologies understand and maintain/improve relationships and maximise reach.	3.7
• Staff awareness of work of ICS and ICB programme, to enable recruitment of advocates for the work.	3.8
• Communications and Engagement Strategy refresh required.	3.9
• Systematic change programme approach to system development and transformation not yet articulated/live.	3.10
• Clear roll out timescale for transformation programmes.	3.11

• Evidence of tangible inputs and outputs aligned to key strategies and plans.	3.12
• Assurance on skills relating to cultural engagement and communication across all JUCD partners.	3.13
• Ability to articulate momentum behind coherent priorities and approach to delivering strategy, transformation and mitigation of financial challenge.	3.14
• Evidence of tangible inputs and outputs aligned to key strategies and plans.	3.15

Actions	Action Ref	Owner(s)	Timescale	Assurance Level
• Ongoing implementation of Engagement Strategy frameworks and evaluation.	3.1 3.2	Karen Lloyd	Continuous – next review June 2025	Partial
• Engagement Strategy Refresh taking heed to frameworks evaluation and embedding, seeking to move into Influence, Developing our Practice and Insight strategic phase.	3.1	Karen Lloyd	Ongoing - Update in line with model ICB	Partial
• Assess current team skills in cultural engagement and communications, including channel assessment, and devise action plan to close gaps/implement training and development.	3.4 3.6 3.7 3.13 3.14	Christina Jones/Karen Lloyd/Claire Warner	On hold, subject to model ICB and cost reductions	Partial
• Strengthen communications and engagement support to 2025 JFP development, with programme of public discussion to help inform.	3.10 3.12	Christina Jones/Karen Lloyd	Commenced – 2025/26 planning and onward JFP approach.	Partial
• Revision of Communications Strategy, to incorporate prior work on stakeholder strategy and take account of internal & external communications surveying.	3.6 3.7 3.9 3.14	Christina Jones	On hold, subject to model ICB and cost reductions	Partial
• Implement scoping exercise across system/ICB delivery boards and other groups to establish C&E work programme and capacity requirements.	3.2 3.3 3.8 3.11	Sean Thornton, Karen Loyd, Christina Jones	Commenced June 2024. Align with Transformation Coordinating Group and 2025/26 operational priorities	Partial
• Secure ICB Board Development session on insight strategy to ensure oversight and mandate.	3.15 3.8	Helen Dillistone	Not started	Partial
• Assess transformation programme delivery and associated use of insight to inform plans.	3.5	Karen Lloyd	Not started	Partial

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Strategic Risk 4 – Finance and Performance Committee

Strategic Risk: There is a risk that the NHS in Derbyshire is unable to deliver a sustainable financial position in the medium term and achieve the best value from the available funding for the population of Derby and Derbyshire.	Current Risk score **20**

If we are unable to deliver a sustainable financial position	***Then*** the medium-term financial plan will not be realised	***Resulting in*** the inability to achieve best value from the available funding

Overall Assurance Level	***Strategic threats*** (what might cause this risk to materialise)
Partially Assured	1. Rising activity needs, capacity issues, and availability and cost of workforce. 2. Shortage of out of hospital provision across health and care impacts on productivity levels. 3. The scale of the challenge means a recurrently affordable underlying position can only be achieved by structural change and real transformation. Failure to deliver against plan and/or to transform services. 4. National funding model does not reflect clinical demand and operational / workforce pressures. 5. National funding model does not recognise that Derbyshire Providers receive c.£900m from other ICBs. 6. National policy decision to reduce ICB funding by 50% during Quarter 3 2025/26.

Strategic Aim: To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.

	Probability	Impact	Score
Current	**4**	**5**	**20**
Risk Target	**3**	**3**	**9**
Risk Tolerance	**3**	**4**	**12**

Risk Trend

Executive Officer	Bill Shields, Chief Finance Officer	Assurance committee	Finance and Performance

System Controls	System Sources of Assurances
• Detailed triangulation of activity, workforce and finances in place. • Contract Performance meetings in place overseeing 'performance'. • Transformation programmes to deliver improvement in productivity. • The CIP and Transformation Programme is owned by the Transformation Co-ordination Group. • Efficiency Schemes reviewed and carried out and recommendations approved by NHS Executives. • Financial Sustainability Board meets monthly and receives updates on efficiency delivery.	• Financial data and information is provided to the Finance and Performance Committee monthly. • Medium term financial plan for the system is updated quarterly and reviewed by System Committees and Board regularly. • Integrated Assurance and Performance report is presented to the Finance and Performance Committee and Quarterly System Review meeting. • Productivity assessment tool in use. • SLT monthly finance updates provided including recalibration of programmes in response to emerging issues.

System Controls	System Sources of Assurances
Areas 'off track' are escalated and remedial actions discussed. • Financial Intelligence reporting to Delivery Boards and Finance and Performance Committee demonstrates financial performance of service lines across the system and supports identification of financial improvement.	• System wide Finance Director meetings focussed on long term financial stability, with real evidence of effective distributive leadership and collegiate decision making. • Financial Sustainability Board to understand and alleviate the financial challenges.

Gaps in Controls and Assurances	Action Ref
New Workforce and Clinical Models Plan.	4.1
Triangulated Activity, Workforce and Financial Plan.	4.2
Understanding the low productivity to address the clinical workforce modelling.	4.3
The Integrated Performance and Assurance report needs to be developed further to triangulate areas of activity, workforce, and finance.	4.4
National shortage in supply of out of hospital beds and services for medically fit for discharge patients prevents full mitigation.	4.5
Currently there is no 'Group' meeting in place whose priority is identifying opportunities and holding to account the delivery of the efficiency programmes.	4.6
Risk of a loss of the skills, knowledge and momentum required to deliver the ICB priorities and plans.	4.7

Actions	Action Ref	Owner(s)	Timescale	Assurance Level
The Integrated Performance report continues to be developed and refined. The report has been updated, and further integration is in development which will include performance through both contract and Delivery Board routes.	4.1 4.2 4.4	Michelle Arrowsmith	Quarter 2 2025/26	Partial
Review benchmarking information continues per NHS benchmarking guidelines such as model health system, value weighted activity metrics etc to ensure optimum productivity and efficiency across Derby and Derbyshire.	4.1 4.3 4.5	Craig Cook	Review June 2025	Partial
Reviewing the scope of the Financial Sustainability Board (FSB) and developing intelligence to support opportunity identification. The FSB met on 19th May 2025 where the Terms of Reference were reviewed, and clear actions identified.	4.6	Jen Leah	Quarter 2 2025/26	Partial
Developing our clinical commissioning and prioritisation.	4.6	Craig Cook	Quarter 2 2025/26	Partial
ICB Blueprint letter sets out priorities for ICBs, future of current functions is not yet clear. Weekly Team Talk meetings, staff questions, intranet page containing information received and FAQs. HR have shared wellbeing support information across the organisation.	4.7	Helen Dillistone	Quarter 3 2025/26	Partial

Strategic Risk 5 – People and Culture Committee

Strategic Risk: There is a risk that the system is not able to maintain an affordable and sustainable workforce supply pipeline and to retain staff through a positive staff experience.		Current Risk score **16**
If we are unable to maintain an affordable and sustainable workforce	***Then*** the workforce supply pipeline will be affected	***Resulting in*** the inability to retain staff through a positive staff experience
Overall Assurance Level **Partially Assured**	***Strategic threats*** (what might cause this risk to materialise) 1. Current system financial position makes the current workforce model unsustainable. 2. Staff resilience and wellbeing across the health and care workforce is negatively impacted by environmental factors e.g. the industrial relations climate and the financial challenges in the system. 3. Employers in the care sector cannot attract and retain sufficient numbers of staff to enable optimal flow of service users through the pathways due to the scale of vacancies across health and care and some specific professions.	
Strategic Aim: To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.		

	Probability	Impact	Score	Risk Trend
Current	**4**	**4**	**16**	
Risk Target	**3**	**4**	**12**	
Risk Tolerance	**4**	**4**	**16**	

Executive Officer	Lee Radford, ICB Chief People Officer	Assurance committee	People and Culture Committee

System Controls	System Sources of Assurances
• Organisational vacancy controls in place. • Agency Reduction plan and steering group meetings in place. • Engagement and Annual staff opinion surveys are undertaken across the NHS Derbyshire Providers and ICB. • Enhanced Leadership Development offer to support Managers and promoting Health and Wellbeing for NHS providers. • Promotion of social care roles as part of Joined Up Careers programme. • ICB has direct links into VCSE and social care sector workforce leads. • ICS Step into Work programmes supporting recruitment in health and care sectors.	• NHS Workforce Plan developed and triangulated with finance and performance. • Monthly monitoring of workforce numbers and temporary staffing spend vs budget and agency spend. • Outputs from provider vacancy control panels received on a monthly basis. • NHS Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • People and Culture Committee assurance to the Board via the ICB Board Assurance Report including NHS workforce. • The ICB People and Culture Committee provides oversight of workforce across the system. • A Comprehensive staff wellbeing offer is in place and available to Derbyshire NHS and

System Controls	System Sources of Assurances
	local authority ICS Employees from each provider organisation. • Monthly monitoring of absence in NHS and local authority. • Health Assessments continue to provide impact and now embedded within People Services to support long-term sickness within NHS and Local Authority providers. • County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Better Care funding supports the Joined Up Careers team to work in partnership with Health and Social Care. • Action Plan including a range of widening participation and resourcing proposals to support with DCC Homecare Strategy. • Implementation of new JUCD system apprenticeship strategy. • Development of a system One Workforce approach to improve collaborative talent pipelines.

Gaps in Controls and Assurances	Action Ref
• The Leadership Development offer is not yet fully embedded in each organisation.	5.1
• Independent social care providers and VCFSE sectors have variable health and well-being offers.	5.2
• Limited information on social care, VCFSE and local authority sectors workforce plans, costs and risks that would provide a fuller system perspective.	5.3
• Lack of inclusive talent management and succession planning strategies and processes across the system that identifies succession planning risks	5.4
• Lack of visibility of top 10 system hard to recruit to posts across all sectors.	5.5
• No defined talent plan or pipeline to support fragile services workforce challenges across the system.	5.6

Actions	Action Ref	Owner(s)	Timescale	Assurance Level
• To develop system OD strategy to improve culture, wellbeing and inclusion.	5.1 5.2	Tracy Gilbert	June 2025	Partial
• Develop a One Workforce Strategy which delivers a sustainable workforce pipeline.	5.3 5.5	Lee Radford/Sukhi Mahil Susan Spray	December 2025	Partial
• Build better workforce intelligence of social care, VCSFE and local authority sectors to give a more informed workforce position across the system.	5.3	Lee Radford/Sukhi Mahil	September 2025	Partial
• To develop a system talent management and succession planning approach to develop talent opportunities to attract and retain our people.	5.4 5.6	Tracy Gilbert	September 2025	Partial

Joined Up Care Derbyshire

Strategic Risk 7 – Strategic Commissioning and Integration Committee

Strategic Risk: There is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	Current Risk score **12**

If decisions and actions taken by individual organisations are not aligned	***Then*** the strategic aims of the system will not be aligned	***Resulting in*** the scale of transformation required being impacted

Overall Assurance Level **Adequately Assured**	***Strategic threats*** (what might cause this risk to materialise) 1. Lack of joint understanding of strategic aims and requirements of all system partners. 2. Demand on organisations due to system pressures/restoration may impact ability to focus on strategic aims. 3. Time for system to move more significantly into "system think". 4. Statutory requirements on individual organisations may conflict with system aims.

Strategic Aim: To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.

	Probability	Impact	Score	Risk Trend
Current	**4**	**3**	**12**	
Risk Target	**3**	**3**	**9**	
Risk Tolerance	**3**	**3**	**9**	

Executive Officer	Michelle Arrowsmith, Chief Strategy and Delivery Officer	Assurance committee	Strategic Commissioning and Integration Committee

System Controls	System Sources of Assurances
• JUCD Transformation Co-ordinating Group in place with responsibility for delivery of transformation plans across system. • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis • Delivery Boards engagement with JUCD Transformation Board. • Provider Collaborative Leadership Board in place overseeing Delivery Boards and other delivery groups. • System planning & co-ordination group managing overall approach to planning. • Formal risk sharing arrangements in place across organisations (via Section 75s/ Pooled Budgets).	• Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • SCIC assurance to the ICB Board via the Assurance Report and Integrated Quality and Performance Report. • Audit and Governance Committee oversight and scrutiny. • Internal and external audit of plans (EA). • Health Oversight Scrutiny Committees. • Delivery Highlight and Escalation Report and Transformation report shared with ICB Finance and Performance Committee. • System Delivery Board agendas and minutes. • Provider Collaborative Leadership Board minutes. • Health and Well Being Board minutes. • ICB Scheme of Reservation and Delegation

System Controls	System Sources of Assurances
• Health Oversight Scrutiny Committees (HOSCs)/ Health and Wellbeing Boards are in place with an active scrutinising role . • Dispute resolution protocols jointly agreed in key areas e.g. CYP joint funded packages – reducing disputes. • Currently the system part funds the GP Provider Board (GPPB) which provides a collective voice for GP practices in the system at a strategic and operational level. • System performance reports received at Quality, Safety and Improvement Committee will highlight areas of concern. • ICB involvement in NOF process and oversight arrangements with NHSE. • GPPB and LMC both provide some resourced 'headspace' giving GP leaders time and opportunity to focus on strategic aims. • PCN funding gives GP Clinical Directors some time to focus on the development of their Primary Care Networks. • System Planning and Co-ordination Group ensuring strategic focus alongside operational planning. • SOC/ICC processes – ICCs supporting ICB to collate and submit information. • GPPB and LMC both provide some resourced 'headspace' giving GP leaders time to focus on system working. • Development and delivery of Integrated Care System Strategy. • Embedded Place Based approaches that focus partners together around community / population aims not sovereign priorities. • Provider collaborative board 'Compact' and MOU document system behaviours and guide decision making in the system interest. • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis.	• Agreed process for establishing and monitoring financial and operational benefits • Joint Forward Plan, Derby and Derbyshire NHS Five Year Plan 23/24 to 27/28 in place and published. • Quality, Safety and Improvement Committee assurance to the ICB Board via the Assurance Report and Integrated Performance Report. • System Quality Group assurance to the Quality, Safety and Improvement Committee and ICB Board. • System Quality Report. • Measurement of relationship in the system: embedding culture of partnership across partners. • Daily reporting of performance and breach analysis – identification of learning or areas for improvement. • Resilience of OCC in operational delivery including clinical leadership. • Transformation Co-ordinating Group and NHS Executives minutes.

Gaps in Controls and Assurances	Action Ref
• Values based approach to creating shared vision and strong relationships across partners in line with population needs.	7.1
• Agree and embed the prioritisation framework ensuring robust business cases are used to inform decision making.	7.2
• Understand impact of changes, how they support operational models, how best value can be delivered, and prioritised.	7.3
• System Delivery Board Plans agreed and in place.	7.4
• Level of maturity of Delivery Boards.	7.5
• Agreed Delivery Board Plans to be in place including benefits plan, reported via system ePMO.	7.6
• Prolonged operational pressures ahead of winter and expected pressures to continue / increase.	7.7
• The Integrated Performance Report is in place and continues to be developed further as reported to ICB Board.	7.8

Actions	Action Ref	Owner(s)	Timescale	Assurance Level
• The Prioritisation Framework has now been developed and agreed. The next stage is embedment.	7.1 7.2 7.3	Dr Tim Taylor	Quarter 2 2025/26	Partial
• The Integrated Performance report continues to be developed and refined. The report has been updated and further integration is in development which will include performance through both contract and Delivery Board routes.	7.8	Michelle Arrowsmith	Quarter 2 2025/26	Partial
• System Delivery Board Plans will detail where projects achieve the commitments made in the Joint Forward Plan and ICS Strategy. Draft Delivery Board Plans in place, further work required to strengthen the link to our strategic ambitions.	7.4	Michelle Arrowsmith	Quarter 2 2025/26	Partial
• Work on a more comprehensive and quantified benefits approach is continuing, UEC and 'doing hubs once' programmes are being prioritised in the first instance. Recommendations about future capacity and skills development to be produced in Q4.	7.5	Tamsin Hooton	Quarter 1 2025/26	Partial
• The 2025/26 Operational Plan was submitted on 27th March 2025. This forms the basis of the Delivery Board Plans. The Delivery Board Plans detail where projects will achieve the commitments made in the Joint Forward Plan and ICS Strategy.	7.6	Michelle Arrowsmith	Quarter 2 2025/26	Partial
• Periscope initial version is currently live in the ICB. Processes are now being created to enable routine use of this data.	7.7	Michelle Arrowsmith	Quarter 2 2025/26	Partial

Strategic Risk 8 – Strategic Commissioning and Integration Committee

Strategic Risk: There is a risk that the system does not establish intelligence and analytical solutions to support effective decision making.		Current Risk score **12**
If the system does not establish intelligence and analytical solutions	***Then*** this will affect decision making	***Resulting in*** unsupported ineffective decision making
Overall Assurance Level **Adequately Assured**	***Strategic threats*** (what might cause this risk to materialise) 1. Agreement across the ICB on prioritisation of analytical and BI activity is not realised and therefore funding and associated resources are not identified to deliver the analytical capacity.	
Strategic Aim: To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.		

	Probability	Impact	Score	Risk Trend
Current	**3**	**4**	**12**	
Risk Target	**2**	**4**	**8**	
Risk Tolerance	**3**	**4**	**12**	

Executive Officer	Prof Chris Weiner, ICB Chief Medical Officer	Assurance committee	Strategic Commissioning and Integration Committee

System Controls	System Sources of Assurances
• Digital and Data Board (D3B) in place. This provides board support and governance for the delivery of the agreed Digital and Data strategy. • D3B responsible for reporting assurance to ICB Finance and Performance Committee and assurance and direction from the Provider Collaborative Leadership Board. • Strategic Intelligence Group (SIG) established with oversight of system wide data and intelligence capability and driving organisational improvement to optimise available workforce and ways of working. • Analytics and business intelligence identified as a key system enabler and priority for strategic planning and operationally delivery in the Digital and Data strategy and Strategic Intelligence Group (SIG). • NHSE priorities and operational planning guidance 23/24 requires the right data architecture in place for population health management.	• Data and Digital Strategy • CMO and CDIO from ICB executive team are vice chairs of the D3B. • Regional NHSE and AHSN representation at D3B provide independent input. • Monthly Reporting to Finance and Performance Committee, ICB Board, NHSE and NHS Executive Team.

Gaps in Controls and Assurances	Action Ref
• Identified three priority areas of strategic working: ○ System surveillance intelligence ○ Deep dive intelligence ○ Population Health Management	8.1
• JUCD Information Governance Group needs formalisation and work required on using data for planning purposes.	8.2
• The Integrated Assurance and Performance Report is in place and continues to be developed further as reported to ICB Board.	8.3

Actions	Action Ref	Owner(s)	Timescale	Assurance Level
• Periscope initial version is currently live in the ICB. Processes are now being created to routinely use this data in decision making.	8.1	Prof Chris Weiner	Quarter 2 2025/26	Partial
• Use of the Data Platform has commenced, however, there is no General Practice or acute detail and a Data Sharing Agreement is required/in progress. The intention is that GP practice data and acute detail will be incorporated by the end of October 2025.	8.2	Helen Dillistone	Quarter 3 2025/26	Partial
• The Integrated Performance report continues to be developed and refined. The report has been updated and further integration is in development which will include performance through both contract and Delivery Board routes.	8.3	Michelle Arrowsmith	Quarter 2 2025/26	Partial

Joined Up Care Derbyshire

Strategic Risk 10 – Finance and Performance Committee

Strategic Risk: There is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	Current Risk score **12**

If decisions and actions taken by individual organisations are not aligned	***Then*** the strategic aims of the system will not be aligned	***Resulting in*** the scale of transformation required being impacted

Overall Assurance Level **Partially Assured**	***Strategic threats*** (what might cause this risk to materialise) 1. Agreement across the ICB on prioritisation of digital and technology activity may not be realised and therefore budget allocation and reconciliation process across ICB for digital and technology are not agreed. 2. Digital improvements and substitutions to clinical pathways are not delivered through either a lack of citizen engagement and/or clinical engagement.

Strategic Aim: To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.

	Probability	Impact	Score
Current	**4**	**3**	**12**
Risk Target	**3**	**3**	**9**
Risk Tolerance	**4**	**3**	**12**

Risk Trend

Executive Officer	Andrew Fearn, Interim Joint Chief Digital Officer	Assurance committee	Finance and Performance Committee

System Controls	System Sources of Assurances
• D3B responsible for reporting assurance to ICB Finance and Performance Committee and assurance and direction from the Provider Collaborative Leadership Board. • Digital programme team leading and supporting key work in collaboration with system wide Delivery Boards e.g., Urgent and Emergency Care, Elective to embed digital enablement in care delivery. • Digital and Data identified as a key enabler in the Integrated Care Partnership strategy. • NHSE priorities and operational planning guidance requires the right data architecture in place for population health management. • Clear prioritisation of clinical pathway transformation opportunities needs formalising through Provider Collaborative and ICB 5 year plan.	• Data and Digital Strategy approved by ICB and NHSE. • CMO and CDIO from ICB executive team are vice chairs of the D3B. • Representation from Clinical Professional Leadership Group on D3B. • Regional NHSE and AHSN representation at D3B provide independent input. • Formal link to the GP IT governance and activity to the wider ICB digital and technology strategy in place via Chief Data Information Officer. • GP presence on Derbyshire Digital and Data Board. • Exploitation of Derbyshire Shared Care Record capabilities; demonstrated through usage data. • Acceptance and adoption of digital

System Controls	System Sources of Assurances
• Citizen's Engagement forums have a digital and data element.	improvements by operational teams (COO, primary care and comms support needed – links to digital people plan and Delivery Board outcomes) • Engagement around digital as part of the 10-year plan. • ICB and provider communications team plans with evidence of delivery, team also engaged with messaging (e.g. Derbyshire Shared Care Record). • Staff surveys showing ability to adopt and influence change. • Patient surveys and D7F results. • Data and Digital Strategy adoption reviewed through Internal Audit • ICB Board, Finance and Performance Committee Assurance Report to escalate concerns and issues.

Gaps in Controls and Assurances	Action Ref
• ICB prioritisation and investment decision making process is required to fully implement the digital and data strategy priorities.	10.1
• Digital literacy programme to support staff build confidence and competency in using technology to deliver care.	10.2
• Development of a 'use case' library to help promote the benefits of digitally enabled care and now under construction for Shared Care Record.	10.3
• Improved information and understanding of Citizen and Community forums that could be accessed to discuss digitally enabled care delivery.	10.4
• Increased collaboration with the Voluntary Sector across Derby and Derbyshire to harness capacity and expertise in place with Rural Action Derbyshire.	10.5

Actions	Action Ref	Owner(s)	Timescale	Assurance Level
• Develop and roll out staff digital literacy programme. Linked to Project Derbyshire (Digital HR) – no resource allocated / prioritised at this time. Digital Programme role and responsibility needs to be defined, further action required.	10.2	Andrew Fearn / Workforce lead	From 2025/26 financial year	Partial
• Adopt ICB prioritisation tool to enable correct resource allocation.	10.1	Andrew Fearn / Richard Coates	TBC – requires prioritisation tool	Partial
• A review of the system communications methods in progress that will support digital comms.	10.4	Andrew Fearn /Sean Thornton	Continuous – Next review June 2025	Partial
• Deliver digital (and data) messaging through ICB communications plan. JUCD NHS Futures site established (staff facing). Further work and agreement on route for local public facing information. All nationally directed public facing communications facilitated through Communication Team.	10.4	Andrew Fearn /Sean Thornton	Continuous – Next review June 2025	Partial
• JUCD NHS Futures site provides 'use case' examples of the benefits that can be delivered through the effective use of the DSCR. New and updated use cases will be added as and when available.	10.3	Andrew Fearn/Dawn Atkinson	Continuous – Next review December 2025	Partial

Actions	Action Ref	Owner(s)	Timescale	Assurance Level
• Meetings with Rural Action Derbyshire (RAD) completed, and project agreed, in collaboration with Derbyshire County Council (DCC) to support digital inclusion/confidence. • ICB Digital Programme team working with RAD to deploy support to increase awareness and use of the NHS App.	10.5	Andrew Fearn /Sean Thornton	Continuous - Next review June 2025 Quarter 2 2025/26	Partial

Strategic Risk 11 – Finance and Performance Committee

Strategic Risk: There is a risk that the core patient care and business functions of Derbyshire system partners could be compromised or unavailable if there were a successful cyber-attack/disruption, resulting in threats to patient care and safety, and loss or exploitation of personal patient information, amongst others.	Current Risk score **12**

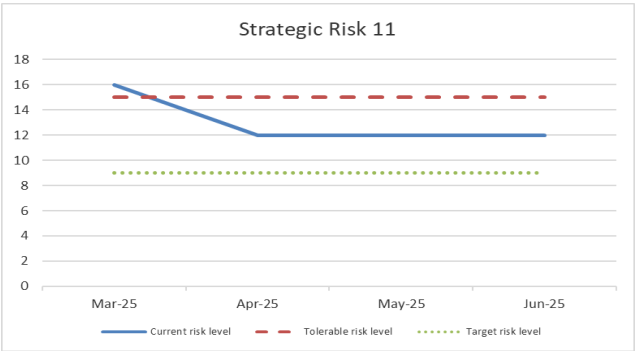
If there were a successful cyber-attack/disruption	***Then*** there is a risk that the core patient care and business functions of Derbyshire system partners could be compromised or unavailable	***Resulting in*** threats to patient care and safety, and loss or exploitation of personal patient information, amongst others

Overall Assurance Level	***Strategic threats*** (what might cause this risk to materialise)
Adequately Assured	1. The system does not have a system wide cyber security plan and strategy in place nor therefore a clear understanding of all digital systems and processes in use and their potential vulnerabilities and therefore will not have comprehensive business continuity plans in place. 2. Cyber security is a complex and changing field, with growing sophistication in the methods used by bad actors, with threats being generated by Ransomware, Malicious Attacks, accidental IT incident. 3. Contracts held by the ICB do not always contain the necessary controls to ensure appropriate cyber resilience for direct and sub-contracted suppliers.

Strategic Aim: To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.

	Probability	Impact	Score
Current	**3**	**4**	**12**
Risk Target	**3**	**3**	**9**
Risk Tolerance	**3**	**5**	**15**

Risk Trend



Note: March 2025 included on graph to display the proposed decrease in score for Q1

Executive Officer	Bill Shields, Chief Finance Officer	Assurance committee	Finance and Performance Committee

System Controls	System Sources of Assurances
• Main providers of digital systems have cyber security arrangements in place. • Business Continuity Plans in place aligned to ISO22301. • Appropriate use of DTAC (Digital Technology Assessment Criteria). • Incident Response Plans in place for each organisation, these to a varied level cover Cyber Incidents.	• Successful completion and review of DTAC responses. • Completed Data Protection Impact Assessment (DPIA), Information Asset Register (IAR) and Information Sharing Agreement (ISA) to ensure the ICB understand the data being shared/processed and the associated risks. • Business Continuity arrangements are all aligned to ISO 22301 as per NHS standing

System Controls	System Sources of Assurances
• Health Emergency Planning Officers Group and the Local Health Resilience Partnership have oversight of risks pertaining to cyber-attack/disruption as identified in the National Security Risk Assessment. • Cyber Teams within organisations have good communication pathways that link into the ICB • ICB is part of the Cyber Assurance Network – peer groups share issues and alerts, learning shared. • The ICB, through NECS, are members of the NHS Bitsight and Vulnerability Management Service (VMS). These provide third-party assurance of the security of the perimeter network and the sharing of information on the dark web which could be used to instigate an attack. • NHS Standard contract request production of the Business Continuity Plan for those providing services to/on behalf of the NHS. • Audit programme for produced BC Plans by the EPRR Team. • IAO data mapping process is in place to ensure data flows are monitored and appropriate protection in place. • Assurance of all organisations being signed up at both Cyber and EPRR/Operational level for NHS Digital Cyber Alerts for horizon scanning. • ICS Cyber Resilience Working Group to share best practice and changes in Cyber risk/threat.	guidance. • Cyber Alerts NHS Digital. • National Cyber Security Centre resources. • NHS EPRR Guidance and Frameworks. • JUCD Cyber Security Subgroup. • EPRR Core Standards. • NHS Standard Contract. • Reviews of Digital and IG teams to ensure data appropriately managed and protected.

Gaps in Controls and Assurances	Action Ref
• Smaller providers, e.g. for websites, apps etc may not have sufficient arrangements evidenced.	11.1
• Business Continuity plans need full awareness of Digital risks included which are outside of the scope of current templates in usage.	11.2
• Limited assurance in most organisations around Core Standard 53 "assurance of 3rd party suppliers" this will include digital provision.	11.3
• IT provision to the system is fragmented with different IT providers in organisations.	11.4
• Assurance not available as to taking learning from across the system and outside of it.	11.5
• Business Continuity Plans are produced however these are not fully audited at present; a process is now in place to review this.	11.6
• Not all contracts currently contain appropriate clauses including those for sub-contractors.	11.7
• JUCD Cyber Security Subgroup does not have dedicated resource to enable it to maintain system oversight and co-ordinate cyber activity and consistent levels of protection and learning.	11.8
• Delivery of system oversight assurance under Core Standard 53	11.9
• Embedding of skillsets within teams to understand and action the requirements.	11.10

Actions	Action Ref	Owner(s)	Timescale	Assurance Level
• Organisations to refresh their business continuity plans in light of the outcomes of the system event and to ensure inclusion of digital risks. System event planned for 1st July 2025.	11.2	Chris Leach	Quarter 2 2025/26	Partial

Actions	Action Ref	Owner(s)	Timescale	Assurance Level
• Assurance of commissioned providers process to be enacted during 2025 in relation to cyber resilience and business continuity. Process being enacted.	11.1 11.3 11.6 11.8 11.10	Chris Leach	Quarter 3 2025/26	Partial
• D3B to ensure technical oversight of any ongoing or emergency risks, through technical design and/or any other associated sub groups- link into ICB/ICS Cyber Response Plan(s). Next D3B due 19th June 2025.	11.4	Chair of JUCD Cyber Security sub-group	Quarter 2 2025/26	Partial
• Alignment of learning from incidents processes between EPRR and Digital. Digital Leads sit on internal EPRR groups and learning captured as part of this.	11.5	Chris Leach	Completed June 2025	Complete
• Head of Digital & IG to liaise with Joint Chief Digital Officer to identify how to address this gap.	11.5	Ged Connolly-Thompson	Completed June 2025	Complete
• Embedding of skillsets within teams to understand and action the requirements within contract management around IG, EPRR and digital clauses. Working with ICB Delivery Group to embed cultural change.	11.10	ICB Executives	Quarter 3 2025/26	Partial
• DSPT return completion this year will show what contracts we have in place and what assurance we have of contracts. Incomplete Asset Register and lack of evidence.	11.7 11.9	ICB Executives / Information Asset Owners	Quarter 3 2025/26	Partial

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

17th July 2025

Item: 040

Report Title	Integrated Care Board Risk Register Report – as at 30th June 2025						
Author	Rosalie Whitehead, Risk Management & Legal Assurance Manager						
Sponsor	Helen Dillistone, Chief of Staff						
Presenter	Helen Dillistone, Chief of Staff						
Paper purpose	Decision	☒	Discussion	☐	Assurance	☒	Information ☐
Appendices (reports attached)	Appendix 1 – Corporate Risk Report Appendix 2 – ICB Corporate Risk Register Appendix 3 – Movement in risk summary – June 2025						

Recommendations

The ICB Board are requested to **RECEIVE** and **NOTE:**

- Appendix 1, the Risk Register Report;
- Appendix 2, which details the full ICB Corporate Risk Register;
- Appendix 3, which summarises the movement of all risks in June 2025.

APPROVE CLOSURE of:

- Risk 06A relating to the delivery of the 2024/25 financial plan;
- Risk 06B relating to the delivery of a 2 year break even position;
- Risk 21 relating to contractors not being able to fulfil their financial and performance obligations;
- Risk 32 relating to delivery of the capital programme.

Report Summary

The report summarises any movement in risk scores, new risks to the organisation and any risks approved for closure by the relevant committee. Click here for the link to the full Corporate Risk Register on the ICB website.

How does this paper support the 3 shifts of the NHS 10-Year Plan?

From hospital to community	☒	From analogue to digital	☒	From sickness to prevention	☒

Integration with Board Assurance Framework and Key Strategic Risks

SR1	Safe services with appropriate levels of care	☒	**SR2**	Reducing health inequalities, increase health outcomes and life expectancy	☒
SR3	Population engagement	☒	**SR4**	Sustainable financial position	☒
SR5	Affordable and sustainable workforce	☒	**SR7**	Aligned System decision-making	☒
SR8	Business intelligence and analytical solutions	☒	**SR10**	Digital transformation	☒
SR11	Cyber-attack and disruption	☒			☐

Conflicts of Interest	None identified

Have the following been considered and actioned?

Financial Impact	Yes ☐	No ☐	N/A ☒
Impact Assessments	Yes ☐	No ☐	N/A ☒
Equality Delivery System	Yes ☐	No ☐	N/A ☒

Health Inequalities	Yes ☐	No ☐	N/A ☒
Patient and Public Involvement	Yes ☐	No ☐	N/A ☒
ICS Greener Plan Targets	Yes ☐	No ☐	N/A ☒

CORPORATE RISK REGISTER REPORT

INTRODUCTION

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

The ICB currently has ten very high risks, eight high scoring risks and one moderately scored risk on the corporate risk register.

NEW RISKS

Four new risks have been identified:

1. Risk 39: *The ICB does not achieve a breakeven/balanced financial position in 2025/26.*

   This risk has been scored at a high 12 (probability 3 x impact 4).

2. Risk 40: *Risk that we are unable to deliver the system financial plan resulting in a deficit and/or financial penalty. This maybe as a result of:*
   - *Operational pressures above planned levels.*
   - *Inability to deliver the required level of system efficiency*
   - *Other unplanned for financial event/planned financial events not occurring.*

   This risk has been scored at a very high 16 (probability 4 x impact 4).

3. Risk 41*: Risk that the system is unable to deliver the capital programme. This could be due to:*
   - *Strategic need exceeding resource available resulting in expenditure exceeding available resource.*
   - *Programme progress being delayed resulting in capital recognition of spend being stunted and failure to maximise the opportunity from available resource (underspend of capital resource).*

   This risk has been scored at a very high 12 (probability 3 x impact 4).

4. Risk 42: *There is a risk that providers do not have sufficient cash to pay staff and creditors.*

   This risk has been scored at a very high 16 (probability 4 x impact 4).

   The four new risks were approved by the Finance and Performance Committee held on 27th May 2025.

CLOSED RISKS

Four risks are proposed for closure, which are the responsibility of the Finance and Performance Committee:

1. Risk 06A relating to the delivery of the 2024/25 financial plan;
2. Risk 06B relating to the delivery of a 2 year break even position;
3. Risk 21 relating to contractors not being able to fulfil their financial and performance obligations;
4. Risk 32 relating to delivery of the capital programme.

The risks relate to 2024/25 and as such were requested to be closed as new, equivalent risks have been identified for 2025/26.

Closure of the four risks were approved by Finance and Performance Committee at the meeting held on 27th May 2025.

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

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Appendix 2 - Derby and Derbyshire ICB Risk Register - as at June 2025

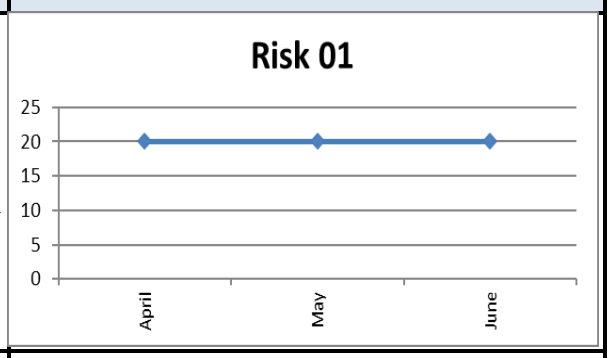
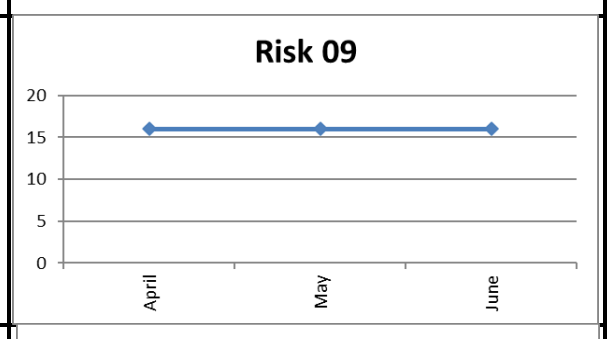
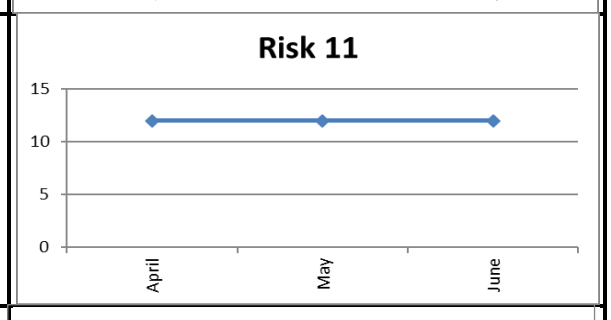
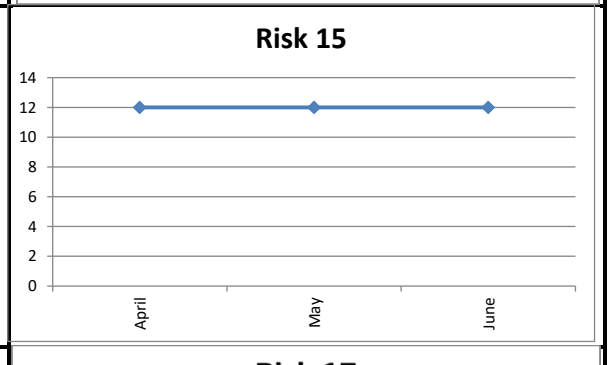
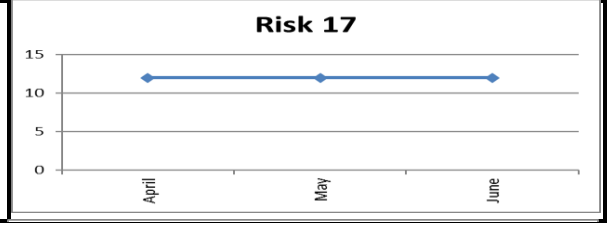
NHS Derby and Derbyshire Integrated Care Board

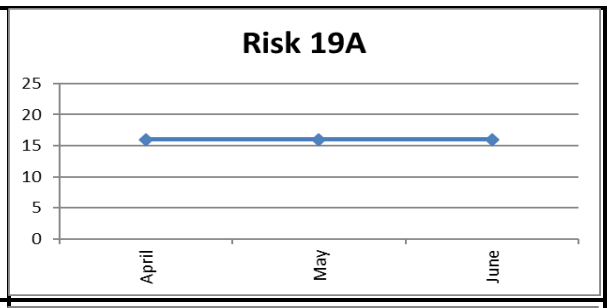
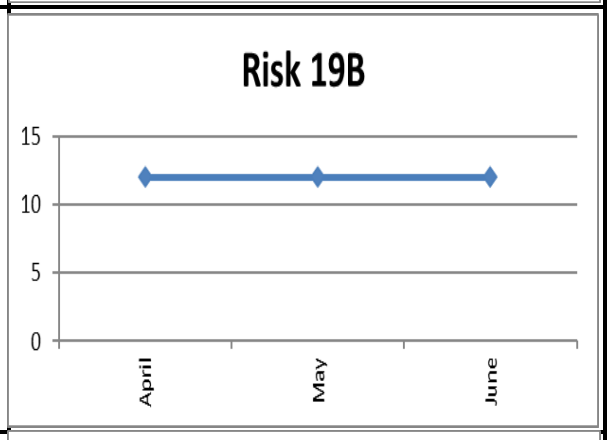
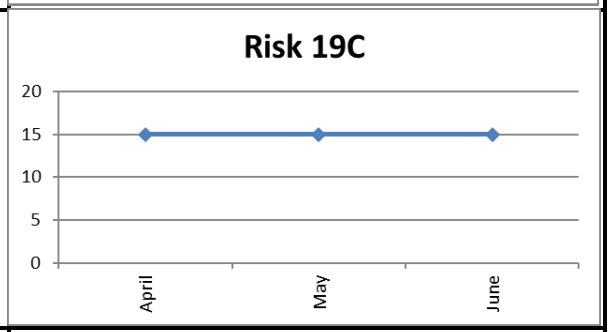
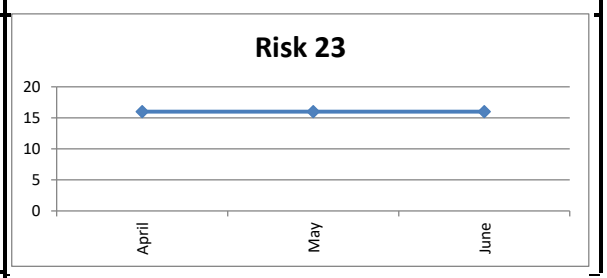
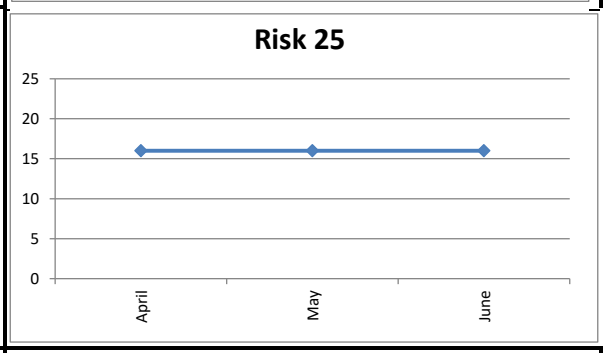
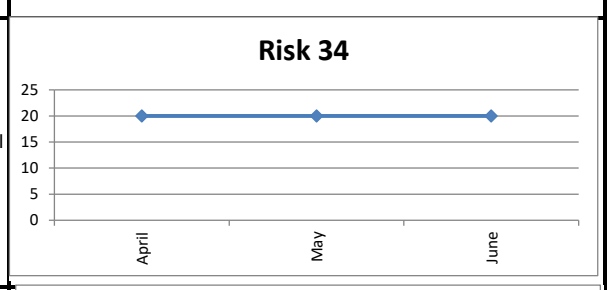
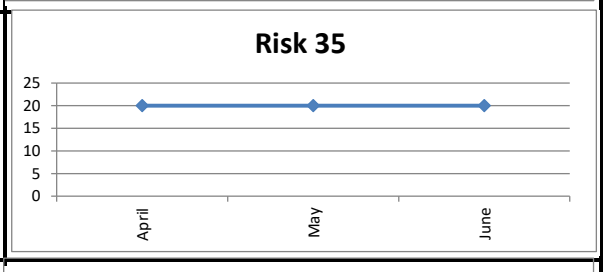
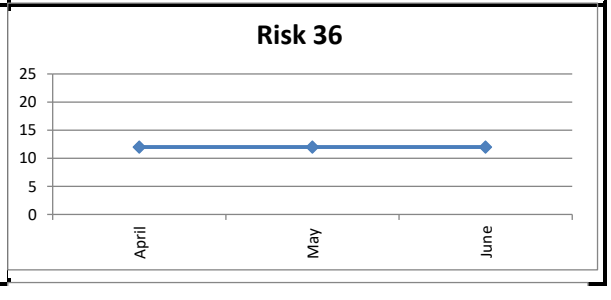
Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
01	25/26	The Acute providers may not meet the new target in respect of 78% of patients being seen, treated, admitted or discharged from the Emergency Department within 4 hours, resulting in the failure to meet the ICB constitutional standards and quality statutory duties, taking into account the clinical impact on patients and the clinical mitigations in place where long waits result.	System Quality Group	Constitutional Standards/ Quality	3	4	12	**1. Strengthening Front Door and Same Day Emergency Care (SDEC) Access** - A system-wide approach to SDEC is underway, aiming to increase same-day discharges and improve patient flow. - At Royal Derby Hospital, co-located SDEC and Urgent Treatment Centre (UTC) pathways have been developed and are expanding to provide direct access for EMAS, reducing ED attendances. - Through the Team Up programme, discussions are progressing on extending SDEC flow into community services to avoid unnecessary admissions. **2. Enhancing System Navigation and Alternatives to ED** Joint, face-to-face multidisciplinary working is embedded at the EMAS Specialist Practitioners Hub in Ripley, promoting the Right Care First Time model to prevent inappropriate conveyance and maximise community-based responses. - Work continues to expand the number of clinical pathways accessible through the Central Navigation Hub (CNH) and Single Point of Access (SPoA). - A high-level milestone plan for the "Doing Hubs Once" initiative is in development, with a proposed pilot in the High Peak area bringing together the CNH, Care Transfer Hub (CTH) and Local Navigation Hub (LNH) to facilitate earlier discharge and reduce ED demand. - The CRH Service Specification is completed, with final refinements outstanding. **3. Improving Ambulance Handover Times** - Derbyshire went live with the 45-minute ambulance handover initiative on 29 January 2025. Daily performance monitoring is in place, showing a step improvement in DDICB handover times and improvements in Category 2 response times. - Ambulance handover times are further being addressed through increased senior clinical ownership within EDs and the application of Releasing Time to Care principles in EMAS. **4. Data-Driven System Coordination and Oversight** - The SHREWD live dashboard system is operational, providing real-time visibility of urgent and emergency care (UEC) pathways across the system. - A new OPEL framework covering acute, community, mental health, and NHS111 providers is live. Data quality improvement work to align this with operational reporting will continue. - The System Coordination Centre (SCC) leads daily check-in calls with system partners to support operational management, enhance coordination, and strengthen system relationships. - Daily regional RCC calls continue to support strategic oversight and escalation. **5. Strengthening Urgent Treatment Centres (UTCs)** - NHS UTC standards have been published, and key performance indicators (KPIs) have been agreed across all UTCs. - Work is ongoing to improve data collection for UTC performance monitoring, with inclusion of KPIs in 2025/26 contractual arrangements.	**Work on-going with the acutes to support improvement in the 4 hour performance:** Demand Management & Front-Door Streaming - Improve triage, redirect non-urgent cases to alternative services, and expand Same Day Emergency Care (SDEC) and virtual wards. Work is on-going to: Optimise ED Flow - Streamline ED processes, explore increasing senior clinical decision-making, and implement Rapid Assessment and Treatment models. Workforce & Staffing Resilience - Ensure safe staffing levels, enhance flexible workforce arrangements, and support staff wellbeing to reduce burnout. Improve Hospital Flow & Capacity - Implement daily ward rounds, accelerate internal flow, and develop robust escalation and surge plans. Efficient Discharge Planning - Strengthen Discharge to Assess (D2A), improve multi-agency coordination, and explore working towards a 7-day discharge services. System-Level Coordination - oversight to track performance, resolve system-wide bottlenecks, and implement real-time monitoring tools. Communication & Public Messaging - Maintain transparent communication with patients, run public campaigns on appropriate ED use, and engage clinical leaders in planning. One of the key areas supporting the improvement of DDICS's 4 hour performance is the Clinical Navigation hub (CNH). Detailed updated provided below: **CRH Performance - May 2025** EMAS Cat 3&4 Activity & Deflection Activity was 1368, which is an increase on April's 1257. Deflection was 65.1%, representing 891 ambulance dispatches avoided in May. The mean response time was 13 minutes and 9 seconds, this is over a 5-minute decrease on April's 18 minutes and 23 seconds, and within the target of 30 minutes. Performance for May increased to 91.9% from April's 83.9% despite an increase in activity. DHU and EMAS continue to monitor activity for assurance. 111 Online Cat 3&4 Activity in May saw 447 patients. 94.4% of patients avoided an ambulance (422). Most patients referred to UTC/PCC (38.5%) or ED walk in (18.3%). The mean response time for May was 17 minutes and 35 seconds which is a decrease on April's 23 minutes and 59 seconds and within the target of 30 minutes. In Hours Primary Care Validation - Telephony Activity fell in May, in line with typical seasonal variation. An average of 23.1% of patients were referred to their own GP in May, a slight increase on April. . Work is already underway to review Primary Care Validation Outcomes and identify opportunities to enhance processes and reduce the volume of GP referrals. This is being progressed alongside continued monitoring of operational patterns at local UTCs. In Hours Primary Care Validation - NHS111 Online Derbyshire are the first system nationally to clinically validate NHS111 Online in hours primary care dispositions (1 and 2 hours) and went live on the 6th November 2024. May saw 104 referrals, which is a slight increase on April's 99. 33.7% of patients were referred to a UTC or PCC. This is an increase on April's 30%. 24% of patients were referred to their own GP practice following validation this is a increase on April's 16.7%, 15% of patients were See, Treat & Discharge or Self-care. Mean performance was 26 minutes (1 hour dispositions) and 1 hour 27 minutes (2 hour dispositions). May saw a combined total of 1659 patients, which is a decrease on April's 1862 patients. Communications have been sent out to 111 to ensure they are selecting this option on DoS as this is the top return. HCP Referrals 32 falls referrals were made for clinical review and onward referral in May with only 5 receiving an ambulance response. Non-falls HCP referrals to CNH for May were 22, this is a decrease on April's 28. Following CNH intervention only 3 non-falls patients attended hospital via direct admission/made their own way to ED, resulting in 19 (86%) patients avoiding hospital. UCR Elements These are collected from 999 Cat 3 & 4 (Push and Automation), 111 Online Cat 3 & 4, Primary Care Validations, SPoA Line including Medequip It is challenging to present all Social Care referrals as there are currently no DoS Profiles which help capture this data. These cases are normally referred via telephony. Falls Service 65, Home Visiting Service 181, Therapy & Nursing 20, Social Care 2 EMAS DoS Referrals to CRH In May EMAS referred 82 patients using the ED profiles, which is an average of 2.6 patients per day. 57.3% of patients were deflected away from the hospital front door (ED/Ambulance). In addition 238 patients were referred to alternative CNH profiles, which is an average of 7.7 patients per day. 198 of these were to IUC CAS profiles and 40 to in-hours primary care validation.	May 2025 performance CRH reported 81.0% (YTD 80.3%) and UHDB reported 76.5% (YTD 76.2%). CRH: The Type 1 attendances and Type 3 streamed attendances remain high, with an average of 241 Type 1 and 209 streamed attendances per day. UHDB: The volume of attendances remains high, with Derby seeing an average of 220 Type 1 adult attendances per day, 87 children's Type 1s and 199 co-located UTC. At Burton there was an average of 157 Type 1 attendances per day and 70 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 11 Resuscitation patients & 210 Major patients per day and Burton seeing 60 Major/Resus patients per day. The system is not meeting the target in respect of 78% of patients being seen, treated, admitted, or discharged from the Emergency Department within 4 hours across all sites, with the national overall target of 95%. •The likelihood of not meeting the target for the system remains very high, reflected in the score of 20. While improvements have been seen to the 4-hour performance target at both acute trusts, the system is not meeting the target in respect of 78% of patients being seen, treated, admitted, or discharged from the Emergency Department within 4 hours across all sites, with the national overall target of 95%. The likelihood of not meeting the target for the system remains very high, reflected in the score of 20. The rationale for this is: •Performance Remains Below Target: Despite some improvements, current Emergency Department (ED) performance remains below the 78% trajectory, and there is limited evidence of sustained or consistent achievement across all sites. •Mitigations Not Yet Fully Embedded: Key actions—such as internal flow improvements, and discharge pathway enhancements—are still in progress and not yet delivering significant results across the system. •Ongoing Clinical Impact: Prolonged ED waits continue to pose a clinical risk to patients, particularly for those awaiting timely assessment, treatment, or transfer. While mitigations are in place, they cannot fully eliminate the risk of harm associated with long delays. •Systemic and Seasonal Pressures: The system remains vulnerable to demand surges, staffing challenges, and winter pressures—all of which could reverse recent improvements and further impact performance. •Accountability and Compliance Risk: Failure to meet the 78% target has implications for compliance with constitutional standards and statutory quality duties, reinforcing the need for continued risk visibility at a strategic level. Maintaining the current risk score ensures that the issue remains a system priority, supports oversight, and reflects the ongoing uncertainty around sustained delivery of the national standard.	5	4	20	5	4	20	3	3	9	On going	SR1 SR2 SR3 SR4 SR5 SR7 SR8	Jun-25	Jul-25	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Amy Grazier Senior Operational Resilience Manager Dan Merrison Senior Performance & Assurance Manager Jasbir Dosanjh
09	25/26	There is a risk to patients on Provider waiting lists due to the continuing delays in treatment resulting in increased clinical harm.	System Quality Group	Clinical	4	4	16	• Risk stratification of waiting lists as per national guidance • Work is underway to attempt to control the growth of the waiting lists – via MSK pathways, consultant connect, ophthalmology, reviews of the waiting lists with primary care etc. • Providers are providing clinical reviews and risk stratification for long waiters and prioritising treatment accordingly.	• An assurance group is in place to monitor actions being undertaken to support these patients which reports to PCDB and SQP • Providers are capturing and reporting any clinical harm identified as a result of waits as per their quality assurance processes • An assurance framework has been developed and completed by all providers the results of which will be reported to PCDB • A minimum standard in relation to these patients is being considered by PCDB • Work to control the addition of patients to the waiting lists is ongoing	May/June 2025 Waiting lists remain significant therefore risk remains and score will be unchanged despite mitigations in place. Provider organisations continue to review waiting lists and prioritise as per SOPs. Harm reviews process remains in place according to the individual pathway with regular reviews ICB Quality teams continue to monitor this risk via updates to CQRG for assurance and it remains a rolling agenda item with quarterly updates for oversight. Review date September 2025	4	4	16	4	4	16	3	2	6	Mar-25	SR1 SR2 SR3 SR4 SR5 SR7 SR8	Jun-25	Jul-25	Prof Dean Howells Chief Nursing Officer	Letitia Harris Assistant Director of Clinical Quality
11	25/26	There is a risk that failure to meet the NHS Net Zero targets will put further pressure on the NHS's ability to meet the health and care needs of our patients in two ways: •Contributing to a warming climate and subsequent increase in extreme weather events impacting on business continuity •The production of harmful emissions impacting upon air quality which is in turn damaging to the health of our population.	Audit and Governance Committee	Corporate	4	4	16	System Net Zero SRO is Helen Dillistone, each Provider Trust has a Net Zero SRO in place. Trusts and systems have Green Plans in place for 2022 - 2025 which detail the actions to be taken to reach net zero. NHS Green Plans currently being refreshed in line with statutory guidance for Board approval and then publication in July 2025. Quarterly system meetings in place to monitor delivery of Trust and system NHS Green Plans. Regular interface with NHSE Regional Leads and other systems through quarterly Midlands SRO Meeting. Data capture from all Trusts and ICB to the national Greener NHS dashboard to monitor progress towards Net Zero Derbyshire specific dashboard developed. Dedicated staff resource in the ICB to support and monitor delivery of the system Green Plan and provide support to Provider Trusts. Strategic partnerships formed with Local Authorities and EMCA.	Strong system leadership to support delivery - Helen Dillistone, Net Zero Executive Lead for Derbyshire ICS. Robust governance and oversight in place: NHSE Midlands Greener Board established and in place Derbyshire ICS Greener Delivery Group established and in place NHSE Midlands regional priorities identified for each year. Derbyshire ICS Green Plan 2022 - 2025 approved by Trust Boards and CCG Governing Body on 7th April 2022. Refresh of ICS System plan required - due July 2025. Derbyshire System assessed as 'maturing' by NHSE in 2023, and actions identified to become 'thriving' will be embedded within Green Plan refresh. Strong relationships in place with NHSE Regional Team and Provider Trusts facilitates collaborative working across the system and with regulators.	June 2025: The JUCD Derbyshire Green Plan has a set of draft actions which focus on the system working together, co-ordinated by the ICB, to progress some of shared challenges, and support the cultural shift required to ensure that sustainability becomes embedded as BAU, and that all organisations (including the ICB) are embedding climate related risk into our governance and decision-making processes through the TCFD requirements. Work to finalise the Green Plan continues with a focus on sustainability in terms of the developing role of the ICB as the strategic commissioner and acknowledging that delivery for some of the actions will be passing to providers in the future. The plan will completed to deadline and in accordance with the ICB's statutory duty with regards to climate change, however future delivery arrangements are still to be clarified. Whilst the current risk scoring of 12 remains appropriate until more it known, it may be that this needs to be revised and increased when more detail on future direction of travel is available.	4	3	12	4	3	12	3	2	6	Mar-28	SR1 SR2 SR3 SR4 SR5 SR7 SR8	Jun-25	Jul-25	Helen Dillistone - Chief of Staff	Katy Dunne Head of Corporate Programmes
15	25/26	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	Audit and Governance Committee	Corporate	4	4	16	The current function in the process of delegation is Specialised Commissioning. Commissioning responsibility for 59 Acute Specialised Services were delegated to ICBs in April 2024. The transfer of support staff to the host ICB does not take place until July 2025. Responsibility for delivery sits with the East Midlands Joint Committee. A delegation agreement is in place for phase 1 which will be updated for phase 2. Six workstreams have been established to work through the necessary actions for safe and timely delegation, with an Executive Leadership Group established to provide strategic direction. The ICB has an established Programme Board to manage this programme of work for Derbyshire. The Programme Board is now also overseeing the process of delegation for Vaccinations, Immunisations and Screening and over the next few months will be working through potential impacts on the ICB and the Derbyshire system. Vaccinations, Immunisation and Screening: NHSE have stood up an Operating Model Group (OMG) to oversee the delegation for Vaccinations, Immunisations and Screening and over the next few months will be working through potential impacts on the ICB and the Derbyshire system. Delegation is planned from 1st April 2026. The ICB Delegated Services Programme Board will oversee the transition.	Pre-delegation assurance framework process completed and in place. Delegation framework for phase 1 - in place. Delegation framework for phase 2 expected. ICB Programme Board to work through next steps. Collaboration and Delegation Agreements for Specialised Commissioning delegation to be submitted to Board and signed off in March. Vaccinations, Immunisation and Screening: Critical path established for delegation from Jan 25 to Oct 25 Operating model to be signed off at ICB CEO time out session on 8th April 2025, led by NHSE. Pre delegation assessment framework will be underway in May 2025 with final sign off to ICB Board in September 2025. Capacity to deliver both programmes is a risk. Established ICB system wide for over two years Vaccinations and Immunisations Delivery Board in place. Screening Delivery Board stood up in January 2025. Finance and Contracting Workstream established under Operating Model Group	April: Delegation is still taking place, however the operating model cannot be agreed until ICB functions have been agreed also. No further information has been received at this stage. May: Delegation has been confirmed, however the operating model cannot be agreed until ICB functions have been agreed also. No further information has been received at this stage and no further meetings regarding delegation with NHSE have taken place to date. Delivery Boards for both Immunisation and Screening are in place and continue to meet monthly. In the background, we have been working closely with our acute providers in UHDB and CRH to understand the screening programmes further, introductory meetings with management and staff regarding the services they provide. June: Delivery Boards Continue. No further update regarding delegation although we understand that discussions are underway at national and regional level regarding the screening services previously identified for retention in NHS England to consider where they should be commissioned from in future.	3	4	12	3	4	12	2	2	4	Mar-26	SR4 SR5 SR7	Jun-25	Jul-25	Helen Dillistone - Chief of Staff	Chrissy Tucker - Director of Corporate Governance and Assurance
17	25/26	Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.	Strategic Commissioning and Integration Committee	Corporate	4	3	12	The system has an agreed Communications & Engagement Strategy which continues to be implemented. This includes actions supporting broadening our communications reach across stakeholders, understanding current and future desired relationships and ensuring we are reaching deeper into the ICB and components parts to understand priorities and opportunities for involvement. The Public Partnership Committee is now established and is identifying its role in assurance of softer community and stakeholder engagement. Communications and Engagement Team leaders are linked with the emerging system strategic approach, including the development of place alliances, seeking to understand the relationships and deliver an improved narrative of progress. JFP engagement approach remains in development.	*- Continued and accelerated implementation of the Communications and Engagement Strategy actions plan priorities across stakeholder management, digital, media, internal communications and public involvement. *- Continued formation of the remit of the Public Partnership Committee *- Key role for C&E Team to play in ICB OD programme *- Continued links with IC Strategy development programme *- Continued links with Place Alliances to understand and communicate priorities	April: Awaiting guidance on 'Model ICB' and cost reductions which will inform revised communications and engagement strategies. Developing communications approach to support 25/26 operational plan, connected across NHS system partners, for issue in May 2025 after local authority elections are completed. May: Model ICB blueprint received - aligned communications planning with potential cluster ICBs. Risk of reduction of communications and engagement capacity through period of change, and % reduction of team/capacity required as part of organisational approach. User involvement encouragingly at heart of Model ICB. 25/26 operational plan communications remains in progress, including ICB-specific work programme/priorities. JFP update to May ICB Board, requires development of communications approach. Local authority elections complete with new administration. Neighbourhood summit held, with comprehensive communications and stakeholder engagement programme required. June: 25/26 operational plan communications approach remains in progress. Consideration of Model ICB Blueprint within ICB Communications and Engagement team, along with proposed cluster ICBs.Pivot of emerging Engagement Strategy refresh in context of Model ICB Blueprint. Initiation of communications and engagement discussions to support Neighbourhood Health and Community Transformation programme, requiring system partners to support resourcing.	4	3	12	4	3	12	3	2	6	Mar-26	SR1 SR2 SR3 SR4 SR5 SR7 SR8	Jun-25	Jul-25	Helen Dillistone - Chief of Staff	Sean Thornton - Director of Communications and Engagement
19A	25/26	Failure to deliver a timely response to patients due to excessive handover delays. Leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential levels of harm.	System Quality Group	Clinical	5	5	25	**UECC mitigations.** 1.System leaders and clinician(s) in charge are aware of the risk across the acute pathway, including patients end route to hospital, awaiting an ambulance response as well as those already in the department. 2.Ambulance handover delays and the numbers of patients waiting for an ambulance response are reported at site-wide bed meetings to facilitate a system-wide response. 3.Named senior leads from both the acute and ambulance trust are responsible for overseeing the development and implementation of clinical handover processes which focus on patient safety. 4.Information sharing through the SCC and Daily System Call. 5.Escalation processes in place with SCC including process to stand up a dedicated call if required. 6.UECC Transformational leads to ensure proactive streaming, redirection and care navigation supports professionals directly access alternative appropriate community pathways and in hospital pathways, right care first time. **Discharge mitigations.** 1.Pathway operational group meet weekly (with the ability to step up to Daily) to expedite discharges to support flow within the acute trusts. 2.Discharge pathway improvement group meet weekly to provide a joined up approach to discharge improvement and to ensure pathways of care are working to an optimised model of delivery by defining the metrics required and monitoring performance and progress against agreed local targets.	**UECC actions to treat risk** **1. Strategic Leadership and System Coordination** - A monthly Ambulance Handover Improvement Group brings together EMAS and acute provider colleagues to coordinate and deliver targeted actions addressing ambulance handover delays and Category 2 (C2) performance. - Daily operational system calls are held with representation from all system partners to ensure real-time coordination and collective management of pressures. - Local system governance structures – including the System Coordination Centre (SCC), Tactical and Strategic forums – oversee system-level decisions. The Derbyshire System Pressures Quality Review Panel ensures clinical scrutiny and quality oversight. - Regular risk and action monitoring is conducted through the Clinical Quality Review Group (CQRG) to ensure visibility and accountability. **2. Data-Driven Oversight and Operational Intelligence** - The SHREWD live data system is being rolled out to provide real-time visibility across the urgent and emergency care (UEC) pathway. Efforts to improve data quality are ongoing. - A system-wide overview of handover delays and robust scrutiny of progress against improvement trajectories supports transparent performance management. - Performance management of EMAS workforce and abstraction rates ensures appropriate resourcing is maintained to meet demand and reduce delays. **3. Hospital Flow and On-the-Day Operational Support** - Acute providers have formally recognised the impact of ambulance handover delays on C2 performance and are focused on improving internal patient flow and 15-minute ambulance turnaround times. - There has been a measurable reduction in handover delays at both acute sites, supported by proactive use of escalation areas, such as those at RDH, to enable timely offloading. - EMAS duty managers provide on-the-ground support to EDs during peak periods to aid ambulance turnaround and mitigate risk. - The EMAS Hospital Handover Harm Prevention Tool has been implemented at acute sites to identify and reduce clinical risks associated with prolonged handovers. - Continued support for rapid and immediate handover processes, including minimum care standards during Period of Ambulance Overwhelm (POA), remains in place to ensure patient safety. **4. Alternative Care Pathways and Conveyance Reduction** - Work continues to reduce ED conveyance through redirection of Category 3 and 4 patients via the Central Navigation Hub (CNH), SPoA, and predefined patient cohorts within the ambulance stack. - EMAS clinicians now have direct referral access to UTC and SDEC, enabling quicker handover and faster redeployment to community calls. - Additional direct access pathways are being commissioned for specialties such as surgery, gynaecology, and urology, as well as expanded urgent two-hour community responses for suitable patients to support care closer to home.	April: The score was reduced in March 2025 and remains at that reduced score. This is based on reporting that shows a notable improvement in the DDICS handover position since go-live, along with positive movement in the C2 position. However, while the C2 average response time has improved to 47 minutes and 40 seconds, it remains above the 33-minute target. Additionally, handover times—particularly at UHDB (Derby site)—continue to be challenged during periods of high demand, with Mondays and evenings emerging as the most difficult times. Given these factors, the risk score is recommended to remain very high but at the reduced score of 16. May: The trajectory has been missed by just under 2 minutes within April however, improvements have been made within the month for C2 across the system. Actual the performance for April 25 is 31 minutes and 30 seconds against a trajectory of 29 minutes and 21 seconds - monitoring continues to take place. June: Performance improved slightly during May, at 31 minutes and 26 seconds. This is better than the expected 38 minutes and 46 seconds in the plan. This expected time was higher than April's. Despite ongoing and positive mitigation efforts, including improved handover performance, pathway development, and enhanced system coordination, the underlying factors contributing to ambulance handover delays and community response times remain present and volatile. Specifically: •Sustained Operational Pressure - Acute and ambulance services continue to operate under significant and often unpredictable pressure, with high levels of demand, workforce constraints, and complex patient flows affecting response capacity. •Inconsistent Delivery of Mitigations - While improvement trajectories are in place, delivery across sites and days is variable. Key mitigations such as internal hospital flow improvements and pathway adoption are still embedding and are not yet consistently delivering sustainable reductions in delays. •Ongoing Clinical Risk to Patients - The risk to patients waiting in the community for a timely ambulance response remains considerable. Delays in C2 (and lower category) responses continue to pose a real risk of harm, particularly for time-sensitive conditions	4	4	16	4	4	16	2	5	10	Ongoing	SR1 SR2 SR3 SR4 SR5 SR7 SR8	Jun-25	Jul-25	Dr Chris Weiner Chief Medical Officer	Andrew Sidebotham Associate Director, Urgent and Emergency Care Amy Grazier Katie Evans
19B	25/26	The risk of delayed or inadequate patient discharge is heighted by factors including, unsuitable home environments, limited availability of community and home care services, and delays in providing necessary and equipment. Poor coordination among health providers, insufficient rehabilitation and long-term care options, rigid discharge policies, and ineffective communication and data management is further exacerbated by seasonal increases in patient volumes and inadequate transport services. The result is that the system struggled to effectively manage and support patient transitions from hospital to home or long-term care, leading to potential harm and unmet patient needs.	System Quality Group	Clinical	5	2	10	Pathways Operations Group established to monitor pathway numbers and provide a forum to escalate concerns with system partners. An escalation framework developed and now in use Jan 25 outlining process for partners to step up calls to support with system escalations. Winter System Coordination Lead commenced Mid December 24 to proactively support escalations, seek earlier additional support and ensure all provider actions are undertaken. Discharge Planning and Improvement Group monitoring workstream progress for key discharge priorities as outlined in the Discharge Improvement Strategy for Joined Up Care Derbyshire. System daily flow calls. Jan 25 Care transfer hub : Phase 1 (For out of area hospitals) launched to improve coordination of discharges out of acute hospitals.	Developed a discharge escalation framework to maintain flow to reduce harm associated with delays - Completed Nov 2024 Improving the involvement of people who are being discharged in shaping discharge outcomes and pathway developments. Create a single data and intelligence approach to help us manage transfers of care between settings and reduce unnecessary delays. Enhancing the offer for people returning home with no formalised care or support needs, including improving transport and "settling in" support. - Adult Social Care Discharge Fund panel approved additional ringfenced ambulances for discharge from 1st Oct anticipated 500 journeys/month. ICB supporting work to look at Easter 2025 period when EMAS contract ends. Delivering our agreed operating model or home based reablement and rehabilitation so more people can go home and stay at home after a stay in an acute hospital. Improve coordination with community health services to ensure availability of support personnel and resources : integration of health and social care. - Consultation Section 75 with Derbyshire County Council and DCHS to launch Dec 24. Transforming our operating model for reablement and rehabilitation in a bed-based setting so more people can return home, and to ensure less people going into permanent care straight from hospital (Pathway 3). Create a multi-disciplinary team for Derby and Derbyshire to take responsibility for individuals needing discharge from hospital to deliver our mission of 'Why not home? Why not today?' - Phased approach to CTH development to be launched, commencing with out of area discharges. Embed a culture and practice of "Trusted" information sharing so we complete assessments outside of hospital and make sure these are "strengths based". - System Quality Group approved piloting of Trusted Intermediate Care Referral (TICR). Older peoples mental health services to support private providers and engage with new providers to create suitable placements for patient's with organic diagnosis. Adult mental health services- to reduce discharge delays, support Early Discharge where appropriate and support with re-entry to the community. Providing the support needed to sustain the progress achieved during in-patient care.	May 25 - Community transformation programme expected to launch in April/May to support a number of the discharge priorities to move forwards. Community Support Beds opened at Bennerley Fields - the first phase in the transformation plan to increase beds from 77 to 92. Update provided to 360 Assurance on actions against the plan. Updates not ratified by System Delivery Group as this meeting was stood down in May. June 25 - Community Transformation programme delayed to June. 8 additional Community Support Beds to open at Staveley 12th June. From w/c 30th June Bennerley Fields will have 20 beds, 0 beds at Meadow View, 8 beds Oaklands, 32 beds Staveley, 17 beds Thomas Fields. Aiming September for a total of 89 beds. Care Transfer Hub to commence Phase 2 from Jun 22. Score remains the same and system pressures have remained high despite the time of year	3	4	12	3	4	12	3	2	6	April 2026	SR1 SR2 SR3 SR4 SR5 SR7 SR8	Jun-25	Jul-25	Strategic Discharge Group	Jodi Thomas Discharge Improvement Lead JUCD
19C	25/26	Lack of digital interoperability across information platforms leads to inadequate visibility of discharge information and communication between providers. There are a lack of effective performance indicators to monitor and manage discharge processes. Inadequate data collection and analysis to identify bottlenecks in discharge pathways. Lack of system data intelligence to inform decision making to manage risks when in system escalation.	System Quality Group	Clinical	5	3	15	Weekly Discharge to Assess (D2A) summary data pack developed and circulated amongst partners. Pathway Data Group provides a joint forum to escalate data concerns and aim to find solutions - Discharge Planning and Improvement Group developed a Logic Model for discharge data and have requested support for this from the Pathway Data Group. Doing Hubs Once and Care Transfer Hub working groups established to identify the gaps and create a joined up approach to managing them. OPTICA system rolled out at CRH and UHDB to provide increased visibility. CRH utilising OPTICA in daily escalations - increased understanding of delay reasons and where to focus efforts. UHDB developing an implementation plan to complete roll out by Jan 2025.	Use data analytics to track and analyse discharge trends, identifying and addressing bottlenecks. Development and implementation of an interoperability API and system-level data warehouse will enable information flows between existing systems. Implement key performance indicators (KPIs) to monitor discharge processes and identify areas for improvement. Pathway data group to support the development of a data dashboard as outlined in the logic model. Care Transfer Hub to be developed to monitor and own system data. Initial digital specification drafted. Interim digital solutions scoped ready to support a pilot.	May 25 - PVI data now routinely captured in weekly reporting. Review of PDG being undertaken to confirm purpose. OPTICA use workshops being held in late April. Failed discharges being monitored and reported to DPIG in May. Updates not ratified by System Delivery Group as this meeting was stood down in May. Jun 25 - Review of pathway data group being undertaken throughout June focusing on nomenclature with all system partners. OPTICA use workshops held with trusts working through improvement plans. Score remains the same and system pressures have remained high despite the time of year	5	3	15	5	3	15	3	2	6	October 2025	SR1 SR2 SR3 SR4 SR5 SR7 SR8	Jun-25	Jul-25	Strategic Discharge Group	Jodi Thomas Discharge Improvement Lead JUCD
23	25/26	There in a risk to RTT and cancer performance due to increased demand and insufficient capacity. The total waitlist size has increased by over 90% since 2020. UHDB has also seen an increase in referrals from Staffordshire due to the growth of Tamworth/Lichfield capacity and changes to SSICB pathways, making UHDB pathways more preferable for patient flow.	System Quality Group	Clinical	4	4	16	The change in referral over last 18mth a result of a range of factors - including Staffs practices focusing on early cancer diagnosis, changes in how services are configured/offered across west midlands and increased use of Tamworth/Lichfield all of which influence patient/GP choice of providers. UHDB in tier 1 for cancer performance so plans being managed through national oversight to develop recovery action plans. UHDB remain in Tier 2 for elective recovery so long waiter assurance through fortnightly regional calls in addition to JUCD elective oversight.	•Recruitment to range of posts funded through EMCA to support recovery. •Prioritisation of Best Practice timed pathways across key tumour sites – LGI, Urology, Skin and Gynae •Development of UHDB tumour site recovery action plans (with support from NHSEI IST team) due – Oct-23 •Development of referral triage functions: Gynae, LGI and Urology •Work underway to understand drivers for variance in Histology TAT at tumour site level. •Work going to enhance access to PET scanning (Longer term ambition to develop PET service within Derbyshire) •Oncology challenges supported through regional alliance support – longer term workforce development	April: The System Improvement Plan is expected to be signed off in May-25. Plans include an ambition to reduce the elective waiting list by 6% in year. May: UHDB remains in Tier 2, with long-waiter assurance managed via fortnightly regional calls and JUCD oversight. Trusts must reduce their total waiting list size as part of operational plan submissions, supported by programmes managed through PCDB. June: In the 2024/25 NHS Operational plan JUCD have agreed to deliver on this standard by end of March 2026. Progress will be measured through Contractual processes and Improvement aligned to this overseen by the Planned Care Delivery Board. Moderate the growth in new demand, by increasing the use of pre-referral specialist advice, which is estimated to divert 10-15% of "unnecessary" outpatient first attendances; and adhering to the ICB's clinical policies in relation to evidence-based interventions.	4	4	16	4	4	16	2	4	8	Jun 25	SR1 SR2 SR3 SR4 SR5 SR7 SR8	Jun-25	Jul-25	Prof Dean Howells Chief Nursing Officer	Monica McAlindon Associate Director of Planned Care
25	25/26	There is a risk of significant waiting times for moderate to severe stroke patients for community rehabilitation. This means, patients may have discharges from acute delayed, be seen by non-stroke specialist therapists and require more robust social care intervention.	System Quality Group	Clinical	4	5	20	•Risk matrix in community services is used to triage referrals- this addresses risk and clinical need and is used to prioritise waiting lists •Regular waiting list reviews are conducted in community to ensure patient needs/risk continue to be managed. This is done every 12 weeks to ensure patients are in the right place from a triage decision perspective. •When referral is accepted the service, patients receive condition specific resources which includes signposting to services and wider resource packs. Guidance is given on when to contact services, which is based on the risk matrix. •Staffing resource is redeployed/flexed across the county to manage staffing shortfalls. •Advice clinic has been established to allow non-specialists to bring Stroke and Neuro cases for advice from stroke specialists. •Provider Collaboration Leadership Board (Nov 23) and NHSE (Jan 24) have agreed to provide oversight and assurance to the project.	•Undertake a review of current service provision to better understand the patient level impact of the current service •Explore opportunities alongside the Stroke and Neuro Rehabilitation task and finish group partners for rapid service improvement measures •Develop business case for enhanced funding to move the service in line with regions best practice. The Integrated Stroke Delivery Network have identified recommendations for improvement that relate to commissioning, access, service gaps, low staffing levels, psychology provision and life after stroke. Implemented Public Engagement	April: The T&F group are to submit a paper this month to the Medical Directorate SMT to request funding from the NHSE LTC/Prevention allocation. Funding to enhance skill mix, establish provision in the High Peak and extend early supported discharge offer that will provide additional support to moderate patients leading to reduced demand on community services. Should the funding be agreed this will be included within the business case options and will have a direct impact on the risk score. The T&F group expect the business case to be completed by May/June for approval. May: MD SMT support option 2 proposal and release of ringfenced funding (£280k) for a one year period. The T&F group business case continues to be fully worked up for approval and scrutiny. June: Business case still in development, with aim for first draft end of month. Providers to request that any investment approved is agreed on a recurrent basis to enable workforce recruitment and retention.	4	4	16	4	4	16	2	4	8	March 2026	SR1,SR2,SR4,SR7	Jun-25	Jul-25	Dr Chris Weiner Chief Medical Officer	Scott Webster Head of Programme Management, Design, Quality & Assurance

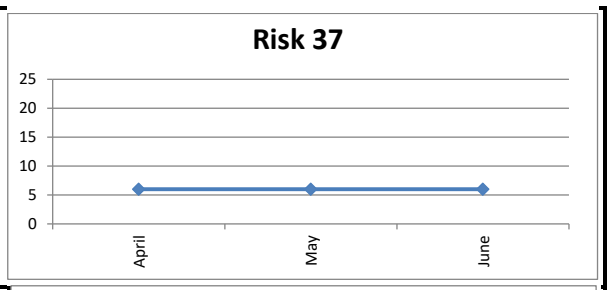
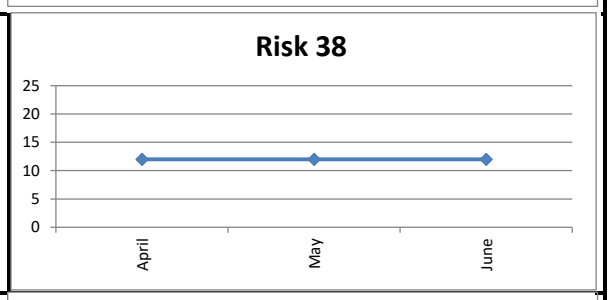
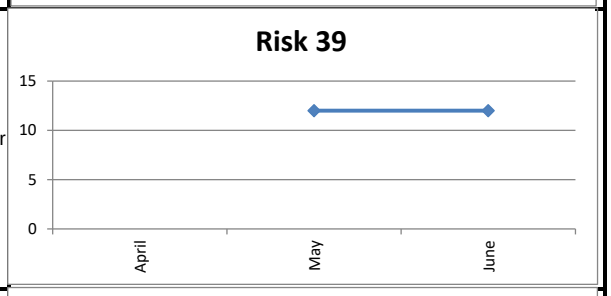
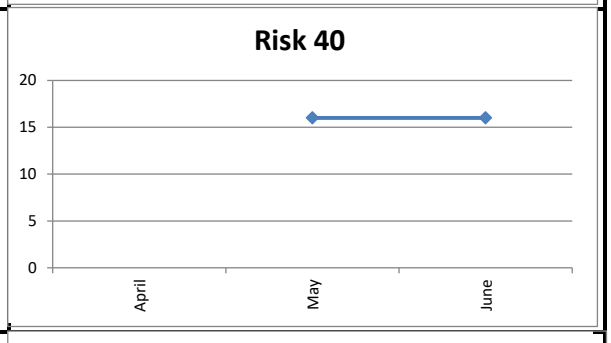
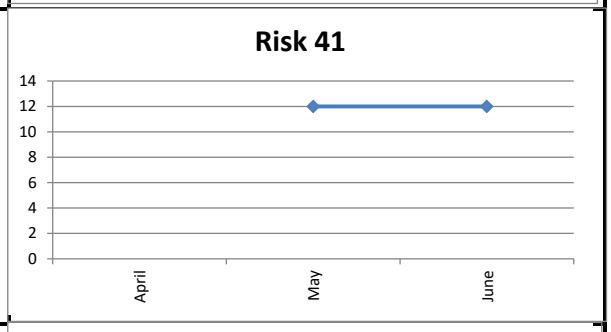
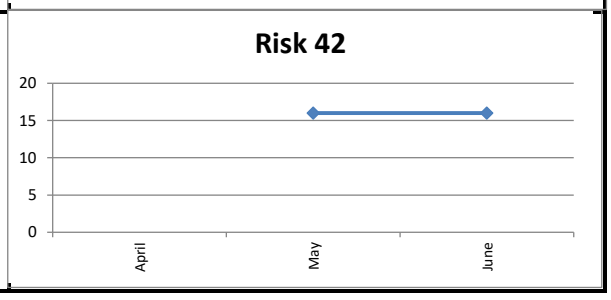
34	25/26	The health and wellbeing of ICB staff could be negatively affected by the announcement of the required ICB cost savings on 12th March 2025 and the resulting uncertainty as to the future role of ICBs.	Audit and Governance Committee	Corporate	5	4	20	Updates and platform for discussion provided at weekly Team Talk meetings; staff encouraged to ask questions. FAQ area available on the intranet showing questions asked and answers where they are available. Weekly Staff Bulletin email from Dr Chris Clayton providing any further updates as they become available. Reminders to staff on wellbeing support available and contact details for Mental Health First Aiders. Line managers reminded to ensure regular 1:1s are taking place and team meetings held to share news and staff concerns. OEIG and DIN in place to provide further support to staff and feedback to the ICB.	Continue with all mitigating actions. Develop communications plan with staff and stakeholders when more detail is known. Develop change process and review policies as necessary.	May: The HR teams have developed a wellbeing support plan that will be communicated to colleagues and signpost to sources of support. HR have also arranged workshops with an external provider on planning for retirement and financial planning. June: Wellbeing support plan communicated to colleagues at Team Talk with signposting to sources of support. Line managers encouraged to have regular one to one meetings with staff to include wellbeing conversations. Additional workshops arranged with Affinity Connect on retirement and financial planning. Pulse survey results identified 70.7% of staff have a negative mood with colleagues feeling demotivated, pessimistic and stressed linked to workload and concerns about job security. Sickness levels in May 2025 (2.92%) were lower than May 2024 (3.91%). There is a significant amount of anxiety/worry from staff around the ICB cost reductions that is impacting on colleagues. There is a real desire for timelines and further information, which regrettably is not available at the current time.	5	4	20	5	4	20	1	3	3	Ongoing	SR5	Jun-25	Jul-25	Helen Dillistone, Chief of Staff	James Lunn, Assistant Director of HR and Organisational Development Sean Thornton, Director of Communications and Engagement
35	25/26	There is a risk of a loss of the skills, knowledge and momentum required to deliver the ICB priorities and plans following the announcement of the required ICB cost savings and whilst clarity as to the future responsibilities of ICBs is awaited.	Audit and Governance Committee	Corporate	5	4	20	Regular communication with staff. Continue to share information with staff as soon as possible. Line management support to focus on existing priorities.	Undertake a review of what the ICB priorities will be once it is known what the likely operating model and duties are.	May: The ICB Blueprint letter has now been received and shared with staff. The letter sets out a number of priorities for ICBs although the future of all current functions is not yet clear. Team Talk meetings take place each week at which staff can raise questions, along with an intranet page containing information received and FAQs. HR have shared wellbeing support information across the organisation. June: Communication to staff/managers encouraging teams to meet and discuss the model ICB blueprint and feedback to their Director. ICB submitted financial template to NHSE. Team Talk meetings take place each week at which staff can raise questions, along with an intranet page containing information received and FAQs. ICB cost reductions updates discussed with the Organisational Effectiveness and Improvement Group and the Diversity & Inclusion Network. Chef People Officer arranging a meeting with CPOs/Trade Unions/ Professional Representative Bodies in the proposed cluster to commence engagement and discussions on how best we can support their members (our staff).	5	4	20	5	4	20	3	2	6	Ongoing	SR5	Jun-25	Jul-25	Helen Dillistone, Chief of Staff	Chrissy Tucker, Director of Corporate Governance & Assurance
36	25/26	There is a risk that the ICB does not prioritise and commission efficiently and effectively to better improve health outcomes for the residents of Derby and Derbyshire. •By not identifying opportunities to utilise existing capacity in the current commission and contracts to meet demand •By not allocating sufficient resources available in the ICB to effectively manage, review and monitor contracts	Strategic Commissioning and Integration Committee	Clinical	4	4	16	Strategic Commissioning and Integration Committee (SCIC) to receive a prioritisation framework to help direct the order of which services/commissions are reviewed in a forward plan. SCIC to receive all recommendations relating to commissioning of services and ensure sufficient detail/specification to ensure we have the most effective, efficient care delivered within the commission.	Create the capacity within the ICB to deliver key commissioning activities. Enhance the capability of ICB teams to deliver key commissioning activities. Create a tactical and strategic commissioning plan and approach to support the ICBs Joint Forward Plan and medium term Financial Strategy.	March/April update: 25/26 Operational planning process surfacing some commissioning issues and giving opportunity to address these. Contracts are being reviewed where these end in the next 12 months. Forward Plan for procurements under constant review. May/June: Contract negotiations are currently taking place. Formal, robust contract management meetings are being re-introduced with each Provider. Sufficient resources have been identified to enable this process.	4	3	12	4	3	12	3	3	9	Sep-26	SR2, SR7	Jun-25	Jul-25	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive Craig Cook, Director of Strategy & Planning
37	25/26	There is a risk that the ICB makes commissioning decisions and/or operational decisions that are not aligned with the strategic aims of the system; which impact on the scale of transformation and change required to deliver the 5 Year Forward View.	Strategic Commissioning and Integration Committee	Clinical	3	3	9	System response to winter and recovery planning. Senior Leadership of ICB Executive Team providing assurance to the ICB Board. System Oversight and Assurance Group providing assurance on system performance and delivery. SCIC receives and reviews decisions and actions to assure members these are aligned to strategic objectives. These should evidence consistency with delivery plans. SCIC decisions are evidenced to align with strategic aims of the system. Maturity of ICB – Internal controls and governance. BI, analytics and reporting in place populational health to be developed through population health management programme	ICB Executive Team are re-grouping to take further actions relating to the Joint Forward Plan. Roadmap to be devised to identify the System work required for the 5 year plan. Linking the ICB and NHS Partnerships and Provider organisations to work to the JFP and delivery of this.	March/April: 2025/26 Operational Plan development includes strategic shifts from hospital to community and illness to prevention, including development of our neighbourhood health offering. This all links to the Joint Forward Plan. May/June: Programme Delivery Boards inform the strategic direction of the programme of work. The 2025/26 Operational Plan includes projects and progress which will deliver the system strategic ambitions. The detailed commitments made in the 2025/26 Operational Plan are used to inform the Delivery Board Plan and Integrated Place Executive.	3	2	6	3	2	6	2	2	4	TBC	SR2, SR7	Jun-25	Jul-25	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Emma Ince Director of Delivery
38	25/26	There is a risk that patient care is affected by the fragility of service delivery caused by lack of available and adequate resources and service investment.	Strategic Commissioning and Integration Committee	Clinical	3	4	12	Established a Fragile Services Oversight Group: -Membership includes JUCD Chief Medical Officers and Chief Operating Officers. - Agreed working definition of fragility, where there is a risk to the sustainability of clinical services within JUCD, - Developed a comprehensive list of fragile services identified by providers, which is reviewed regularly by the group. The list includes an assessment of the level of risk in each service, using NHS England's three categories of 'Worried, watchful and assured'. -Developed an approach to deciding the right organisation/group/geography for addressing the risk and finding solutions to strengthen and maintain service sustainability, which has been developed in the light of Regional guidance and is consistent with EMAP's processes.	Developing a fragile service reporting template to be submitted bi-monthly by providers for each service identified as fragile. Ongoing Actions: - Identify mitigations to manage or reduce service risk. - Escalate issues where progress is not being made due to external factors. - Continuous live monitoring of all services by providers to monitor fragility status.	April: Fragile services reporting guidance and template developed to be completed by relevant SRO in advance of meetings. High risk service updates and mitigations provided for CAMHS, Hyper Acute Stroke, Oncology, Ophthalmology, Paeds, Pharmacy (aseptic) and Huntington's Disease. May/June: No update. Fragile Services Oversight Group have not met this month. Next meeting 8th July.	3	4	12	3	4	12	2	4	8	Mar-26	SR2, SR7	Jun-25	Jul-25	Dr Chris Weiner Chief Medical Officer	Scott Webster Head of Programme Management, Design, Quality & Assurance
39	25/26	The ICB does not achieve a breakeven/balanced financial position in 2025/26.	Finance and Performance	Corporate/Financial	4	4	16	Formal governance arrangements exist where the risks are reviewed and issues addressed, e.g. Board, Finance and Performance Committee, etc. Robust internal systems and controls (including internal audit arrangements). Strong and compliant policies and procedures, e.g. Scheme of Delegation, etc. Robust ICB financial plan. Reporting of financial position (including efficiencies) to NHSE, executives and committees.	Continued reporting of the ICB's financial position to Executive Team and relevant committees. Ensure operational controls and governance arrangements in respect of the ICB's efficiencies are sufficient. On-going review of risks and mitigations.	May: Reporting and governance arrangements in place. Confirm/establish operational management arrangements re efficiencies. Robust plan for 2025/26. However, risk and mitigations will need on-going management. June Update: Month 2 financial position on-plan for both efficiencies and overall position. Weekly ICB CIP Group established. The group provides fortnightly updates to the ICB's Executive Team. Highlights to be shared with the Finance and Performance Committee. On-going management of ICB risk and mitigations.	3	4	12	3	4	12	2	3	6	On-going	SR4	Jun-25	Jul-25	Bill Shields, CFO	David Hughes, Director of Finance - ICB
40	25/26	Risk that we are unable to deliver the system financial plan resulting in a deficit and/or financial penalty. This maybe as a result of: * Operational pressures above planned levels * Inability to deliver the required level of system efficiency * Other unplanned for financial event/planned financial events not occurring.	Finance and Performance	Corporate/Financial	4	4	16	Operational Performance: System CFO's and / or Deputies meet at least weekly to ensure the delivery of the best possible out-turn position. HR and Operational colleagues involved in oversight of financial impact in various meetings considering performance targets and are setting out what is needed to ensure the best possible outcome. Executives and F&P receive integrated / aligned financial, operational and workforce reporting to support understanding of performance and impact. Efficiency Delivery: The System has committed to delivering a £181m CIP target in 2025/26. All schemes monitored by JUCD system finance team aligned to PFR reporting to NHSE. Financial Sustainability Board meets monthly with the purpose to gain assurance on the ability to deliver on the efficiency plan and recommend remedial action where required. Performance on efficiencies escalated to System NHS Executives and Finance & Performance Committee. Other Items: Good network with Deputy CFO meetings weekly - financial position discussed on working day 6 of each month and financial forecast and risks regular discussion at a system and ICB level. Any items which are raised are escalated appropriately to CFO's, FSB, Execs, System Execs and / or F&P to enact mitigating action.	**Operational Performance:** Service line reporting into Delivery Boards to demonstrate system financial plan and actual position on a monthly basis is in progress. This isn't yet available at a service line level (expected at a programme board level for F&P by M2) however to inform decision making on operational performance this needs extending to services which should be available later in 2025/26	June update: Efficiency Delivery To strengthen oversight of efficiency delivery risks, the Financial Sustainability Board has been refreshed, with updated terms of reference scheduled for approval at the upcoming June meeting. The Board is now receiving enhanced reporting on assurance metrics and the variance from the risk-adjusted position (which continues the NHSE weekly submissions format). Of the £181m system plans, there is a difference of £55m to the weighted risk adjusted position.	4	4	16	4	4	16	3	3	9	On-going	SR4	Jun-25	Jul-25	Bill Shields, CFO	Jen Leah Director of Finance - Strategy and Planning
41	25/26	Risk that the system is unable to deliver the capital programme. This could be due to: * Strategic need exceeding resource available resulting in expenditure exceeding available resource * Programme progress being delayed resulting in capital recognition of spend being stunted and failure to maximise the opportunity from available resource (underspend of capital resource).	Finance and Performance	Corporate/Financial	3	4	12	System capital oversight group meets monthly and reports to system Deputy CFO's. Any matters for escalation are reported onwardly to CFO's. Capital reporting is regularly presented to F&P Committee. Forecasts are maintained for capital along with 3 year plans. System finance team maintain a good relationship with NHSE capital and cash colleagues.	Development of the capital plan into an integrated medium term plan with revenue financial planning.	June update: Multiyear plans are scheduled to undergo internal organisational governance processes prior to system-wide collation during the week commencing 25th July. At this early stage of in-year delivery, the primary concern is the delay in receiving Memoranda of Understanding (MOUs) associated with the national process for constitutional standards.	3	4	12	3	4	12	3	3	9	On-going	SR4	Jun-25	Jul-25	Bill Shields, CFO	Jen Leah Director of Finance - Strategy and Planning
42	25/26	There is a risk that providers do not have sufficient cash to pay staff and creditors	Finance and Performance	Corporate/Financial	4	4	16	The system is in receipt of Revenue Deficit Support and cash support from NHSE. The ICB plans cash drawdown to support timing of cashflow for providers. Providers maintain rolling daily cashflow's which inform decisions on payment and receipts. Cash and liquidity forms regular updates on the agenda for system Deputies. System finance team maintain good relationship with national capital and cash team.	System policy for cash management and management of cash at a system level. Delivery of cash releasing efficiencies	June update: The on-going management of this risk will form part of the ICS's wider financial performance management. In particular, financial performance in respect of efficiency delivery and organisational balance will help ensure that the ICS secures its (cash backed) deficit funding and is therefore less likely to need any additional cash support. This on-going ICS financial management takes place at a variety of fora, including the Financial Sustainability Board, System CFOs and System Deputy CFOs.	4	4	16	4	4	16	3	3	9	On-going	SR4	Jun-25	Jul-25	Bill Shields, CFO	Jen Leah Director of Finance - Strategy and Planning

ICB Risk Register - Movement - June 2025

NHS
Derby and Derbyshire
Integrated Care Board

Risk Reference	Risk Description	Previous Rating (May)			Residual/ Current Risk Rating (Jun)			Movement -June	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
01	The Acute providers may not meet the new target in respect of 78% of patients being seen, treated, admitted or discharged from the Emergency Department, resulting in the failure to meet the ICB constitutional standards and quality statutory duties, taking into account the clinical impact on patients and the clinical mitigations in place where long waits result.	5	4	20	5	4	20	⟺	The system is not meeting the target in respect of 78% of patients being seen, treated, admitted, or discharged from the Emergency Department within 4 hours across all sites, with the national overall target of 95%.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Amy Grazier Senior Operational Resilience Manager Dan Merrison Senior Performance & Assurance Manager Jasbir Dosanjh	
06A	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position. **Delivery of 24/25 Financial Plan**	3	3	9	3	3	9	**RISK RECOMMENDED FOR CLOSURE**	Risk recommended for closure. New 2025/26 risk approved.	Bill Shields Chief Finance Officer	David Hughes Director of Finance Derby and Derbyshire ICB Tamsin Hooton, Programme Director, Provider Collaborative	Risk recommended for closure
06B	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position. **Delivery of 2-year Break Even**	4	5	20	4	5	20	**RISK RECOMMENDED FOR CLOSURE**	Risk recommended for closure. New 2025/26 risk approved.	Bill Shields Chief Finance Officer	David Hughes Director of Finance Derby and Derbyshire ICB Tamsin Hooton, Programme Director, Provider Collaborative	Risk recommended for closure
09	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	4	4	16	4	4	16	⟺	Waiting lists remain significant therefore risk remains and score will be unchanged despite mitigations in place.	Prof Dean Howells Chief Nursing Officer	Letitia Harris Assistant Director of Clinical Quality	
11	If the ICB does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	4	3	12	4	3	12	⟺	Work to finalise the Green Plan continues with a focus on sustainability, developing role of the ICB as the strategic commissioner, future delivery arrangements still to be clarified.	Helen Dillistone Chief of Staff	Katy Dunne Head of Corporate Programmes	
15	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	3	4	12	3	4	12	⟺	No further update regarding delegation but discussions underway re screening services previously identified for retention in NHS England to consider where should be commissioned from in future.	Helen Dillistone Chief of Staff	Chrissy Tucker - Director of Corporate Governance and Assurance	
17	Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.	4	3	12	4	3	12	⟺	Model ICB Blueprint within ICB Communications and Engagement team being considered, along with proposed cluster ICBs.	Helen Dillistone Chief of Staff	Sean Thornton - Director of Communications and Engagement	

19A	Failure to deliver a timely response to patients due to excessive handover delays. Leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential levels of harm.	4	4	**16**	4	4	**16**	⟺	Despite ongoing and positive mitigation efforts, the underlying factors contributing to ambulance handover delays and community response times remain present and volatile.	Dr Chris Weiner Chief Medical Officer	Andrew Sidebotham Associate Director of Urgent Care	
19B	The risk of delayed or inadequate patient discharge is heightened by factors including, unsuitable home environments, limited availability of community and home care services, and delays in providing necessary equipment. Poor coordination among healthcare providers, insufficient rehabilitation and long-term care options, rigid discharge policies, and ineffective communication and data management is further exacerbated by seasonal increases in patient volumes and inadequate transport services. The result is that the system struggles to effectively manage and support patient transitions from hospital to home or long-term care, leading to potential harm and unmet patient needs.	3	4	**12**	3	4	**12**	⟺	Score remains the same and system pressures have remained high despite the time of year.	Strategic Discharge Group	Jodi Thomas Discharge Improvement Lead JUCD	
19C	Lack of digital interoperability across information platforms leads to inadequate visibility of discharge information and communication between providers. There are a lack of effective performance indicators to monitor and manage discharge processes. Inadequate data collection and analysis to identify bottlenecks in discharge pathways. Lack of system data intelligence to inform decision making to manage risks when in system escalation.	5	3	**15**	5	3	**15**	⟺	Review of pathway data group being undertaken throughout June focusing on nomenclature with all system partners.	Strategic Discharge Group	Jodi Thomas Discharge Improvement Lead JUCD	
21	There is a risk that contractors may not be able to fulfil their obligations in the current financial climate. The ICB may then have to find alternative providers, in some cases at short notice, which may have significant financial impact.	3	4	**12**	3	4	**12**	**RISK RECOMMENDED FOR CLOSURE**	Risk recommended for closure. New 2025/26 risk approved.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Craig Cook Director of Acute Commissioning, Performance and Contracting & Clive Newman Director of Primary Care	Risk recommended for closure
23	There is an ongoing risk to performance against RTT and the cancer standards due to an increase in referrals into UHDB resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment.	4	4	**16**	4	4	**16**	⟺	In the 2024/25 NHS Operational plan JUCD have agreed to deliver on this standard by end of March 2026.	Prof Dean Howells Chief Nursing Officer	Monica McAllindon Associate Director of Planned Care	
25	There is a risk of significant waiting times for moderate to severe stroke patients for community rehabilitation. This means, patients may have discharges from acute delayed, be seen by non-stroke specialist therapists and require more robust social care intervention.	4	4	**16**	4	4	**16**	⟺	Business case still in development, with aim for first draft completion of end June.	Dr Chris Weiner Chief Medical Officer	Scott Webster Head of Programme Management, Design, Quality & Assurance	
32	Risk of the Derbyshire health system being unable to deliver it's capital programme requirements due to capacity and funding availability.	2	4	**8**	2	4	**8**	**RISK RECOMMENDED FOR CLOSURE**	Risk recommended for closure. New 2025/26 risk approved.	Bill Shields Chief Finance Officer	Jennifer Leah Director of Finance	Risk recommended for closure
34	The health and wellbeing of ICB staff could be negatively affected by the announcement of the required ICB cost savings on 12th March 2025 and the resulting uncertainty as to the future role of ICBs.	5	4	**20**	5	4	**20**	⟺	There is a significant amount of anxiety/worry from staff around the ICB cost reductions that is impacting on colleagues.	Helen Dillistone, Chief of Staff	James Lunn, Assistant Director of HR and Organisational Development Sean Thornton, Director of Communications and Engagement	
35	There is a risk of a loss of the skills, knowledge and momentum required to deliver the ICB priorities and plans following the announcement of the required ICB cost savings and whilst clarity as to the future responsibilities of ICBs is awaited.	5	4	**20**	5	4	**20**	⟺	Communication to staff/managers encouraging teams to meet and discuss the model ICB blueprint and feedback to their Director	Helen Dillistone, Chief of Staff	Chrissy Tucker, Director of Corporate Governance & Assurance	
36	There is a risk that the ICB does not prioritise and commission efficiently and effectively to better improve health outcomes for the residents of Derby and Derbyshire; •By not identifying opportunities to utilise existing capacity in the current commission and contracts to meet demand •By not allocating sufficient resources available in the ICB to effectively manage, review and monitor contracts.	4	3	**12**	4	3	**12**	⟺	Formal, robust contract management meetings are being re-introduced with each Provider.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive Craig Cook, Director of Strategy & Planning	

37	There is a risk that the ICB makes commissioning decisions and/or operational decisions that are not aligned with the strategic aims of the system; which impact on the scale of transformation and change required to deliver the 5 Year Forward View.	3	2	**6**	3	2	**6**	⟷	The 2025/26 Operational Plan includes projects and progress which will deliver the system strategic ambitions.	Michelle Arrowsmith Chief Strategy and Delivery Officer, and Deputy Chief Executive	Emma Ince Director of Delivery	
38	There is a risk that patient care is affected by the fragility of service delivery caused by lack of available and adequate resources and service investment.	3	4	**12**	3	4	**12**	⟷	Fragile services reporting guidance and template developed to be completed by relevant SRO in advance of meetings.	Dr Chris Weiner Chief Medical Officer	Scott Webster Head of Programme Management, Design, Quality & Assurance	
39	The ICB does not achieve a breakeven/balanced financial position in 2025/26.	3	4	**12**	3	4	**12**	⟷	Month 2 financial position on-plan for both efficiencies and overall position. On-going management of ICB risk and mitigations.	Bill Shields, CFO	David Hughes, Director of Finance - ICB	
40	Risk that we are unable to deliver the system financial plan resulting in a deficit and/or financial penalty. This maybe as a result of: * Operational pressures above planned levels * Inability to deliver the required level of system efficiency * Other unplanned for financial event/planned financial events not occurring.	4	4	**16**	4	4	**16**	⟷	To strengthen oversight of efficiency delivery risks, the Financial Sustainability Board has been refreshed, with updated terms of reference scheduled for approval.	Bill Shields, CFO	Jen Leah Director of Finance - Strategy and Planning	
41	Risk that the system is unable to deliver the capital programme. This could be due to: * Strategic need exceeding resource available resulting in expenditure exceeding available resource * Programme progress being delayed resulting in capital recognition of spend being stunted and failure to maximise the opportunity from available resource (underspend of capital resource).	3	4	**12**	3	4	**12**	⟷	At this early stage of in-year delivery, the primary concern is the delay in receiving Memoranda of Understanding (MOUs) associated with the national process for constitutional standards.	Bill Shields, CFO	Jen Leah Director of Finance - Strategy and Planning	
42	There is a risk that providers do not have sufficient cash to pay staff and creditors	4	4	**16**	4	4	**16**	⟷	The on-going management of this risk will form part of the ICS's wider financial performance management.	Bill Shields, CFO	Jen Leah Director of Finance - Strategy and Planning	

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

17th July 2025

Item: 041

Report Title	Committee Assurance Reports
Authors	ICB Committee Chairs
Sponsors	ICB Executive Directors
Presenters	ICB Committee Chairs
Paper purpose	Decision ☐ Discussion ☐ Assurance ☒ Information ☐
Appendices (reports attached)	Appendix 1 – Audit & Governance Committee Assurance Report Appendix 2 – Finance & Performance Committee Assurance Report Appendix 3 – People & Culture Committee Assurance Report Appendix 4 – Strategic Commissioning & Integration Committee Assurance Report Appendix 5 – Quality, Safety & Improvement Committee Assurance Report Appendix 6 – Joint ICB Transition Committee Assurance Report

Recommendations
The ICB Board are recommended to **RECEIVE** the Committee Assurance Reports for assurance.
Report Summary
This report presents an overview of the work of the ICB Board's Committees since the last Board meeting in May. The report aims to provide assurance that the Committees are effectively discharging their delegated duties and to highlight key messages for the Board's attention. The report includes the Committees' assessments of the levels of assurance they have gained from the items received and any actions instigated to address any areas where low levels of assurance have been provided.

How does this paper support the 3 shifts of the NHS 10-Year Plan?					
From hospital to community	☒	From analogue to digital	☒	From sickness to prevention	☒

Integration with Board Assurance Framework and Key Strategic Risks					
SR1	Safe services with appropriate levels of care	☒	**SR2**	Reducing health inequalities, increase health outcomes and life expectancy	☒
SR3	Population engagement	☒	**SR4**	Sustainable financial position	☒
SR5	Affordable and sustainable workforce	☒	**SR7**	Aligned System decision-making	☒
SR8	Business intelligence and analytical solutions	☒	**SR10**	Digital transformation	☒
SR11	Cyber-attack and disruption	☒			

Conflicts of Interest	Conflicts of interest are managed accordingly at all meetings.

Have the following been considered and actioned?			
Financial Impact	Yes ☒	No ☐	N/A ☐
Impact Assessments	Yes ☒	No ☐	N/A ☐
Equality Delivery System	Yes ☒	No ☐	N/A ☐
Health Inequalities	Yes ☒	No ☐	N/A ☐
Patient and Public Involvement	Yes ☒	No ☐	N/A ☐
ICS Greener Plan Targets	Yes ☒	No ☐	N/A ☐

NHS
Derby and Derbyshire
Integrated Care Board

Audit & Governance Committee Assurance Report

Meeting Date(s):	19 June 2025
Committee Chair:	Sue Sunderland

Assurances Received:

Item	Summary	Previous Level of Assurance	Current Level of Assurance
External Audit ISA 260 report and annual letter	Took significant assurance from External Audit's feedback on the completion of their external audit work noting the positive feedback on the finance and corporate governance team.	Not previously rated although early feedback was positive	**Full**
Internal Audit final Head of Internal Audit Opinion	Took significant assurance from the final Head of Internal Audit opinion which confirmed the draft assessment of significant assurance.	**Full**	**Full**
Preparation of annual report and financial statements	Took positive assurance on the ICB's arrangements for the preparation of the annual report and financial statements. Whilst we noted a number of changes to both the annual report and financial statements none of these were material and many were presentational. This reflects well on all the staff involved in the preparation of these key documents and we thank them for their hard work and dedication.	**Full**	**Full**
Fit and proper person test submission	Took positive assurance on the ICB's arrangements for the management of the fit and proper person arrangements including the annual return.	Not previously rated	**Full**
New financial ledger	Took positive assurance that the team are gearing up to manage the transition to the new national ledger including identifying the risks. However we noted serious concerns and risks linked to the national decision that the new ledger system will go live on 1 October. The Chair and Chief Executive agreed to escalate this nationally and to also ensure that the transition committee is sighted on this.	Not previously rated	**Partial**

Other consideration:

Decisions made:
Approved the changes made to the annual report and financial statements since the drafts approved in May Approved the Annual report and financial statements for signing and submission. Approved the letter of representation for signing. Delegated approval for any late changes to the annual report and accounts to the Chief Finance Officer and Chief Executive Officer. Approved the updated Commercial Sponsorship and Joint Working with the Pharmaceutical Industry Policy

Information items and matters of interest:
None

Matters of concern or key areas to escalate:
Chair and Chief Executive agreed to escalate the concerns and risks over the decision to change the ledger system with effect from 1 October given the other changes in train.

Derby and Derbyshire Integrated Care Board

Finance & Performance Committee Assurance Report

Meeting Dates:	24 June 2025
Committee Chair:	Nigel Smith

Assurances Received:

Item	Summary	Previous Level of Assurance	Current Level of Assurance
Chief Finance Officers Report	The Committee were asked to note the update from the Chief Finance Officer (CFO) The committee discussed the system's financial position which is favourable to plan. The CFO went on to discuss the ICB CIP programme which continues to target above the required level to allow for slippage and shortfall in the programme and assurance in achieving the £44m is growing. The stepping up of the weekly internal CIP meeting has supported this improved assurance, however risks do remain. The meeting is chaired by either the CFO or ICB DoF and is attended by all execs and Directors. The CFO continued to explain the further stretch in the ICS plan around decommissioning which is in addition to the CIP target. The system £5.3m is sat with the 2 acute providers and whilst the CRH element shows a route to achieving the plan ask, the £3.7m with UHDB remains a challenge. The ICB are working with the Trust to identify services which can be stopped to release the saving required. The conversation went onto contracting outside of JUCD, in which the DDICB team had met with Sheffield, Manchester & Stockport to identify routes to financial resolution for cross boarder patient flow. Progress was more advanced with Sheffield and a solution was expected. There was more work to be done to resolve patients attending in the Manchester / Glossop area.	**Adequate**	**Adequate**
DDICB Financial Position	The paper was presented to the committee for assurance – the Associate Director of Finance presented the paper. The paper presented the Month 2 (M2) and full-year outturn (FOT) position for the Integrated Care Board (ICB), reflecting a favourable £78k to a breakeven plan in M2. A detailed conversation was had regarding many of the underlying challenges within the position including overspends in planned &	**Adequate**	**Adequate**

Item	Summary	Previous Level of Assurance	Current Level of Assurance
	urgent care and a £1.4m overspend in mental health budgets (mainly due to ADHD patient choice and out of area PICU placements). Despite these ongoing operational and financial challenges, the forecast outturn remained at breakeven, which was discussed. The committee asked for a focus on the run rate in a future meeting – this was expected to include efficiency route to delivery and financial impact, low volume activity impact and a focus on planned & UEC spending. The committee asked for assurance on the contractual discussions. The Medium-Term Financial Plan was presented as the underlying deficit for the ICB alone of £7.4m. This position will contribute to the overall ICS MTFP which has been discussed previously and aims for a timeline of July presentation to F&P. The Committee asked about the expected planning assumptions around timeframe for recurrent balance in the plan; it was confirmed at this stage the MTFP is to understand the financial position currently in place so that system Execs can discuss and recommend to system Boards the underlying planning assumptions which need to be made to form a system financial strategy. Those will include the period to which financial balance should be achieved and the route to deliver this including medium term assumptions in efficiency delivery and commissioning decisions.		
System Financial Position	The paper was presented to the committee for assurance. It was noted that the paper for M2 included capital for the first time in 2025/26 reporting and Service Line Reporting in a live state for the first time ever. It was expected that the detail in this reporting was expected to improve over time. The Month 2 (M2) system position was reported as £0.6m favourable to plan. While the system remains on track for a full-year outturn (FOT) that achieves the required break-even plan, the committee noted three key risks in the delivery of the system position: 1) Efficiency Delivery - if the current M2 trajectory continues, the run rate indicates that the system would be circa £75m deficit by the end of the year. The plan however is for break even due to planned levels of efficiency in the second half of the year being circa £69m ahead of the run rate position plus a one-off item in UHDB position for £6.5m in M12. 2) Pay Spend – the system position at M2 whilst marginally favourable overall, is adverse to plan within pay (offset in non-pay and income). The adverse pay position was in part offset by a £1.3m favourable position in pay within DHcFT due to MRFD delays which caused overspend	**Partial**	**Partial**

Item	Summary	Previous Level of Assurance	Current Level of Assurance
	elsewhere. Without this underspend, the pay position is circa £2m adverse which is mainly in UHDB. 3) UEC spending – the service line reporting indicated a £4m YTD overspend in UEC which is being offset by favourable position within corporate areas. Therefore, the committee emphasized the need for clear mitigating actions to provide assurance. The committee have asked for a short statement from each of the 6 organisations to state what is being done to turn around the run rate. The committee reviewed the system's efficiency programme, targeting £181.7m in savings. They noted significant variability in the risk-adjusted forecast delivery rates across organisations, the committee expressed concern over its current risk weighting. The committee welcomed an update on the Financial Sustainability Board's (FSB) oversight of efficiency delivery and acknowledged the work commissioned to strengthen assurance.		
Performance Report	The paper was sent to the committee for assurance The report outlined system performance against key constitutional metrics, highlighting planned performance shortfalls in several areas. RTT performance at UHDB was showing on track although other areas of concern were noted including outpatients & theatres. The committee discussed additional un-commissioned activity carried out by UHDB putting pressure on the planned care financial position. CRH remain a worry due to growth since the beginning of the year, and in comparison, to the same point last year, in the waiting list and 18 week wait for some areas. The committee discussed whether the productivity assumption within CRH had been too ambitious. Cancer remained an area of concern for the committee – CRH had hit their target last year by focusing on high volume activity however this was having an impact with the remaining area of challenge in gynae. While other metrics remained in line with planned levels, the committee acknowledged that the plan anticipates performance improvements throughout the year. However, many metrics have remained static over recent months. Consequently, the committee continued to request further insight into provider-led initiatives aimed at improving this flat trajectory, to ensure national targets are met by year-end—something asked for in the previous meeting.	**Limited**	**Partial**

Item	Summary	Previous Level of Assurance	Current Level of Assurance
Elective Care Deep Dive	The paper was presented to the committee for information As part of the Committee's responsibility to oversee performance, a deep dive into elective care activity was presented. The paper highlighted ongoing challenges in meeting key national targets. Many of the challenges had been discussed as part of the previous paper including waiting list performance and cancer pathway plans. Committee noted the increased use of the Independent Sector to manage waiting lists and associated costs.	**Not previously presented**	**Partial Assurance**
Risk Register & BAF	The paper was presented for approval. The committee noted that again performance related risks had not been presented to the committee. An action was taken to ensure that the committee is sighted on all risks within the new portfolio. The committee noted the risk presented within the risk register. The committee went on to discuss the finance BAF risks including detailed conversation on BAF scores. It was agreed to maintain the BAF score for BAF 4 and BAF 10 however recommend reducing the score for BAF 11 and improve to adequate.	**Adequate**	**Adequate**

Other considerations:

Decisions made:
Not applicable.

Information items and matters of interest:
The committee noted that this was the last meeting for the Director of Finance – Strategy & Planning who was about to take on a 12 month secondment with Derbyshire Community Health Service as their Chief Financial Officer and welcomed Marcus Pratt who will be extending his system finance lead role currently with Nottingham & Nottinghamshire ICB to also support the Derbyshire system.

Matters of concern or key areas to escalate:
Not applicable.

Derby and Derbyshire Integrated Care Board

People and Culture Committee Assurance Report

Meeting Date(s):	1st July 2025
Committee Chair:	Margaret Gildea

Assurances Received:

Item	Summary	Previous Level of Assurance	Current Level of Assurance
Derbyshire Leader Programme	The Committee received and approved a system wide report on the delivery of the Derbyshire Leader Programme linked to the ICS Mandated People Function of Educating, training and developing people, and managing talent and the ICB's strategic risk 5. The report was very positively received and the Committee acknowledged the breadth and depth of the leadership development offer and system wide take up from all sectors. This was a good example of a One Workforce approach in practice by working together with all partners across Derbyshire.	Not applicable due to first report	**Adequate**
Report on NHS NETS and student retention in health and care workforces	The Committee received a presentation from the Derbyshire Academy on the last National Education and Training Survey (NETS) for NHS nursing, AHP and midwifery students on placement across NHS providers in Derbyshire. Key items to note included a 34% increase in responses from the previous year, 248 in 2022 to 333 in 2024, all 13 survey indicators were above the national average and 91% of respondents would recommend their placements. The quality of our student placements is a key determining factor in attracting our future workforce.	Not applicable due to first report	**Partial**
Month 12 Workforce Reports	The month 2 system workforce plan demonstrated that the overall workforce WTE's for month two was 288.21 WTE under plan and the overall pay bill was underspent by £339k at the end of month 2. The Committee raised concerns that pay costs did not appear to triangulate to the number of WTE's particularly on bank and agency spend. Whilst assurances were given around the use of additional backed funded programmes such as WLI posts and pension contribution payments which were skewing the planned pay costs against plan, it was felt that greater transparency and details were needed to provide the Committee with greater assurance.	**Adequate**	**Partial**

Item	Summary	Previous Level of Assurance	Current Level of Assurance
BAF Q4 Review	The Committee decided to keep the existing risk and tolerance scores at the current levels. There is a strong feeling amongst committee members that there is an absence of wider system assurance on non-NHS workforce levels and challenges due to a lack of intelligence on the local authority, voluntary sector and social care workforces and cultural challenges to allow a robust review of the current risk and tolerance scores. The Committee agreed to keep this scoring in place for the time being and to review the feedback from the One Workforce engagement process to better inform an appropriate risk score.	**Partial**	**Partial**
One Workforce Update Report	The Committee received an update report on the progress of the system One Workforce Strategy and approach and noted that the programme remained on plan. During the engagement phase of this programme, over 350 people from 56 different organisations across Derby and Derbyshire attended a range of face to face, online and bespoke team engagement sessions. Over 2,000 pieces of feedback were also received to help the development of this strategy which is extremely positive. During July and August this feedback will be analysed and presented back to partners to identify further opportunities for collaboration and defining our future workforce's desired state.	**Adequate**	**Adequate**

Other consideration:

Decisions made:
The Committee approved the recommendations on the priorities for delivery of the Derbyshire Leader programme for 2025/2026.

Information items and matters of interest:
The Committee received an informative update on the new national Extended Social Care Workforce Pathway which will be an important component in developing the social care workforce needed for the future to support the shift from acute into community.

Matters of concern or key areas to escalate::
The need for greater clarity to understand the granular details on the misalignment between WTE numbers and financial pay costs in the monthly workforce and financial reports was a matter for concern and improvement

Derby and Derbyshire Integrated Care Board

Strategic Commissioning and Integration Committee Assurance Report

Meeting Date(s):	8th May 2025 and 12th June 2025
Committee Chair:	Jill Dentith

Assurances Received:

Item	Summary	Previous Level of Assurance	Current Level of Assurance
8th May 2025 meeting Strategic Commissioning and Integration Committee			
Board Assurance Framework	The Strategic Commissioning and Integration Committee discussed the Board Assurance Framework Strategic Risks 2, 7 and 8 for the final quarter 4 2024/25 position then accordingly the opening position of quarter 1 2025/26. The Strategic Commissioning and Integration Committee agreed to keep the quarter 3 risk scores.	**N/A**	**Adequate**
Risk Register Report	The Strategic Commissioning and Integration Committee approved the three proposed new corporate risks, noting the revised risk descriptions for risks 34 and 35, which will be the responsibility of the Strategic Commissioning and Integration Committee.	**Partial**	**Partial**
ICB Policy Position	The Strategic Commissioning and Integration Committee received this report and noted a good level of assurance on the breadth and depth of the commissioning and prioritisation policies in use within the ICB relating to service provision and treatments and noted limited assurance on the effective implementation of those policies at the point of application within provider organisations.	**N/A**	**Partial**
Implementation of Tirzepatide NICE TA	The Strategic Commissioning and Integration Committee considered the progression of the implementation of Tirzepatide NICE TA and agreed the proposed next steps, noting the potential risks and potential financial issues and the need for clear and transparent communication with both providers and the public.	**N/A**	**Adequate**
Population Health and Strategic Commissioning Committee Annual Report and Self-Assessment 2024/25	The Strategic Commissioning and Integration Committee approved the Population Health and Strategic Commissioning Committee's Annual Report 2024/25 and discussed the Population Health and Strategic Commissioning Committee's Self-Assessment 2024/25.	**N/A**	**Full**

Item	Summary	Previous Level of Assurance	Current Level of Assurance
12th June 2025 meeting Strategic Commissioning and Integration Committee			
Board Assurance Framework	The Strategic Commissioning and Integration Committee noted the revised format of the Board Assurance Framework, discussed the current risk scores and approved the Board Assurance Framework Strategic Risks 2,3, 7 and 8 for the final quarter 1 2025/26. The Strategic Commissioning and Integration Committee gave an assurance level of adequate.	**Adequate**	**Adequate**
Risk Register Report	The Strategic Commissioning and Integration Committee received the corporate risks which are the responsibility of the Strategic Commissioning and Integration committee and agreed the assurance level as adequate.	**Partial**	**Adequate**
Status report on all contracts	The Strategic Commissioning and Integration Committee received this report and noted the level of assurance as partial.	**N/A**	**Partial**
Decommissioning and Service change decisions	The Strategic Commissioning and Integration Committee received this report and noted the level of assurance as partial.	**N/A**	**Partial**
Pharmacy, Optometry & Dental Services Update	The Strategic Commissioning and Integration Committee received the Pharmacy, Optometry & Dental Services quarterly report and noted the level of assurance as adequate.	**N/A**	**Adequate**
Clinical Policy Advisory Group – East Midlands IVF Policy Review	The Strategic Commissioning & Integration Committee noted the update on the progress of the East Midlands IVF Policy Review and requested to be kept informed of progress.	**N/A**	**Adequate**
Tirzepatide Update	The Strategic commissioning & Integration Committee noted the structured planning and mitigations in place and acknowledged the ongoing risks. The committee noted an adequate assurance rating.	**Adequate**	**Adequate**
Better Care Fund Update	The Strategic Commissioning & Integration Committee received the Better Care Fund report, considered future reporting to come to the committee and agreed for it to be	**N/A**	**Adequate**

Item	Summary	Previous Level of Assurance	Current Level of Assurance
	added to the forward planner. The committee considered the impact of limited capacity and joint resources in making progress and agreed an adequate assurance rating.		
Women's Health Hub Programme and Gynaecology Elective Recovery	The Strategic Commissioning & Integration Committee received the Women's Health Hub and Gynaecology Elective recovery update reports. The committee noted the progress made to date and the reporting route for Gynaecology Elective Recovery through the Planned Care Deliver Board. The committee agreed an assurance level of adequate.	**N/A**	**Adequate**

Other consideration:

Decisions made:
Not applicable.

Information items and matters of interest:
12th June 2025 Clinical Policy Advisory Group Updates - The Strategic Commissioning & Integration Committee noted the updates from the Clinical Policy Advisory Group and agreed an assurance level of full assurance.

Matters of concern or key areas to escalate:
Nil for escalation

Derby and Derbyshire Integrated Care Board

Quality, Safety and Improvement Committee Assurance Report

Meeting Date(s):	26th June 2025
Committee Chair:	Adedeji Okubadejo

Assurances Received:

Item	Summary	Previous Level of Assurance	Current Level of Assurance	Action	Timescale
Risk Stratification and Harm Review Update Quarter 3 2024 - 2025	The Committee took partial assurance from the report as there is a challenge regarding the data quality, there is further work to do across the system to ensure that this work is more focussed. Later in 2025/26 a regional template will be developed and launched with agreed standardised metrics.	**Partial**	**Partial**	Committee assurance reporting needs to be more data-driven and thematic in its presentation.	By quarter 4 2025/26

Other consideration:

Decisions made:
Board Assurance Framework (BAF) – Quality, Safety and Improvement Committee Strategic Risk 1 – Quarter 1, 2025/26: The Committee agreed that the BAF score remains unchanged at 16 due to the current uncertainty regarding ICB form and function and its system role into 2025/26 and the potential impact on delivery.

Information items and matters of interest:
Operation Periscope: The Committee received an update on Operation Periscope and the use of SPC Charts to enable understanding of the data presented. **25/26 Quality Framework:** The Committee had a verbal update on development which is awaiting the output from provider Quality Accounts and identification of quality priorities from the system Delivery Boards. **Quality Strategy:** The Committee had a verbal update; the team are awaiting the publication of the 10 Year NHS Plan before the strategy can be finalised.

Derby and Derbyshire Integrated Care Board

Information items and matters of interest:
System Quality Group Reports May and June 2025: These reports are presented for information only. **Development Session – Quality and the ICB Blueprint:** The Committee took the opportunity to have a discussion regarding the role of quality going forwards within strategic commissioning organisations.

Matters of concern or key areas to escalate:
Nil of Note

Derby and Derbyshire Integrated Care Board

Joint ICB Transition Committee Assurance Report

Meeting Date(s):	12 and 25 May 2025 – Joint Committee meeting between NHS Derby and Derbyshire ICB and NHS Nottingham and Nottinghamshire ICB 27 June 2025 – Joint Committee meeting between NHS ICB Derby and Derbyshire, NHS Nottingham and Nottinghamshire ICB, and NHS Lincolnshire ICB
Committee Chair:	Margaret Gildea, Senior Non-Executive Member

Assurances Received:

Item	Summary
1. Terms of Reference	The Joint Committee reviewed and endorsed its terms of reference for onward presentation to the three ICB's Boards for approval in July 2025. Members noted that the Joint Committee's primary role was to oversee the transition to a new ICB cluster operating model, seeking assurance on development and delivery of the transition programme plan and the management of transition risks. It was agreed that fortnightly Joint Committee meetings would continue for three months to maintain momentum, to be reviewed again in September 2025.
2. Transition Planning and Financial Modelling	The Joint Committee oversaw the development of the ICBs' planning submissions to NHS England by 30 May 2025, ahead of approval by each ICB's Board. The submissions responded to the mandate to reduce ICB management costs to £18.76 per head of population (subsequently uplifted to £19.00 per head). Members discussed the need to balance national guidance, strategic commissioning needs and talent retention/development, and the importance of establishing robust governance arrangements for the ICB cluster was also emphasised during discussions. A three -phase transition programme was agreed: • Phase 1: Operating model design and management of change. • Phase 2: Function transfer aligned with the Model ICB Blueprint. • Phase 3: Establishment of the future strategic commissioning form.
3. Transition Programme	Members reviewed and approved the programme management arrangements for the transition programme. This included the establishment of an ICB Transition Programme Group that would oversee the work of five operational

Item	Summary
Architecture	workstreams: operating model design; management of change; governance; finance; and stakeholder communications. Members noted the importance of having a single, fair and transparent management of change process and a clear vision across all ICBs to underpin the process. Members also discussed concerns relating to short delivery timelines that were dependent on national guidance and processes and the capacity of staff to manage both transition requirements and their day-to-day duties. Members were assured that a detailed programme plan with milestones and interdependencies was in development, which would be finalised ahead of the next meeting. This would form the basis of future assurance reporting to the Joint Committee.
4. Transition Risk Log	The Joint Committee considered an initial set of transition risks and noted that a consolidated risk log for the ICB cluster was in development, which would be finalised ahead of the next meeting.

Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

17th July 2025

Item: 042

Report Title	ICB Constitution							
Author	Suzanne Pickering, Head of Governance							
Sponsor	Helen Dillistone, Chief of Staff							
Presenters	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Not applicable.							

Recommendations

The ICB Board are recommended to **NOTE** the proposed changes to the ICB Constitution.

Report Summary

It has been confirmed that NHS Derby and Derbyshire ICB will cluster with NHS Nottingham and Nottinghamshire ICB and NHS Lincolnshire ICB.

The clustered ICB will develop a single Board, with a single Chair and Chief Executive. The appointment process for the single Chair is expected to be completed by the end of July 2025, followed by the appointment of the single Chief Executive Officer.

The NHS England model ICB Constitution currently prevents a joint Chief Executive Officer appointment.

The ICB have received advice from the NHS England national legal team to amend clause 3.5 of the ICB constitution, to read as follows allowing joint Chief Executive Officer appointments for the clustering ICBs.

The change to the constitution is shown in red below:

3.5 Chief Executive

3.5.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.5.3 The Chief Executive must fulfil the following additional eligibility criteria:

(a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act; and

(b) meets the requirements as set out in the Chief Executive role description and person specification.

3.5.4 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) subject to clause 3.5.3(a), they hold any other employment or executive role other than Chief Executive or another Integrated Care Board;

(c) the process of disqualification is to be overseen by NHS England and Improvement and the Independent Non-Executive Member for Audit.

Further review and alignment of ICB Constitutions will be required over the coming months to reflect revised Board composition, refine the approach to participants/observers, and align Standing Orders to enable effective running of Cluster Board meetings.

How does this paper support the 3 shifts of the NHS 10-Year Plan?					
From hospital to community	☒	From analogue to digital	☒	From sickness to prevention	☒

Integration with Board Assurance Framework and Key Strategic Risks					
SR1	Safe services with appropriate levels of care	☐	**SR2**	Reducing health inequalities, increase health outcomes and life expectancy	☐
SR3	Population engagement	☐	**SR4**	Sustainable financial position	☐
SR5	Affordable and sustainable workforce	☐	**SR7**	Aligned System decision-making	☒
SR8	Business intelligence and analytical solutions	☐	**SR10**	Digital transformation	☐
SR11	Cyber-attack and disruption	☐			

Conflicts of Interest	None identified.

Have the following been considered and actioned?			
Financial Impact	Yes ☐	No ☐	N/A ☒
Impact Assessments	Yes ☐	No ☐	N/A ☒
Equality Delivery System	Yes ☐	No ☐	N/A ☒
Health Inequalities	Yes ☐	No ☐	N/A ☒
Patient and Public Involvement	Yes ☐	No ☐	N/A ☒
ICS Greener Plan Targets	Yes ☐	No ☐	N/A ☒

Item 044 2025/26 Board Forward Planner – Public

NHS Derby and Derbyshire Integrated Care Board

"To support people in Derby and Derbyshire to live their healthiest lives, creating a sustainable, joined-up health and social care system for now and the future".

Our aims: to **improve outcomes** in population health and healthcare; **tackle inequalities** in outcomes, experiences and access; enhance **productivity and value for money**; and support broader **social and economic development**.

Please note that, for the purposes of this draft, regular items such as Chair, CEO and committee assurance reports have been omitted as they are business as usual.

Agenda item	22 May	17 Jul	18 Sep	20 Nov	22 Jan	17 Mar	Link to BAF	Notes
Leadership and operating context								
Annual Report and Accounts (AGM to follow Sept Board)			✓					
ICB Annual Assessment outcome letter			✓					
Strategy								
Joint Capital Resource Use Strategy and Plan	✓					✓		
ICB Plan for refreshing the Joint Forward Plan in line with 10 year plan	✓							
Joint Forward Plan				✓				
10 Year Health Plan for England		✓						
2025/26 Operational and Financial Strategy and Plans	✓					✓		17th March 2026/27 plans
Financial Recovery Plan and Stocktake					?			
Winter Plan/ Urgent Emergency Care			✓	✓				
Infrastructure/ Estates Strategy				✓				
Working with People and Communities			✓					
Research and Innovation Update					✓			
NHS England Delegations / Specialised Commissioning			✓					
NHS England Delegations / Vaccinations and Screening			✓					
Operating Model Group Pre-Delegation Assessment Framework			✓					
Integrated Care Partnership				✓				
Provider Collaborative at Scale				✓				

2025/26 Board Forward Planner – Public

Agenda item	22 May	17 Jul	18 Sep	20 Nov	22 Jan	17 Mar	Link to BAF	Notes
Neighborhood Health Update	✓		✓					
Shift progress – Sickness to Prevention Update				✓				
Shift progress – Analogue to Digital					✓			
Health Inequalities Statement								
Digital, Data, and Technology Strategy Update					✓			
Cyber Security Strategy								March 2025 Confidential
Primary Care GP Strategy Update						✓		
Blood Enquiry								
Dementia Strategy			✓					
Community Pharmacy Update			✓					
Delivery and performance								
Integrated Performance Status Report • Quality • Performance • Finance • Workforce	✓	✓	✓	✓	✓	✓		
Finance Report	✓	✓	✓	✓	✓	✓		
H1 and H2 Progress against plan				✓				
One Workforce People Plan		✓						
ICB Staff Survey				✓				
ICS Green Plan			✓					
ICB Internal governance and assurance								
Governance								
Board Assurance Framework	✓	✓		✓	✓			Q4 May 2026
ICB Corporate Risk Register Report	✓	✓	✓	✓	✓	✓		

2025/26 Board Forward Planner – Public

Agenda item	22 May	17 Jul	18 Sep	20 Nov	22 Jan	17 Mar	Link to BAF	Notes
Committee Terms of Reference/ ICB Governance Handbook	✓		✓					
Remuneration Committee Assurance report			✓					
Workforce analytics (for example, vacancies, turnover)	✓			✓				
People and culture (for example, staff sickness stats, FTSU)	✓			✓				

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

17th July 2025

Item: 046

Report Title	Intensive and Assertive Community Mental Health Treatment Update							
Author	Dr. Wendy Brown, Toby Marandure (DHcFT)							
Sponsor	Prof. Dean Howells, Chief Nurse Officer							
Presenter	Mark Powell, ICB Partner Member and Chief Executive DHcFT Prof. Dean Howells, Chief Nurse Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices (reports attached)	Appendix 1: Report to DHcFT Board; 3rd June 2025 Appendix 2: Update from the I&A Working Groups.							

Recommendations
The ICB Board are recommended to **NOTE** the Derbyshire Healthcare NHS Foundation Trust progress report (as requested by NHSE to be tabled at the ICB Board meeting) for the Intensive and Assertive Community Mental Health Treatment
Report Summary
Following the publication of the Independent Mental Health Homicide Review into the tragedies in Nottingham, all Integrated Care boards (ICBs) and Mental Health Trusts have been asked to produce an action plan in relation to the findings from the review. DHcFT has formed a multi-disciplinary working group to focus on the key areas identified. All Trust Divisions are represented. The work of this group builds on, and runs alongside, other workstreams relating to Care Quality Commission (CQC) action plans and the Community Mental Health Maturity Index Action Plan. Divisions have submitted information on their current status and have identified areas where improvements are needed. A table is provided in the main report with an overview of the current status and identified actions. Work is ongoing, with some Divisions awaiting finalisation of their action plans. The group has links with the regional programme managers for Community Mental Health at NHS England. They will provide feedback on the work of the group and also updates on regional and national progress.

How does this paper support the 3 shifts of the NHS 10-Year Plan?					
From hospital to community	☒	From analogue to digital	☐	From sickness to prevention	☒

Integration with Board Assurance Framework and Key Strategic Risks					
SR1	Safe services with appropriate levels of care	☒	**SR2**	Reducing health inequalities, increase health outcomes and life expectancy	☒
SR3	Population engagement	☒	**SR4**	Sustainable financial position	☐
SR5	Affordable and sustainable workforce	☐	**SR7**	Aligned System decision-making	☐
SR8	Business intelligence and analytical solutions	☐	**SR10**	Digital transformation	☐
SR11	Cyber-attack and disruption	☐			

Conflicts of Interest	

Have the following been considered and actioned?			
Financial Impact	Yes ☐	No ☐	N/A ☒
Impact Assessments	Yes ☒	No ☐	N/A ☐

Equality Delivery System	Yes ☒	No ☐	N/A ☐
Health Inequalities	Yes ☒	No ☐	N/A ☐
Patient and Public Involvement	Yes ☒	No ☐	N/A ☐
ICS Greener Plan Targets	Yes ☐	No ☐	N/A ☒

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Intensive and Assertive Community Mental Health Treatment Independent Homicide Review - Nottingham

Purpose of Report

To provide the Board of Directors with a progress report into meeting the recommendations from the independent review and The Care Quality Commission (CQC) Section 48 review of Nottinghamshire Healthcare NHS Foundation Trust.

Executive Summary

Following the publication of the Independent Mental Health Homicide Review into the tragedies in Nottingham all Integrated Care boards (ICBs) and Mental Health trusts have been asked to produce an action plan in relation to the findings from the review.

DHcFT has formed a multi-disciplinary working group to focus on the key areas identified. All Trust Divisions are represented. The work of this group builds on, and runs alongside, other workstreams relating to Care Quality Commission (CQC) action plans and the Community Mental Health Maturity Index Action Plan.

Divisions have submitted information on their current status and have identified areas where improvements are needed.

A table is provided in the main report with an overview of the current status and identified actions.

Work is ongoing, with some Divisions awaiting finalisation of their action plans. The group has links with the regional programme managers for Community Mental Health at NHS England. They will provide feedback on the work of the group and also updates on regional and national progress.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

Risks identified are supported by an action plan under review by the chairs of the Group with escalation as required.

Consultation

This paper has been through the Quality and Safeguarding Committee and has been reviewed by members of the Executive Leadership Team.

Governance or Legal Issues

The work is being carried out in line with direction from NHS England to all ICBs and Mental Health trusts.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

Access to services and health inequalities consideration.

Recommendations

The Board of Directors is requested to note the work undertaken to date in ensuring the recommendations from the independent review are being addressed.

Report presented by: **Tumi Banda**
Director of Nursing, AHPs, Quality and Patient Experience

Report prepared by: **Dr Wendy Brown**
Consultant Psychiatrist

Toby Marandure
Head of Nursing

Update from DHcFT working group on actions from the Independent Mental Health Homicide Review into the tragedies in Nottingham

Background

The Board is asked to discuss the action plan and progress in taking forward to improve the intensive and assertive community treatment for people with mental illness as set out by NHSE in February 2025.

On 5 February 2025, all Integrated Care Boards (ICBs) and Mental Health trusts received a letter from the National Director for Mental Health, Learning Disability and Autism and the Medical Director for Mental Health and Neurodiversity from NHS England. In this letter, it is stated that Mr Valdo Calocane, a patient experiencing serious mental illness, was failed by mental health services, which had devastating consequences.

Whilst acknowledging the work already undertaken by services, the letter sets out the next steps. It asks services to review local actions plans with particular attention to:

1) Personalised assessment of risk across community and inpatient teams
2) Joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies)
3) Multi-agency working and information sharing
4) Working closely with families
5) Eliminating out of area placements in line with ICB three-year plans.

In February 2025, NHS England published an Independent Mental Health Homicide Investigation. This was into the events in June 2023 in Nottingham when three people lost their lives.

In 2024, the Care Quality Commission published "Learning from the Nottinghamshire Healthcare Section 48 reviews" in two main parts. The Section 48 review of Nottinghamshire Healthcare NHS Foundation Trust was commissioned by the Secretary of State for Health and Social Care in response to the conviction of Valdo Calocane. The review aimed to assess patient safety, quality of care, and systemic issues within the Trust's mental health services, with a particular focus on the care provided to Valdo Calocane.

Part 1 (Published March 2024):

- Assessed patient safety and quality of care at Nottinghamshire Healthcare NHS Foundation Trust
- Focused on demand for services, access to care, quality of care, staffing, and leadership
- Included a review of progress at Rampton Hospital since the last inspection in July 2023
- Identified significant failings in the Trust's ability to manage service demand, staffing, and leadership, prompting the Trust to begin addressing these risks through an Improvement Plan.

Part 2 (Published August 2024):

- Provided a rapid review of evidence related to the care of Valdo Calocane
- Further examined systemic issues in community mental health care, particularly in care co-ordination, medication management, and discharge planning
- Benchmarked the Trust's services against findings from the reviews.

Learning and Response to the reviews, Part 1 and 2 the Trust has taken learning from the two reviews and work with partners to implement the actions as follows:

- Following the reviews, the Trust completed the Integrated Care Boards (ICB) Review Outcome Template and the ICB Maturity Index Self-Assessment Tool. These tools are designed to ensure that recommended actions are embedded within senior governance structures at both the Trust and ICB levels
- The ICB Review Outcome Template is mandatory and was submitted by 30 September 2024. These processes support structured evaluation and readiness for providing effective Assertive

Outreach (AO) and Intensive Community Support, aligning with NHS operational planning guidance for 2024/25.

Workshops and collaborative sessions were held to address key learning areas such as care co-ordination (identifying gaps in how patients with complex needs are managed across services), medication management (reviewing monitoring medication in the community), discharge planning (planning and supporting safe transitions from inpatient to community care), management of non-engagement (emphasizing the need for assertive approaches to patients who disengage from services), listening to families (stressing the importance of incorporating family input into care decisions) and risk assessment (underlining the need for robust and ongoing risk assessments, especially for high-risk individuals).

A summary of the risks and mitigations associated with this work is presented in the table below. The organisational risk is captured in the Board Assurance Framework under Risk 1, *"There is a risk that the Trust will fail to provide standards for safety, and effectiveness as required by our patients, regulators, partners and our Board, there is also a risk of poor patient experience and outcomes*".

Area	Mitigation	Risks
Identification of AO patients	Management and Supervision Tool (MaST) is being used to identify AO case and these are then allocated to the AO worker/AO waiting list. AO standard operating procedure in place. AO worker funding is ringfenced.	Some AO workers continue to have high caseloads numbers and mixed caseloads. It is anticipated that numbers will increase as identification methods become more robust.
Risk management	Daily safety huddles to identify increasing risk. Forensic CMHT supervision and social supervision as needed.	Training specific to AO workers needed. Documentation quality need to be improved on the electronic record systems.
Carer involvement	Carer dashboard is being used by AO workers and CMHT staff.	Increased awareness across all teams of the carer dashboard.
Care plans/risk assessments	Quality Dashboards, clinical audits, Fundamental standards of care review, crosscheck meetings, managerial supervision and caseload management. Clarification of the care standards to community staff.	Access to psychological interventions difficult. Quality of care plans can be variable. Care Programme Approach (CPA) compliance is below the expected targets. Care plan and Risk management documentation standard is variable. Care plan and risk management require improvement in involving carers
Discharge processes	Policies amended to ensure that non engagement is not a reason for discharge. Clinical supervision to ensure discharge decisions are multidisciplinary and include inpatient and community teams.	Challenges to co-produce discharge planning with both the person and their families.
Flow	Step up and step-down processes according to need.	Consistency of AO review meetings across teams. Capacity for consultants to do home visits. Robust caseload management required for stepping treatment up or down.

The Trust and Integrated Care Board (ICB) are aligning self-assessment findings with current improvement programmes and developing targeted action plans to drive quality enhancement. Between March and April 2025, the Adults of Working Age Community Mental Health Teams (CMHT) conducted Fundamental of Care Standards visits across 10 teams, interviewing 50 staff and reviewing 164 patient records from various service pathways in the Adult CMHTs. These visits were tailored to incorporate learning from the Section 48 Independent enquiry into Nottinghamshire Healthcare and were mapped to the Care Quality Commission's (CQC) 10 Fundamental Standards of Care.

The ongoing Fundamental of Care Standards reviews will provide assurance to the Adult CMHT Community Operational and Assurance Team (COAT), with findings reported to the Quality and Safeguarding Committee.

In March and April 2025, Fundamental Standard Reviews were completed in line with the highlighted areas in the independent review and Care Quality Commission (CQC) Single Assessment Framework. All the community teams are being supported with areas of improvement identified. Quality visits will continue across all services to ensure sustained improvement and readiness for future CQC inspections. Additionally, the standards will be monitored through weekly cross-check meetings in Adult CMHTs, Inpatients and as a standing agenda item at Clinical Reference Group meetings, with oversight provided by COAT and feedback delivered to Performance Review Meetings and the Trust Leadership Team. The Fundamental of Care visits are scheduled to be repeated in three months to ensure continuous improvement and effective implementation of action plans.

In January 2025, a paper was presented to the DHcFT Executive Leadership Team (ELT) to provide an overview of the current Assertive Outreach (AO) Offer in the Trust and an options appraisal for a future model of Assertive Outreach. Feedback provided from ELT was that the favoured model would be a stand-alone AO team. The future model came from a specific request from NHSE, this was an ask but not a promise to fund.

The investment required is £3m recurrent and £1.6m non-recurrent.

Delivery of the action plan and progress

DHcFT has set up a working group to focus on these actions detailed by NHSE in February 2025. The group is multi-disciplinary, with representation from across all the Trust's Divisions. The group is chaired by a Consultant Psychiatrist and Head of Nursing.

The group is aware that a significant amount of work is already underway in DHcFT, working closely with the system partners, which relates to the findings of the independent report. The group aims to work with the key leads of this work to avoid any unnecessary duplication and ensure collation of information. The work of this group should therefore be considered alongside work undertaken by DHcFT as part of CQC action plans and prior work on the Community Mental Health Maturity Index Action Plan.

The working group will continue to identify, and address identified gaps in each of the key areas of the action plan. The group will continue to meet monthly. Input from NHS England Community Mental Health Programme Managers is planned to provide support to the group. There will be updates provided from the regional/national teams every six months. It is envisaged that the action plans will be monitored via Divisional governance structures in due course. The Trust is engaged in the consultation by NHSE to deliver the Personalised Care Framework to replace the CPA. This framework will also focus on working with families and it is due to be published by end of summer 2025 and the Trust will adopt the framework with a programme transformation programme to transition from CPA.

Please note that point 5) above (Eliminating Out of area Placements in line with ICB three-year plans) forms part the ongoing work of a separate group within DHCFT and is not within the scope of this working group. However the has been progress made to reduce out area placement with various initiatives put in place. The trust finished the year 2024/25 March 31st with 4 Out of area placements. There is fortnightly Flow Escalation meeting chaired by Chief Executive that has been focusing on delivery of rapid acceleration of the 10 High Impact Actions for Discharge.

Below is a summary table capturing an overview of the work so far.

Next steps from NHSE letter	Recommendation from report	Current situation	Identified gaps/risks	Actions needed/timeframe
PERSONALISED ASSESSMENT OF RISK	The recommendation was a National Recommendation for NHS England. However, there is overlap with the care planning recommendation below.	Services complete the risk assessment and care plans as per Trust policy and are monitored through regular audit. Improvement plans are in place for areas where audit standards are not met. Specialist risk assessments are used in some areas of the Trust, eg Forensic and Rehabilitation settings. We currently have an electronic system to pro-actively identify patients at risk.	Substance Misuse Services work from a different module of the electronic patient record. Information, eg risk assessments do not necessarily follow the patient when they become involved in another part of the service. All staff do however have read only access to the substance misuse module. There is no Trust/System or Nationwide database to record those patients with section 117 entitlement*. This would help to pro-actively support those patients with severe and enduring mental illness and also identify those who may be at risk.	Promotion of co-production and exploration of the use of Advance Choice Documents/Advance statements. September 2025 to align with Move Away from CPA. We will roll out our Safety Planning Training which is aligned to Personalised Assessment of Risk before end of 2025, as this will enable clinical practice to move away from risk stratification in an evidence-based way.

Next steps from NHSE letter	Recommendation from report	Current situation	Identified gaps/risks	Actions needed/timeframe
JOINT DISCHARGE PLANNING ARRANGEMENTS between the person, their family, the inpatient and community team (alongside other involved agencies)	The Trust must have processes in place to assure themselves that people who use mental health services, their families, carers and/or support network co-produce care plans. Individuals who use services should be involved in their own personal safety planning arrangements including scenario planning.	CPA** and core care standard principles are in place. This is the framework through which safe discharge planning takes place.	Improvement in processes for pro-actively identifying patients with substance misuse and informing and involving substance misuse services when patients are discharged from inpatient care. Current situation is not consistent. Nationally there is a move away from CPA however, CPA is still in place within DHcFT.	Under review by working group. Action plan to be developed in conjunction with divisional representatives. September 2025 to align with NHSE guidance of Move Away from CPA. Reinforcing message that CPA is still in place within DHcFT is necessary. The Trust will implement the Personalised Care Framework when published by NHSE by end of summer 2025.

Next steps from NHSE letter	Recommendation from report	Current situation	Identified gaps/risks	Actions needed/timeframe
MULTI AGENCY WORKING AND DECISION MAKING	The Trust should develop inter-operable systems and processes to enable sharing of necessary clinical and risk-related patient data across clinical care settings. This should include sharing and increasing the visibility of information across primary and secondary care (NHS & independent providers). The purpose of this is to enable shared decision making and risk management with up-to-date information whilst remaining mindful of a person's privacy when identifying necessary information to share. The Trust, the Integrated Care Board and system partners (for example the Police) should review and evidence the effectiveness and reliability of communication processes across all system partners relevant to mental health care, treatment and risk management.	CPA and core care standard principles are in place. This framework allows for the regular review of the care plan with all involved agencies. This is monitored through care planning audits.	Lack of timely process for staff to obtain risk information from police/safeguarding. Staff request information sharing protocol to be developed.	Review how best to share intelligence with system partners i.e. police, Housing associations, without the breach of patients' privacy and confidently. September 2025, this will with be in line with other pieces of work, ie Right Care Right Person.

Next steps from NHSE letter	Recommendation from report	Current situation	Identified gaps/risks	Actions needed/timeframe
WORKING CLOSELY WITH FAMILIES	The Trust should define what positive family engagement looks like. The offer should be developed with people with lived experience – including people who use services, their families, carers or support network, and be informed by all available information. The Trust should then develop processes, in line with national guidance (ie the Triangle of Care and the Patient and carer race equality framework), to support effective family engagement. The new processes should inform decisions on care, treatment and the management of both safety and risks.	Carer involvement leads actively involved in working group. DHcFT is a Triangle of care level two organisation. Teams complete self-assessment. Triangle of care training is compulsory for all staff. The carer dashboard is available on the EPR. Services have staff who are carer champions.	Carer leads are developing guidance for staff about information sharing with families/carer's when there are risk concern's and patient consent to share information is an issue.	Flow- chart to clearly show when to share information with families where consent is not given. September 2025, this will align with the work from CPA, Care Standards and Carer Co-ordinator. Use of PROMs like Dialog plus will help us embed meaningful involvement from families – May 2026.

* Section 117 entitlement – this refers to a section of the Mental Health Act relating to aftercare for individuals who have been detained under specific sections of the Mental Health Act. It mandates the NHS and social care to provide free after care to these individuals. The aim is to support individuals to remain well and prevent readmissions to hospital.

**CPA is the Care Programme Approach. This is a framework used to co-ordinate and deliver care for individuals with complex needs. It involves development and review of a care plan.