NHS
Derby and Derbyshire
Integrated Care Board

MINUTES OF THE POPULATION HEALTH AND STRATEGIC COMMISSIONING COMMITTEE

STRATEGIC SESSION

HELD ON THURSDAY 23RD OCTOBER 2024, 9.00AM – 11:30AM

MS TEAMS

Present:		
Richard Wright **(CHAIR)**	RW	Non Executive Director, NHS Derby and Derbyshire ICB
Michelle Arrowsmith	MA	Chief Strategy & Delivery Officer, Deputy CEO, Executive lead for PHSCC, DDICB
Robyn Dewis	RD	Director of Public Health, Derby City Council
Wynne Garnett	WG	Programme Lead - Engaging the VCSE sector in the Derbyshire Integrated Care System
Margaret Gildea	MG	Non Executive Member for People & Culture, DDICB
Tamsin Hooton	TH	Programme Director, Provider Collaborative
Ellie Houlston	EH	Director of Public Health, Derbyshire County Council
Steve Hulme	SH	Chief Pharmacy Officer, DDICB
Clive Newman	CN	Director of Primary Care , DDICB
Emma Pizzey	EP	GP representative
Lee Radford	LR	Chief People Officer, DDICB
Suneeta Teckchandani	ST	Consultant Physician in Acute Medicine, Secondary Care Representative
Chris Weiner	CW	Executive Medical Director, DDICB
In Attendance:		
Angela Deakin	AD	Assistant Director for Integrated Programme Delivery, Place & Partnerships, DDICB
Slakahan Dhadli	SD	Associate Director of Clinical Policies & Evidenced Based Medicine, DDICB
Jo Hunter	JH	Deputy Chief Nurse, DDICB
Emma Ince	EI	Director of Delivery, DDICB
Kathy McLean	KM	Chair, DDICB
Prasanth Peddaayyavarla	PP	Associate Director, Business Intelligence, DDICB
Usman Niazi	UN	Client Manager, 360 Assurance
Minute Taker:		
Victoria Wright	VW	Executive Assistant, DDICB
Apologies:		
Avi Bhatia	AB	Representative for Clinical and Professional Leadership Group
Penny Blackwell	PB	Integrated Place Executive Chair, DDICB
Craig Cook	CC	Director of Strategy & Planning, DDICB
Dean Howells	DH	Chief Nursing Officer, DDICB
Adedeji Okubadejo	AO	Non-Exec Director & Chair of the Quality & Performance Committee, DDICB
Lucy Smith	LS	Lead for Allied Health Professionals, CRH

Item No.	Item	Action
PHSCC/2425/78	**Welcome, introductions and apologies** The Chair welcomed everyone to the meeting. The above apologies were noted as were the values and purposes of the Committee: Our Values & Purpose: *In delivering their roles and responsibilities, the Committee shall undertake to contribute towards delivery of the following key purposes of an Integrated Care System:* • *Strive to improve the outcomes in population health and healthcare.* • *Tackle inequalities in outcomes, experience, and access.* • *Enhance productivity and value for money; and* • *Assist the NHS in supporting broader social and economic development.* The Chair informed the meeting that this would be his last meeting as he will be retiring on 8th November. He extended his thanks to the committee. Michelle Arrowsmith (MA) thanked the Chair for his support to both and the ICB, congratulated him on his retirement and sent her best wishes. The committee members echoed MA's sentiment. Chris Weiner (CW) introduced Prasanth Peddaayyavarla to the committee who has just joined the ICB as Associate Director, Business Intelligence and was attending to observe as part of his induction. Apologies were noted as listed above.	
PHSCC/2425/79	**Confirmation of quoracy** The meeting was confirmed as not quorate at time of this item as there was not a System Non Executive at the meeting. The Chair confirmed that any decisions would be ratified appropriately after the meeting if necessary.	
PHSCC/2425/80	**Declarations of Interest** The Chair reminded Committee members of their obligation to declare any interest they may have on any issues arising at Committee meetings which might conflict with the business of the ICB. There were no interests declared.	

Minutes & Matters Arising		
PHSCC/2425/81	**Minutes from the meeting held on 8th August** The minutes from the meetings held on 8th August were agreed as a true and accurate record.	
PHSCC/2425/82	**Action log from the meetings held on 8th August** The Committee agreed to close all actions except action PHSCC/2425/28. NB: In relation to PHSCC/2425/28, Emma Pizzey (EP) declared on the meeting chat that she has now completed her Declaration of Interest form so this item will be requested to be closed at the next meeting.	
Scene Setting		
PHSCC/2425/83	**Terms of Reference** *Kathy McLean (KM) and Ellie Houlston (EH) joined the meeting during this item.* MA has updated the Terms of Reference based on previous discussions at this Committee. There has been a change to membership of the Committee in the document and a change to clarify the purpose of Committee with reference to the Joint Forward Plan, the Operational plan, Prevention, Health Inequalities and bringing Place more front and centre. Cost saving references regarding financial savings have been removed but there is acknowledgment of plans needing to keep within the financial envelope. MA asked the Committee to ratify the Terms of Reference whilst being mindful that there may be future tweaks with Kathy McLean (KM) undertaking a review of DDICB Committees. KM confirmed there may be further changes required to ensure all committees are in line and the review is happening over the next few months. **Key discussion points:** • Steve Hulme (SH) asked for clarification regarding voting members and if there is confidence that it adds value to other committees where decisions are made – eg: the Executive meeting and the Board. He queried if there is enough difference to ensure that the same people are not making the same decisions. • The Chair commented to say that the Terms of Reference focus on the Committee's forward facing direction, looking 3,4,5 years ahead and are indicative of the intention of the gradual shift from treatment to prevention and focus on	

	inequalities and strategic commissioning. The Chair said he felt the new Terms of Reference simplify what this Committee has got to be really focused on for it to deliver the strategy of the system. • MA expressed that it is rare that the committee has needed to vote on anything but when it does need to vote there needs to be a core membership. This Committee has such a broad remit, if a vote is required, there should be a core assurance membership that does that. • WG wanted to reflect on assessing and tracking risks. The Integrated Care Strategy highlights the system's commitment and desire to see a sustainable and diverse VCSE sector as a key part of the left shift and the move to prevention, but in recent months, some initiatives seem to have undermined that direction of travel. How does the Committee ensure it is looking that level of risk, how will it track it and pick up on things that need to be reflected upon. • RW replied that WG's comment is a prime example of why he as a VCSE representative has been added to the membership of the Committee - to be able to raise issues as they arise. It is acknowledged that we can't deliver prevention and better community services without local authorities and the voluntary sector being on board and this Committee about is about looking at what the Executive are doing, getting assurance that everything is going in the right direction and feedback where there could be risks or things not happening. **The Population Health and Strategic Commissioning Committee members attending the meeting ratified the new Terms of Reference.**	
Corporate Assurance		
PHSCC/2425/84	**BAF & Risk Register update** MA explained how she and Rosalie Whitehead (ICB Risk Management & Legal Assurance Manager) have looked at the Committee's BAF risk scoring on a line by line basis. It was identified that there are actions happening in each risk and that the development of Operation Periscope will support Strategic risk 7 & 8 but it was felt that there has not been enough change to improve the scoring. MA asked for the Committee's view on this. **Key discussion points:** • EP highlighted that the risk scoring has not been reduced from when the risks were first adopted by the Committee. She questioned whether the scoring is too difficult to move and therefore whether the risks be on the risk register at all or is it that we are we not doing enough to try and reduce the risk?	

	• CW acknowledged that Strategic Risk 8 has been at a high level for a significant period of time but will reduce significantly over the next three months. The first formal draft of Operation Periscope will be delivered in December of this year and there will be continual development of the model of sharing intelligence to drive improvement. With the appointment of Prasanth, there is someone now to drive the intelligence led decision making for the system. The risk will reduce but it has taken some time to get to this point. • Robyn Dewis (RD) stated that Risk 9 feels like an issue and reflective of the current position and rather than a risk. • CW agreed with RD that there are ongoing issues around Risk 9 and that there is the possibility of making decisions which could widen health inequalities and increase the level of risk that our community faces. There are decisions which haven't been made yet that would influence the future so he believes it is a risk. • In relation to Risk 9, Margaret Gildea (MG) highlighted how not every organization is able to support the strategic direction regarding prevention and reducing health inequalities because of external and cost pressures so this risk could become more acute. • MA acknowledged EP's comment to say that this is a dynamic environment and that it is a challenge to shift the risk scores. Attention needs to be focused on how are we managing the risks and having the risks at top of agenda when decision making is important. • KM reported that there was a recent Board session on BAF where there was debate on the issues that have been raised at this Committee but that the BAF is going to be reviewed. • The Chair stressed the need to ensure that views of population are considered when the Committee makes decisions. He reminded the Committee that the BAF is system wide, this Committee has responsibility for assurance against three risks and it needs to be mindful of the risks in discussions and decision making. **The Population Health and Strategic Commissioning Committee DISCUSSED the Board Assurance Framework Strategic Risks 7, 8 and 9 for the final quarter 2 2024/25 position and REVIEWED the current risk scores and assurance levels for the Strategic Risks 7, 8 and 9.**	
PHSCC/2425/85	**Performance against strategic direction** **This was noted as a Confidential Item.** MA gave an overview on the position with the 24/25 Operational plan and explained that there has been a H1 stocktake against the plan looking at finance, activity and workforce across the system. MA detailed the performance element of the stocktake with the Committee.	

	Urgent and Emergency Care through H1 has been difficult but looking at the activity data, demand is not the overriding factor. There has been some demand increase but length of stay and bed occupancy have also been critical factors. The 4 hour performance has deteriorated and the C2 response time has been 35 minutes rather than 30 planned with the national target being 18 minutes. Handover delays are 52% more than plan. There are challenges around Urgent Treatment Centres and this is affecting the RDH ED. There is not sufficient data currently available to know if GP collective action is affecting the UEC position. There are challenges emerging around District nursing teams which will be dealt with and there has been some protracted long waits for mental health patients both in the Eds and in the community. There has been some good headway with medically fit for discharge work, Team Up work and Urgent community response within the Place arena and there will be some review of what further impact could be made with the current funding. Planned Care performance has been good, particularly at UHDB, but significant funding has gone in to deliver the plan. However, there is a deteriorating position at CRH with Elective and Cancer performance which is being monitored. There has been some really good performance with Cancer activity but there are some Cancer tumour sites where we know we're not doing well on performance which can be masked in the aggregate position so this is being carefully monitored. Community long waits are tracking higher than planned to be. The system are doing well against the Mental Health targets. However, there has been significant investment and some suggestion that the targets are not stretching enough against the amount of investment. There are a number of actions that have arisen through the Stocktake which will be taken forward through the relevant Delivery Boards. **Key discussion points:** • MG queried what are we actually able to do to try and improve in second half of year? • MA responded to say that regarding UEC specifically, there are a number of actions which the Silver command group are taking forward around decompressing ED, and through the stocktake, we are looking at what else can be done within the hospital. With Planned Care, there are areas with which to work together with other partners but it will depend on the triangulation with workforce and money. A lot of	

	investment has gone into Planned Care so we will be looking at what further can be done to improve/maintain performance. There is a weekly meeting in place with NHSE on UEC and Elective and Cancer so we are scrutinised from an assurance perspective. • Suneeta Teckchandani (ST) queried whether it was in the Committees' remit to be looking at difficulties with clinic space that can affect outpatient numbers as is the case with Chesterfield. • MA confirmed this is something that would be picked up in the Planned Care Delivery Board. • EP reported that there is also a big problem with Estates in Primary care which is limiting capacity. EP also said that with regards to targets being met around mental health, the position is likely to deteriorate with many providers closing waiting lists due to overwhelming demand and so it is difficult to find services in which to refer. • MA responded to say that the stocktake specifically looked at performance against the operational plan and there is awareness that there are some risks starting to emerge in H2. Several areas were picked up in discussions and there are some actions to go back through MHLDA delivery board. There are areas to look at to be driving forward in terms of longer term plans but also a need to deliver on the current operational plan. Angela Deakin (AD) then presented a stocktake that has been undertaken to understand the projects and activities being delivered in Place & Partnerships arena. The stocktake was split into four categories of work: Integrated Programme Delivery Team, Team Up, Major Conditions Strategy and the Partnership Team. There is a detailed overview on what is happening on the tool but then different areas have been broken down into further detail. The next phases of this project would be looking at having an detailed interactive map of the geographical area, where you can click on an area to drill down into what is happening and to continue to develop this by mapping to any relevant strategies - including outcomes where applicable- and impact measures linked to performance and/or national targets. Also to create Logic Models for Prevention and Health Inequalities. AD wanted to ask the Committee if they had any suggestions for any other links that could be made and whether the development of an Integrated Prevention Strategy would be something the committee be willing to support? **Key discussion points:** • The Chair acknowledged this tool was a work in progress but felt this was a good management tool for showing what Place is delivering, for looking at consistency across the patch, highlighting where there are gaps and giving	

	assurance to the Committee that we are we filling those gaps. • KM queried whether there was a way to be able to click on the map and for it to be able to show granular information to determine what the population health state is around areas like Hypertension and Smoking levels. • AD replied to say the team have the information so it could be something that could be added but will send KM the information in the meantime. • WG fed back from a recent meeting of VCSE reps across the system and queried whether this stocktake could also include prevention work that is taking place so there is no possibility of missing what is already happening. WG also highlighted issues around access to services in border areas and where people are going cross border for some services and that local Place alliances are not all consistent. WG also highlighted that the Joy platform that is contained within this and this has now been completed but is not being funded so is not going forward. • MG confirmed that she would be supportive of the development of integrated prevention strategy. • TH complimented AD and her Team for their work on this and felt that the stocktake really helps to get to the better understanding of what the different places are working on and whether there is a strategic improvement objective for them to start on. • EP also felt this was a good tool and supported having the population health data embedded within it too. EP also said that she supported the idea of an integrated prevention strategy. • MA reiterated the Committee's view that this is a great piece of work and that it is an evolving piece of work which should come periodically to the Committee to both show the progress of the work and also look at what the tool is showing us performance wise, which Prasanth and his team would be able to support and can be viewed alongside the Operation Periscope work. MA felt the tool should not be circulated with it being an evolving piece of work but for people who have a particular interest to contact Angela who will walk them through it in more detail and can take ideas on further development. **The Population Health and Strategic Commissioning Committee NOTED the Stocktake.** *KM left the meeting.*	
Strategic Commissioning		
PHSCC/2425/86	**Commissioning and Procurement:** • Subgroup report • Future Commissioning and Procurement Intentions	

	The paper was taken as read by the Committee. Appendix B on the Accreditation of Community Health & Eye Care (CHEC) to provide elective ophthalmic services was highlighted to the Committee. MA pointed out that the Commissioning and Procurement subgroup was still in its infancy but the group is evolving and moving forward. We are starting to see improvement in getting a view in all procurement going on, commissioning going ahead and ensuring that we are within the right realms of the PSR. With regards to PSR, there are a couple of pieces of work going through Audit committee that will support that along with some lessons learnt from recent procurements. RW indicated that this was report was an important paper as how we contract sets the tone of what is delivered two to three years ahead. The paper from this subgroup will form the basis of the commissioning intentions going forward to deliver the strategy we want to deliver. MA commented that looking at the commissioning and procurement plan will form part of 25/26 planning WG asked about having some input onto the subgroup to be able give a voice to the VCSE issues relating to procurement and commissioning. MA agreed this would be a good idea. It was decide that MA and WG would pick this up outside of the meeting. **The Population Health and Strategic Commissioning Committee are NOTED the Commissioning and Procurement Subgroup report.**	**MA/WG**
PHSCC/2425/87	**All Age Continuing Care – Risks of Implementation of 2 x CIP Schemes** **This was noted as a Confidential Item.** The paper was taken as read. JH asked to seek the opinion of the Committee on the proposed AACC Cost Improvement Schemes which will significantly contribute to achieving the £9.7m savings required from the AACC budget. Both schemes are contentious and present a number of risks which this Committee are asked to consider prior to the ICB Board receiving the report for approval. JH explained that this paper has been worked through for nine months and it has been discussed at length at the ICB Executive meeting. The proposals have been to the QEIA group who felt that they were very high risk. This will be going to ICB Board this month. DDICB are not alone to be looking at the 2nd scheme - involving using AQP providers because this is one of a number of proposals that have been put forward by ICBs. The advice from the centre was that it is something that can be considered, but there will be exceptions particularly around people who've lived where they live for a long period of time. JH wanted to reiterate that she and the ICB are fully sighted on what the proposal means and that all	

	comments made in this meeting will go into the paper to go to Board. **Key discussion points:** • EP stated that she appreciated this to be a difficult situation but queried whether the savings to be made are worthy of the trauma and upset for patients and families plus the hassle, complaints, agitation and work and potential reputational damage that this will generate for the ICB. Does the cost balance? Is the saving worth the potential risk? • JH confirmed these discussions have taken place and this is how it was discussed at the Executive meeting. • The Chair highlighted that the savings have to be found somewhere, if not here, elsewhere. • With regards to the first proposal, RD asked whether there is an understanding of the implications for hospital discharge? With Winter coming up, there is considerable pressure on beds and finding placements. Is there going to be consequences with that? Will there be a significant impact on costs there which will mean that potential savings through the CIP scheme are not recognised. • JH responded to say that this had been considered as these are challenging placements to find but that there is a robust market and either or both of these suggested projects could have an impact on discharge. One of the issues is that there has already been significant savings made with the CHC budget so the budget is already tightly run but these savings are not sufficient for the target set. JH expressed the need to consider that this is a care budget for people entitled to NHS care, the same as if they were occupying NHS beds. • TH supported RD's comment and wanted to stress the importance of implementation of the schemes proposed to be implemented with some degree of flexibility and pragmatism to reduce unintended consequences such as delayed discharge. • JH said there will need to be flexibility as there are cohorts of patients for whom it would not be appropriate. JH also stated that there almost certainly would need to be a consultation on this and that complaints and legal action MP visits have been considered in the conversations that have been had with the senior staff of the ICB. **The Population Health and Strategic Commissioning Committee are recommended to DISCUSSED and COMMENTED on the All-Age Continuing Care – Risks of Implementation of CIP Schemes.**	
PHSCC/2425/88	**IVF Services Review** The paper was taken as read. Steve Hulme (SH) explained that the paper had been submitted so that the Committee were aware of	

	work going on across East Midlands and also for governance purposes to note the next steps of the review. The work being undertaken is to align East Midlands policies in terms of aims with regards to IVF and reflects boundary changes - particularly for us with Glossop joining the patch and their differences with their fertility policy in relation to the number of IVF cycles. This is to bring a case for change and may lead to consultation and policy change. The first step with this is a Pre-engagement exercise which will begin in November and then next steps will be considered based on the responses following the exercise. **Key discussion points:** • The Chair queried as to whether any particular needs we have in Derby/Derbyshire would be considered. • SH said that this is not to pre-empt what to put in our policy but we may choose to adopt a new Midlands approach in its entirety. We do have local policies which are up to date and are largely aligned with what is being proposed. But there are some differences which are highlighted in the paper. • RD commented that these policies create a high level of work from IFR perspective and create a big challenge with regards to equity and that she would support having an East Midlands' wide policy. She noted that proposed changes with Gamete storage limits may cause potential response from the community. • SH acknowledged that the Gamete issue was picked up through CPAG discussions and is going to go back to the Midlands group to try and understand the proposal but feedback from stakeholders may change things. **The Population Health and Strategic Commissioning Committee NOTED "case for change" proposal which has been agreed by the East Midlands Review Group in preparation for the commencement of the pre-engagement phase.**	
Population Health		
PHSCC/2425/89	**Seasonal Plan update** Emma Ince (EI) presented the seasonal plan summary. The ICB are currently in the final stages of planning for Winter and EI wanted to focus committee on 4 areas within the plan - the Approach to Winter planning inc NHSE requirements, an assessment of the capacity in the system to manage the expected demand, the risks and mitigations, and the escalation and oversight arrangements. In terms of approach, the ICB has worked collaboratively with partners, starting with a review of Winter 2023/24. This resulted in	

	a set of priorities in which all partners are committed to reflecting in their organisational plans. A seasonal planning group has been set up which has good representation from regional partners working through the requirements for this current year. The ICB also attended the regional Winter summit that was hosted by NHSE in September. NHSE sent a letter in mid September setting out requirements of what systems need to have in place for Winter and we have a comprehensive, Urgent Emergency Care recovery plan already and are working on a set of high impact interventions. The plans that we are in place already as a system work through the Urgent Care pathway in three segments, so inflow, flow and outflow. We have mapped back what the Winter letter requirements are, what is already underway as part of the recovery plan, and the high impact interventions, and where we are as a system against those. This information across these three areas was used to inform the key lines of enquiry response that went to NHS England and they have assessed both our contribution at the Winter Summit and our response as part of the key lines of enquiry and feedback an overall mid to high level of assurance in our preparedness as a system. There will be a weekly Winter monitoring group starting on 6th November which will continue through until March which will review any changes to the expected demand profile that people have worked to for Winter and will monitor the delivery of capacity generating plans that are in place. There is indication that there is enough capacity within the system to meet demand but that it is challenging and there is risk, but that there is a level of mitigation that sits within individual organisational plans. Another part of this group's role will be to oversee and manage any changes to that risk profile and any mitigation that's needed to be put in place. There is an already established System Co-ordination Centre, which will become a physical 'Winter room' from 1st Nov based in Scarsdale. In terms of prevention, there is the vaccination programme, infection prevention and control arrangements and there are escalation and monitoring arrangements over Winter above those that are business as usual including trialling extending the opening hours of SCC over Winter til 8pm to see if there is any value from a system perspective and the new 'Winter room' will instigate an incident management team approach. There is also a piece of work underway at the moment reviewing the escalation processes in place, ensuring that the triggers and thresholds are right and that will be tested as part of some scenario testing ahead of Winter to see whether those escalation processes are proportionate and add value, and some work planned on digital and data flows with the intention of replacing the OPEL reporting with a SHREWD dashboard to give a more comprehensive view of the operating environment.	

	There is also a Winter Communications plan focused on enhancing public education. **Key discussion points:** • RD queried a note on the slide regarding IPC which said that the IPC services provided by UHDB and CRH cover Care Homes. RD clarified that this service does not support Care Homes and that there is a gap in the system. • EI confirmed this will be corrected in this presentation and the wider plans. • MA said that Care Homes need some support and that there needs to be a conversation regarding what is and isn't commissioned. • JH confirmed that when the resource was moved to the acutes, the intention was that it should cover care homes but it does not. This is essential to ensure delivery of Winter plan. • EI mentioned that there is a section on infection prevention control in the current Urgent Emergency Care rapid action Plan where we can pick up and escalate that action ahead of Winter to make sure it's included in the plans and she will link in with Tracy Burton (under whose portfolio this is) around that. • ST commented that looking at patients avoiding ED would be one of the first areas to look at and also outflow where there is medically fit for discharge patients are waiting to be discharged.	**EI**
PHSCC/2425/90	**CVD Prevention Plan** CW explained how Cardiovascular Disease remains the single biggest killer in the community and how one of the greatest determining factors to this is Hypertension. If Hypertension is treated then the risk of a cardiovascular event decreases over 12 to 16 weeks. It is also great source of health inequality - if you live in the most deprived decile, you are probably around about 3 to 3.5 times more likely to have a cardiovascular event than somebody living in the least deprived decile. This equates to around 100,000 people across Derbyshire. There is an exceptionally good hypertension identification programme delivered by GPs across Derby and Derbyshire but there is also the greatest inequality between least and most deprived areas in identifying hypertension. There currently is no funding for a CVD prevention programme, but there should be a plan together for when funding becomes available. There is debate across the system on how best to do that and how to allocate money.The area of biggest debate is around whether payment should be upfront or through a payment by results model and CW asked the Committee for their views as this could equally reduce or widen health inequalities across the patch.	

	Key discussion points: • EP agreed this needs to be done and in a collaborative way as it cannot just be delivered using Primary Care alone. However, Place is more of a collaborative concept and is not a provider so who the primary provider should be needs to be considered – perhaps the PCNs? EP also highlighted the potential risk of payment against results and that some upfront payment may need to be made to deliver the service so suggested a proportional payment model - perhaps 75% upfront with 25% payment on results. • RD wished to note that there is already a programme in place through NHS health checks so there would be a need to look at how a new service would fit with that and highlighted how the payment suggested is significantly different from that payment. RD also recommended thinking about the pathway and the use of community Pharmacy to be used not just for diagnosis, but for the management of a particular cohort of low risk hypertensives which would require some ICB work with the LPC. RD also mentioned that the opportunity of other interventions with lower level hypertensives should also be considered - looking at weight loss, exercise and smoking cessation and that action taken on those areas may mean that individuals may not be hypertensive and therefore may not need medication and could enter a period of monitoring through community Pharmacy. • EP acknowledged RD's comments but highlighted in the meeting chat that there are issues with community Pharmacy capacity. • ST raised that medication compliance should be a part of monitoring and reviewing patients in the community. • SH emphasized that prevention is a key focus here and building on RD's point, are we using current assets fully? Hypertension screening is currently not fully utilised so more could be done to maximize potential. There is a need to think about prescribing costs which are going up too. With regards to the payment debate, SH raised that there is a possibility of payment by results destabilising Contractors but acknowledged taht payment up front causes its own difficulties. • Clive Newman (CN) said that he would favour a long term contract with break points rather than a cost per case or item of service approach which would allow for innovative approaches, flexibility and would be a more strategic approach in line with the kind of long term condition strategic commissioning envisioned. • Lee Radford (LR) stated that he echoed many of the points made and that now is the time to enable the left shift and be looking at doing something differently without destabilising what is already happening. • EH raised that there needs to be absolute clarity on be really clear about what our priorities are, how they fit	

	together and how things that are related to one another could be brought together in a comprehensive way eg: Tobacco and CVD. EH agreed with other's comments on looking at what currently exists and highlighted that the NHS Health Checks aren't mentioned in the paper and yet it is a statutory requirement on Public Health to commission this. All GPs can deliver those health checks and there's much more we could do around community health checks now without waiting for funding. EH felt there needs to be clarity on what needs to be seen through this model and what proportion might be through traditional Primary Care and what might be around wider partnerships. • WG reported that he shared this paper with VCSE reps yesterday who were very supportive of it. There were comments around the distinction of who acts as provider at local level and developing a wider plan for what needs to be done. It may be possible for the local place Alliance partnership to deliver a proposal around what is done and by whom but that might be separate from who actually holds the money. WG noted that MA had asked in chat about what role the VCSE sector could play and that it could be the potential for VCSE to access hard to reach communities. WG felt that a payment by results model would exclude VCSE organisations from engaging with this as the risk would be too great. WG also highlighted there could be difficulties for organisations to engage with 8 or 9 Place alliances so that needs to be considered when looking at roll out. • CW confirmed that he was supported any scheme being delivered on a Place footprint. It is the geography which allows the tie up of the voluntary sector with the health service, with the health checks programme, with the Community and the other forms of support which are there. • TH asked in the meeting chat whether there is an option to pilot this in the most deprived PCNs. • SH responded to say that he didn't we need to pilot any other system in a very strong evidence base already. • EP highlighted the work of the Healthy Heart Hubs in Erewash which is already doing some of this work and extended an invitation to any members of the committee who would like to visit this project. It was agreed that the Committee were in favour of a Place based approach and that CW and his team would do an assessment on funding options and return to the committee at a later date with a favoured recommended option. *Post meeting note: this has been scheduled for the December meeting.*	

PHSCC/2425/91	**Gender Dysphoria** This was a confidential item so the minutes have been redacted.	
PHSCC/2425/92	**Update from the Health Protection Board** This was a confidential item so the minutes have been redacted.	
PHSCC/2425/93	**Research Strategy/Applied Research follow on discussion** CW confirmed that we are now moving into implementation phase of the strategy. The Research board is in place, has met and has decided that a key area of development is around developing an active research network. Driving the network will be a key focus of attention in order to bring more research into Derby and Derbyshire and resources alongside that.	
Items for information		
PHSCC/2425/94	**Monthly updates, minutes & bulletins:** • CPAG updates • Derbyshire Prescribing Group report/minutes • JAPC Bulletin • CPLG minutes • GP Strategy Update	
PHSCC/2425/95	**Living Well update** WG noted that this update presents a factual and positive view of the Living Well programme but highlighted that there is quite a lot of discontent in the VCSE sector with regards to Living Well and this is not reflected in this report. WG felt that we need to ensure that the wider perspective is considered within these reports. MA responded to say that this paper was tabled in response to confusion over Living Well in the last meeting and so was factual to show what Living Well is made up of. The paper does say it is not fully deployed everywhere and it is on MA's radar to have conversations about this.	
PHSCC/2425/96	**Primary Care Subgroup Report** This was noted as a confidential item but there was no discussion on the report as the contents are for Committee information only.	
Closing items		
PHSCC/2425/97	**Forward Planner** The Forward Planner was noted as read.	
PHSCC/2425/98	**Bi-Annual Committee Attendance Report** The Chair highlighted the report and said that he is aware that members cannot always attend every time and that there are	

	priorities elsewhere but does help if all people attend for richness of discussion.	
PHSCC/2425/99	**Assurance questions** • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? *Yes* • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? *Yes* • Has the Committee discussed everything identified under the BAF and/or Risk Register, and are there any changes to be made to these documents as a result of these discussions? *Yes, no due to changes to be made.* • Were papers that have already been reported on at another Committee presented to you in a summary form? *Yes* • Was the content of the papers suitable and appropriate for the public domain? *It was identified which were suitable and which were confidential.* • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? *Yes* • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? *No* • What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? *All items to be included on the ICB Board Assurance Report.*	
PHSCC/2425/100	**Any other business** None.	
DATE AND TIME OF NEXT STRATEGY MEETING		
Date: Thursday 14th November		
Time: 9am – 11.30am		
Venue: MS Teams		